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Spiritual Practices and Education of End-of-Life Care Professionals

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Abstract

The preponderance of research indicates that patients have spiritual needs at the end of life, and end-of-life professionals, especially documented with social workers and nurses, deal with spiritual issues frequently, including helping clients examine their beliefs about loss, assessing clients' religious/spiritual background, and helping clients use their spirituality as a coping mechanism. However, current literature shows that professional education often leaves spiritual interventions out of the curriculum, creating a gap in education and preparedness for field work. This study examined whether or not the inclusion of spirituality in professional education predicts the level to which members of different disciplines engage in spiritual care with their clients. An anonymous paper survey was disseminated to Smoky Mountain Home Health and Hospice staff and volunteers. This survey assessed multiple variables, including job title, length of time working in end-of-life care, spiritual practices with clients, and education regarding spirituality. Results of the survey were manually entered into SPSS and analyzed in order to examine the relationship between spiritual practices and spiritual education across professions. Understanding this relationship will enable volunteers and practitioners in the hospice field to provide holistic care to patients.

Introduction

Spirituality and end-of-life care are often inseparable, as it is the job of the hospice professional to provide holistic and person-centered care at the end of life. Patients at the end-of-life often deal with spiritual issues, including reflection on meaning and purpose in their life or religious themes, such as the after-life. Patients who are terminally ill express that they have greater spiritual needs than those who are not (Daaleman & VandeCreek, 2000). Patients at the end of life often use spirituality and religion as a tool to cope with the dying process and the uncertainty regarding the end of life (Callahan, 2009).

It is important to differentiate and define spirituality and religion. Spirituality is the way in which individuals seek to find and express meaning and purpose in life, as well as connection to others, the world, and the sacred, which can be more narrowly expressed through religion, which includes a system of values, systems, and beliefs (Duncan-Daston, Foster, & Bowden, 2016). The National Consensus Project Guidelines for Quality Palliative Care provides recommendations for spiritual care in hospice and recognizes it as a key component of quality care (Puchalski, 2008). However, in general, spirituality is less emphasized in the biopsychosocial model than other elements of assessment and care (Puchalski, 2008).

Patients at the end-of-life report having spiritual needs. In a 2011 survey involving patients at the end of life, researchers measured spiritual needs using the Spiritual Needs Inventory (Milligan, 2011). Patients were asked to what degree they experienced spiritual needs on a Likert Scale, with the aggregated scores on a range from 17-85. The mean score was 61.7 (Milligan, 2011). Additionally, Milligan (2011) found a negative correlation between unmet spiritual needs and quality of life. Other studies note that patients indicate that they have spiritual needs that they would like met that remain unmet by the current system of care (Puchalski,

2008). In a study done with a sample of 40 end-of-life patients who had either heart failure or liver cancer, patients identified their spiritual needs as identifying meaning and purpose. This study found that patients were often reluctant to bring up spiritual issues with health care professionals, but that they were willing to talk about them when engaged about spiritual needs (Murray, Kendall, Boyd, Worth, & Benton, 2004). It is important to note that while most authors writing about spiritual care write that all patients have spiritual needs, others hold that spirituality and spiritual needs should only be addressed by those who those who identify them as such. In other words, professionals should be using the language that the patients use (Walter, 2002).

Hospice professionals also report that they engage in spiritual discussion or practices with patients. In hospice settings, spiritual care is largely the job of the chaplains, however, due to the nature of the dying process, spiritual concerns are prone to arise at any time, and are central to treating the whole person (Callahan, 2009). Due to the frequency of nurse visits and the relationship they often form with patients, studies have shown that nurses often address spiritual concerns. In a study done of hospice nurses, participants reported that they approached spirituality with patients using a high level of professionalism, and just a few nurses were reticent to discuss spirituality at all. Many nurses reported that they used prayer as a tool to address spiritual needs of patients when it was appropriate (Belcher & Griffiths, 2005).

Similarly, social workers have the opportunity to address spiritual needs of patients in a hospice setting. In a review of literature examining the spirituality in practice not specific to hospice, authors found that social workers engage use spiritual interventions in the following ways: helping clients examine their beliefs about loss, assessing clients' religious/spiritual background, helping clients use their spirituality as a coping mechanism, referring to 12-step programs, and addressing spirituality with a significant other (Sheridan, 2009). As spirituality is

often a central piece of a person's identity, an important coping mechanism, and often connected with some form of support system, utilizing spiritual interventions is important. A study done with 62 hospice social workers indicated the importance of spirituality with clients. 87% of the social workers sampled said that spirituality was very important to the patients with which they worked (Wesley, Tunney, & Duncan, 2004). In addition to also engaging in the aforementioned practices, this study, specific to hospice, also indicated that social workers engage in the following interventions: "listening to patients discuss God or spiritual issues (93 percent), linking them to clergy (91 percent), and exploring the meaning of events in their lives (84 percent). The respondents noted praying for their patients (68 percent), praying with them as they prayed (60 percent), and, less frequently, leading them in prayer (25 percent)" (Wesley, Tunney, & Duncan, 2004). In another survey of 16 hospice social workers, the majority reported that spiritual issues frequently arose in their jobs, with several stating that they arose almost everyday (Duncan-Daston, Foster, & Bowden, 2016).

Even in light of the integration of spiritual care in practice, the formal training is often lacking in this area, citing professional boundaries or role confusion. When surveyed, patients said that the most important component of spiritual training was authenticity. Patients expressed that they would not be uncomfortable being asked spiritual questions, and it might enhance their care, but that it was important to them to be able to have control of the conversation and how much they shared (Yardley, Walshe, & Parr, 2009). In one study, nurses expressed that they needed more education on different religions, and 76% of the nurses said that they did not remember discussing spiritual issues in their professional education (Belcher& Griffiths, 2005). Another survey of hospice social workers indicated that they had the need for education in the following areas: assessment skills on spiritual issues (68%), spiritual histories (53 percent),

spiritual genograms (47%), and spiritual rituals (54%) (Wesley, C., Tunney, K., & Duncan, 2004). Due to the frequency of which hospice professionals engage in spiritual discussion, practices, and interventions with clients, not having sufficient training about patient spirituality is a significant gap in education. Not having competency in this area can lead primarily to two outcomes: hospice professionals incorporate spirituality into practice without training, which can lead to unmet needs or needs that are met in a biased way; or professionals can avoid issues relating to spirituality altogether and leave spiritual needs unmet until a chaplain becomes available. While other professionals shouldn't have to take on the entirety of the job of a chaplain, being able to meet spiritual needs as they arise is important.

This current literature indicates that patients have spiritual needs in hospice, and hospice professionals deal with spiritual issues frequently. However, professional education often leaves spiritual interventions out of the curriculum, leaving a gap in education and preparedness for field work. The research question that arises from this research is: Does the inclusion of spirituality in professional education predict the level to which members of disciplines engage in spiritual care for their clients? The purpose of this study will be to explore the integration of spirituality into professional practices among hospice practitioners, to examine the differences in spiritual practices with clients among different disciplines, and to assess to level to which spiritually sensitive practice was incorporated into their formal education or training.

This research will build upon research that has previously been done. The available research is regarding patient spirituality and whether or not professionals engage in spiritual practices with patients. This research examines whether or not there is a relationship between professional education regarding spirituality and spiritual engagement in practice. Furthermore, there is currently no research that includes hospice volunteers, which is a significant gap in

research. This research will examine the spiritual engagement of volunteers with clients. This research will examine the ability of volunteers and practitioners to provide competent and holistic care and in the hospice field. To this end, this research aims to: (1) Describe spiritual practices of professionals at an East Tennessee Home Health and Hospice agency (Smoky Mountain Home Health and Hospice) and (2) Test a relationship between profession, spiritual engagement, and spiritual education.

Methods

The measure was developed by the Principal Investigator and was based on spiritual practices and education common in the literature in order to measure the degree to which formal education influences engagement in spiritual practices with clients. The survey consisted of three question areas: General information (3 Q's regarding length of time in end-of-life care, frequency of visits, and job title), Spirituality in practice (8 Q's regarding different types of spiritual practices), and Education/formal training (4 Q's regarding the level to which formal education and training incorporated spirituality). Key study variables included: education regarding spirituality, profession, and engagement in spiritual practices. For the purposes of this research, spirituality was defined as "the way individuals seek and express meaning and purpose and the way they experience connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Duncan-Daston, Foster, & Bowden, 2016). Types of spiritual engagement measured were: referral to spiritual leader, engagement about purpose or meaning in life, assessment of spirituality, spirituality as a coping mechanism, engagement in conversation about death, and engagement in practices (ie. prayer, meditation, songs, scripture reading). The section regarding formal education on spirituality asked whether or not formal education for the respondent's current position incorporated spirituality, encouraged spirituality, discouraged

spirituality, and incorporated training on spirituality with regard to diverse spiritual populations. Most questions were measured on a Likert scale, ranging from strongly disagree to strongly agree or never to always.

Upon IRB approval, the measure was distributed in the form of an anonymous paper survey to all Smoky Mountain Home Health and Hospice staff. While this agency has seven offices, all employees were required to attend one of two education days. The survey with an altered informed consent was given on both days during an allotted time. A Smoky Mountain Home Health and Hospice staff member read a script prepared by the Principal Investigator, and the Principal Investigator was not present during data collection. The staff member was only able to read the script; they were not be able to answer questions regarding the survey. Similarly, surveys with altered consent form were given to volunteers during the March monthly meetings at each office, which vary in time and days for each office. The data was entered into SPSS by the Principal Investigator and analyzed using bivariate statistics to analyze correlations between variables and one-way ANOVA tests to compare means of spiritual engagement and spiritual education.

201 surveys were returned, and 180 surveys met inclusion criteria. In order to be analyzed, respondents must have indicated that they saw clients at least once per month. The sample characteristics are broken down by profession: Nurse (n=53, 29.4%); Social Worker (n=11, 6.1%); Home Health Assistant (n=33, 18.3%); Community Educator: (n=9, 5.3%); Admin Staff and Office Manager (n= 18, 10%); Chaplain (n=10, 5.6%); Volunteer (n=17, 9.4%); (Other n=29, 16.1%). The mean number of years in end-of-life care was 7.42 years.

Results

Spiritual Engagement

A majority of professionals and volunteers who met inclusion criteria of seeing clients at least once per month indicated that spiritual matters arise in their interactions with clients. 61% stated that spiritual matters often or always arise, and 29% stated that spiritual matters sometimes arise. 10% stated that spiritual matters never arise with clients. Chaplains were the most likely to say that spiritual matters arise in their interactions with clients, followed by nurses, home health assistants, and social workers respectively. 88.3% of respondents said that they agreed that it was their professional responsibility to address spiritual needs.

Types of spiritual practices measured are as follows, with respect to the order of likelihood to engage in the practice, measured by the mean score of each: (1) Refer to spiritual leader, (2) Engage about purpose or meaning in life, (3) Assess spirituality, (4) Help clients utilize spirituality as a coping mechanism, (5) Engage in conversation about death, and (6) Engage in practices (ie. prayer, meditation, songs, scripture reading). Figure 1 shows the percentage of respondents who indicated that they engaged in various types of spirituality with clients.

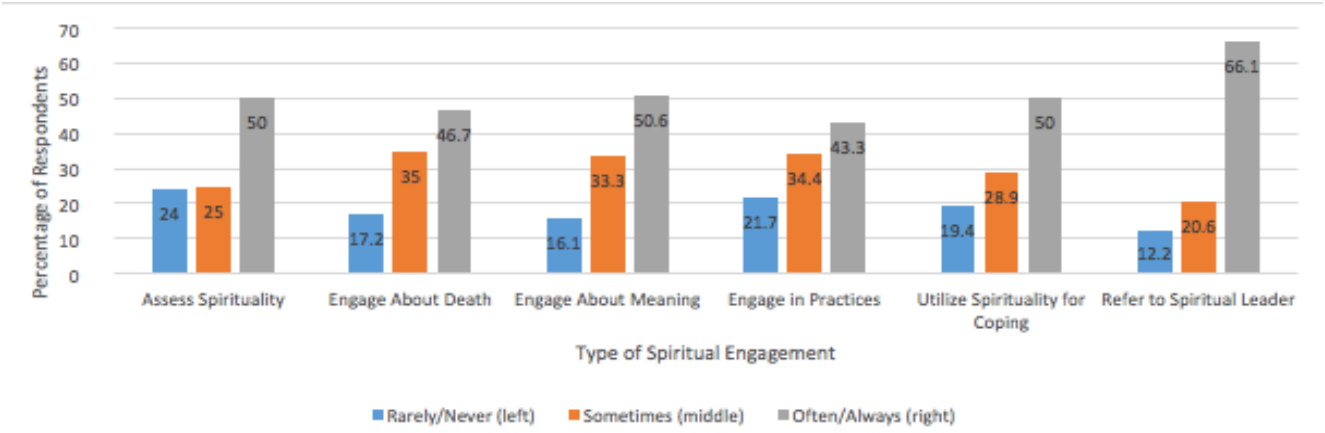

Figure 1. Type of Spiritual Practice. This graph shows the percentage of respondents who engaged in various types of spiritual activities with clients.

Forms of spiritual engagement vary by profession. Table 1 shows the top two forms of spiritual engagement by profession.

Profession	Top Two Types of Spiritual Practice
Nurse	(1) Refer to chaplain, (2) assess spirituality
Social Worker	(1) Assess spirituality, (2) engage in conversations about death
Home Health Assistant	(1) Refer to spiritual leader, (2) engage in conversation about purpose
Community Educator	(1) Refer to spiritual leader, (2) engage in practices
Administrative Staff/Office Manager	(1) Refer to spiritual leader, (2) Utilize spirituality as coping mechanism
Chaplain	(1) Assess spirituality, (2) engage in practice
Volunteer	(1) Engage in practice, (2) Engage in conversations about death
Other	(1) Refer to spiritual leader, (2) utilize spirituality

Table 1. Top two forms of spiritual engagement by profession

On a scale of 1-5 (1 indicating never having spiritual engagement with clients to 5 indicating always), professions reported spiritual engagement in the following order: (1) chaplain, (2) social worker, (3) nurse, (4) home health assistant, (5) community educator, (6) administrative staff, (7) Volunteer, (8) Other. There were found to be significant differences of the mean of spiritual engagement among professions, as determined by one-way (ANOVA $F(7,168)=4.027$, $p<.0001$). Chaplains' spiritual engagement was significantly higher than all other professions besides social work. The mean of social workers' spiritual engagement with clients is significantly higher than all other professions excluding chaplains and nurses. Nurses were significantly more likely to engage in spiritual practices than Administrative Staff, Volunteers,

and "Other." Besides the category "other," volunteers had the lowest level of spiritual engagement with clients, significantly lower than nurses, chaplains, social workers, and home health assistants.

Spiritual Education

This research also aimed to measure the formal training or education received by professionals regarding spirituality. 72.2% agreed that their formal education addressed spirituality. In this data set, there was a positive correlation between education regarding spirituality and spiritual practice with clients ($r=0.545$, $p<.0001$). On a scale of 1-6 (1 indicating strongly disagree that education incorporated spirituality to 6 indicating strongly agree), professions reported formal training on spirituality in the following order: (1) chaplain, (2) nurse, (3) social worker, (4) home health assistant, (5) community educator, (6) volunteer, (7) administrative staff, (8) other. Chaplains, social workers, and nurses were the top three professions to report spiritual engagement with clients and also the top three professions to report spiritual education in regard to spirituality. Chaplains were the highest in both spiritual education and spiritual engagement. Social workers were the second highest in spiritual engagement but the third highest in spiritual education. Likewise, nurses were third most likely to report engaging in spiritual practice and second most likely to report that their formal education incorporated training on spirituality. There are significant differences in the mean spiritual education among professions, as determined by one-way ANOVA ($F(7,168)=8.817$, $p<.0001$). Chaplains' education was significantly higher than all professions other than social work. Nurses' spiritual education was significantly higher than Community Educators, Administrative Staff, Volunteers, and "Other." Figure 2 depicts the means of spiritual education and spiritual practice by profession.

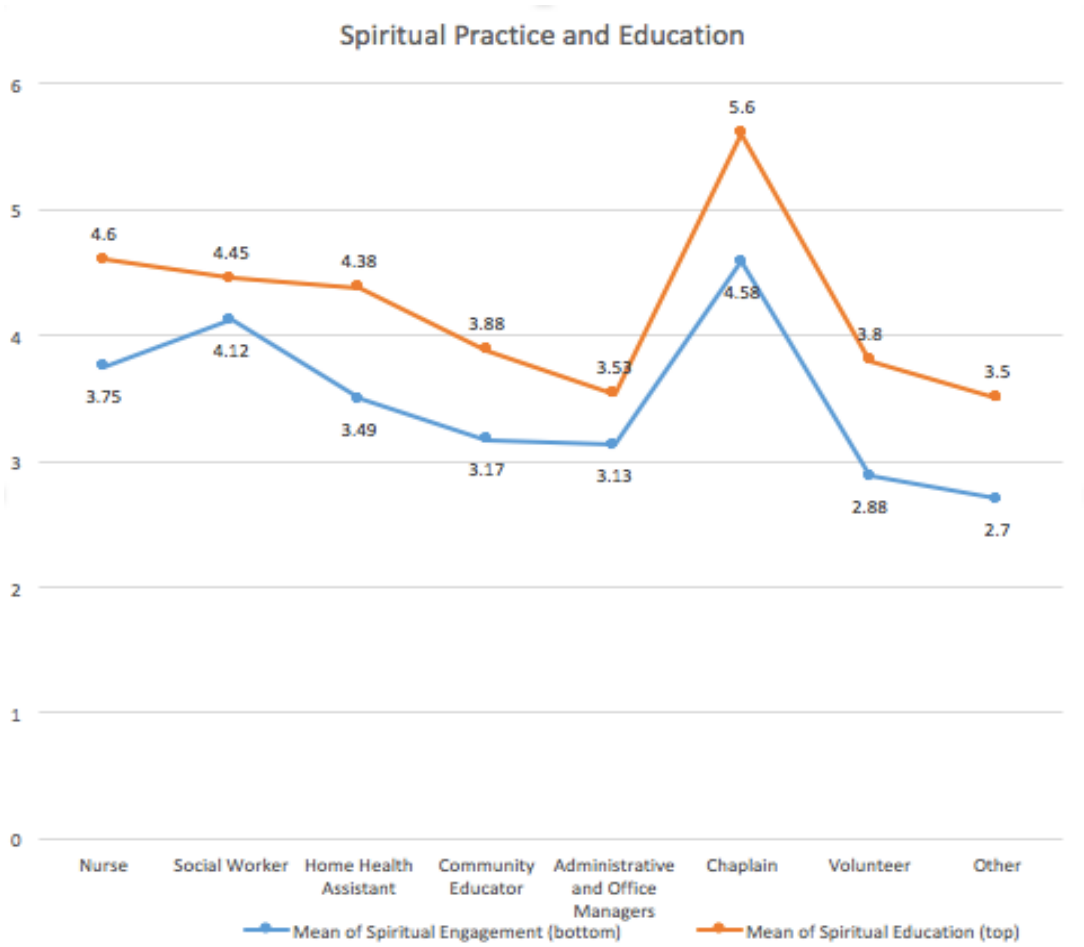

Figure 2. Spiritual Practice and Education. This figure shows the mean of spiritual education (measured on scale of 1-6) and spiritual engagement (measured on scale of 1-5) by profession.

Discussion

The findings offer insight into practices and education of end-of-life care professional but must also be examined with regard to the study's limitations. The external validity of the study is limited, as the study was done with one East Tennessee home health and hospice agency with religious undercurrents present in the organizational culture. Therefore, the ability to generalize the data is limited. Additionally, validity and reliability of the measure still remain to be verified.

Despite the limitations, this research indicates that spiritual matters arise in end-of-life care professionals' interactions with clients, which supports the consensus of current literature.

Spiritual practices vary by profession, and chaplains, social workers, and nurses are the most likely to report engaging in spiritual practices and having formal education regarding spirituality. It is notable nurses in this data set reported that they had more education than social workers on spiritual matters, they reported lower levels of spiritual engagement than social workers. The difference in means was not significant, which could be attributed to the small sample size of social workers, but this is an area for future research. Additionally, home health assistants noted that spiritual matters arise in interactions with clients more social workers but were less likely to engage in spiritual practice or have formal education or training on spiritual matters. They were also less likely to report that they felt like addressing spiritual needs was their professional responsibility. Volunteers were the least likely category (excluding "other") to report spiritual engagement and education. This could be attributed to the fact that administrative and direct care volunteers were not separated (as long as the administrative volunteers had contact with clients at least once per month). It is interesting to examine this finding in the context of the role of the volunteer. Volunteers' roles are more flexible than those of professionals', which in this case led to less reported spirituality with clients rather than more, perhaps because it is not outlined as a professional obligation. However, volunteers were the only category to indicate that engaging in spiritual practice (such as songs, prayer, meditation, etc.) was the most common form of spirituality in practice, which shows flexibility in the role of volunteers as opposed to other professions.

In this data set, there is a correlation between formal education and the extent to which professionals engage in spiritual care. As spiritual matters arise with clients, it is important that professionals are educated so that spiritual needs are met, and this shows that as training increases, so does spiritual engagement. This being said, proselytizing should not be done in a

professional setting and bias should be avoided to the greatest extent possible. Considering that a majority of professionals who interact with clients at least once per month state that spiritual matters arise with their clients and most also say that it is their professional responsibility to address spiritual needs, the way spirituality is addressed in practice should be closely examined. Appropriate protocol should be in place, and education should include spiritual interventions. This is especially pertinent for social workers and volunteers who did not indicate that their most common form of spiritual intervention is referring to a spiritual leader. Training should be specialized for certain professions especially. For example, social workers engage in assessment most commonly, so training on gathering this information in a sensitive and effective way is critical for this profession.

Spirituality in practice is a fine ethical line. On one hand, incorporating spirituality to meet client needs is a standard set forth by National Consensus Project Guidelines for Quality Palliative Care state that spirituality is an important component of care, while on the other hand, incorporating spirituality in an inappropriate way or without proper training is an ethical violation. Implications for practice include the development of protocol and evidence-based practice for professionals engaging in spiritual care and referral to spiritual leaders. While meeting all client needs is important, it is also key that training addresses professional boundaries to avoid role confusion or dual relationships.

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