Abstract: Further improvement of spiritual care in palliative care is warranted. Particularly reducing barriers and enhancing spiritual care competencies among the healthcare professionals is needed. The aim was to develop a training course in spiritual care in close collaboration with patients and staff from two Danish hospices. We applied an action research design to ensure that the training course was rooted in everyday practice of patients and staff. The methodology applied was based on philosophical hermeneutics and existential phenomenology. The action research process enabled the division into three topics on how a training course can reduce barriers towards spiritual care among the healthcare professionals. These three topics functioned as a theoretical framework for educating staff at a hospice in spiritual care. The three topics were: (1) the vulnerable encounter; (2) self-reflection concerning spiritual needs, thoughts, beliefs, and values; and (3) shared professional language for spiritual care. We operationalized the three topics into a flexible course design that could be adaptable to the practical possibilities and limitations of the individual hospice. The curriculum includes theoretical teaching, reflection exercises, and an improvisation theater workshop with professional actors. Educating staff led to the improvement of spiritual care at the hospices involved in the study.

Keywords: spiritual care; hospice; training course; action research; palliative care; Denmark

1. Introduction

International research has shown that life-threatening illness often leads to an increase of spiritual needs, and these intensify in line with the severity, progress, and prospect of imminent death (Jones et al. 2010; Thune-Boyle et al. 2006). The same trend is found in Denmark, where a questionnaire study from 480 Danish patients from Rigshospitalet in Copenhagen investigated the relationship between patients’ health and their existential, religious, and spiritual practices. Positive correlations between the severity of disease and religious, existential, and spiritual thoughts and practices were found (la Cour 2008). Another Danish study among dying patients at a hospice found that patients’ thoughts about religious faith and a longing for spiritual support intensifies in the last part of life (Moestrup 2015). A third Danish study with patients in hospice also supports that people at the end of life often turn to a transcendent reality for support (Stimpel and Raakjær 2017). International studies show that caring for patients’ spiritual needs can increase the quality of life of seriously ill and dying patients in the last part of life (Balboni et al. 2010; El Nawawi et al. 2012).

Caring for the spiritual needs of patients as a part of healthcare through spiritual care has become a growing focus in international healthcare research (Nissen et al. 2020; Blaber et al. 2015). Both in Denmark and internationally, spiritual care has been highlighted over the past decade as an important part of palliative care, just as it is an explicitly formulated area of focus (Best et al. 2020; Sundhedsstyrelsen 2017). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in the United States has stipulated
that spiritual care should be included in medical and nursing education (Hodge 2006). The EPICC (Enhancing Nurses’ and Midwives’ Competence in Providing Spiritual Care through Innovative Education and Compassionate Care) Network exists to promote evidence-based spiritual care education and practice across Europe and beyond (EPICC 2021). Alongside physical, mental, and social pain, WHO defines spiritual pain as one of the four specialized health attention areas in their definition of total pain in palliative care (WHO 2014; Paal et al. 2019). The importance of spirituality in a holistic understanding of health care is broadly recognized among health care professionals (Timmins et al. 2014; van Leeuwen et al. 2006; van de Geer et al. 2017; Ross et al. 2016; Harrad et al. 2019). However, the conceptualization of spirituality and the health care professionals’ role in providing spiritual care are being contested (van Leeuwen et al. 2006). There is no international unified understanding of the concept of ‘spirituality’, nor is there a unified understanding of how this concept relates to health care (Niessen et al. 2020). The different conceptualizations of spirituality in the nursing literature have been emphasized (McSherry et al. 2004). Van Leeuwen and Cusveller (2004) describe spirituality as the religious and existential mode of human functioning, including experiences and the questioning of meaning and purpose. This understanding reflects the view that human beings express their common function of spirituality in different forms and content (van Leeuwen and Cusveller 2004). For this study, we applied the definition of spirituality and a concept of spiritual care of the European Association for Palliative Care (EAPC): spirituality is “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 to the sacred”. Spiritual care encompasses caring for the patients’ existential challenges (e.g., questions concerning identity, meaning, suffering and death, guilt and shame, reconciliation and forgiveness, freedom and responsibility, hope and despair, love and joy), value-based considerations and attitudes (e.g., what is most important for each person, such as relations to oneself, family, friends, work, aspects of nature, art and culture, ethics and morals, and life itself), and religious considerations and foundations (e.g., faith, beliefs and practices, the relationship with God or the ultimate) (Best et al. 2020).

Despite the recognition of spiritual care in health care, international research has clarified that the care for patients’ spiritual pain and needs in palliative care is the most under-developed and overlooked (Mako et al. 2006; Delgado-Guay et al. 2011; Gijsberts et al. 2019). This also seems to be the case in Denmark, which is considered one of the least religious nations in the world (Zuckerman 2008), where even religious Danes exhibit a high degree of individualized and private spirituality (Viftrup et al. 2017; Viftrup et al. 2016). A recent Danish study points to a lack of spiritual and existential vernacular in Danish Health Care for expressing and caring for patients’ spiritual needs and concerns (Viftrup et al. 2020a). Studies find that patients at the end of life do not experience their spiritual needs are being sufficiently met by the healthcare professionals responsible for their treatment and care (Balboni et al. 2013). Although current research findings reflect that spiritual care is integral to the discipline of nursing, implementation of spiritual care still remains a neglected area of practice (Murray and Dunn 2017). It seems that spiritual care is difficult to integrate as a part of daily health care and disease management (Straßner et al. 2019). Furthermore, there is confusion about the role of nurses in relation to spiritual care (Narayanasamy and Owens 2001).

Research suggests that the barriers for providing spiritual care among the healthcare professionals stem from inadequate knowledge and education on spiritual care, lack of self-reflection, understanding of the spiritual needs of patients as well as professional shyness when facing spiritual themes in conversations with patients (Boston et al. 2011; Lundmark 2006; Assing Hvidt et al. 2016; Assing Hvidt et al. 2017). This is in line with Van Leeuwen and Cusveller (2004) who described three domains of nursing competencies for spiritual care: (1) self-awareness and communication, (2) spiritual dimensions in the nursing process, and (3) quality assurance and expertise development on spiritual
care. The EPICC project brought together leading nursing and midwifery educators and practitioners from 21 countries. Based on an evaluation of best practice across Europe, an innovative and creative approach to the teaching of spiritual/person-centered care was put forward: the EPICC Spiritual Care Education Standard (McSherry et al. 2021). The ‘EPICC Standard’ details a table of four key spiritual care competencies. For every competence, the learning outcomes are described in aspects of knowledge (cognitive), skills (functional), and attitudes (behavioral). The competencies are: (1) intrapersonal spirituality (focus on the importance of spirituality on health and well-being); (2) interpersonal spirituality (involves engaging with patients’ spirituality, acknowledging their unique spiritual and cultural worldviews, beliefs, and practices); (3) spiritual care: assessment and planning (concerns assessing patients’ spiritual needs and resources using appropriate formal or informal approaches, and plan spiritual care, maintaining confidentiality, and obtaining informed consent); and (4) spiritual care: intervention and evaluation (involves responding to patients’ spiritual needs and resources within a caring, compassionate relationship).

Studies summarized in two systematic reviews published in 2015 and 2021 suggest that education and training in spiritual care led to “increased levels of competency across intrapersonal spirituality, interpersonal spirituality and spiritual assessment and interventions” (Paal et al. 2015; Jones et al. 2021). A Danish study on the development and evaluation of a course program in existential communication targeting general practitioners likewise showed a significant increase in the participants’ assessed self-efficacy in relation to communicating about spiritual issues and concerns with their patients (Assing Hvidt et al. 2018). A pretest–posttest study on a spiritual care educational workshop for nurses found a statistically significant increase in nurses’ knowledge, self-awareness, and abilities regarding spiritual care practices after the educational workshop (Murray and Dunn 2017).

In order to further improve spiritual care in palliative care in Denmark, we decided to develop a training course in spiritual care at hospices in Denmark. The primary diagnosis for the vast majority of hospice patients is cancer where they are in the terminal phase of their life, and most hospice patients are older (>65 years) (Sundhedsstyrelsen 2011). Therefore, hospices seem like an ideal setting for the study.

The aim of this study was thus to improve spiritual care at hospices in Denmark by developing a training course in close collaboration with patients and staff at two specific hospices. The focus is to explore how a training course can reduce barriers and improve spiritual care competencies among the healthcare professionals and then implement this course at hospices in Denmark.

2. Methods and Data

In order to integrate the perspectives of both patients and staff at hospices and to develop a training course in spiritual care through involvement and collaboration with patients and staff, we applied an action research design for this study. The aim of action research is to improve practice through open, experimenting, collaborative research processes that facilitate new insights and knowledge, and the research ideal of action research is to have an equal and reciprocal relation between researchers and field of practice (Eikeland 2012; Hansen 2016). By using an action research design, we ensured that the training course was rooted in everyday practice of patients and staff at hospices. Studies have shown that participant involvement increases the quality of research and results in greater participant motivation (De Vito Dabbs et al. 2009). The methodology was based on philosophical hermeneutics (Gadamer [1960] 2004; Heidegger [1927] 1962) and existential phenomenology (Logstrup 1997; Merleau-Ponty 1968), which has been positively applied together with action research in other studies concerning death and dying (Hansen 2016). An action research method was considered an apt choice for a study aiming at close collaboration with patients and staff at hospices in developing a training course in spiritual care.
2.1. Data Generation

The data generation consisted of a combination of the two elements of action research: reflection-on-praxis and action-in-praxis (Laursen 2014; Viftrup et al. 2021) combined with the qualitative research methods of observations, semi-structured single interviews, and focus-group interviews (Creswell 2013; Green and Thorogood 2004; Liamputtong 2011; Halkier 2016; Kvale and Brinkmann 2009). The action research project and data generation occurred during the period April 2017 to November 2018. Reflection-on-praxis is a ‘mirror’ method where the researchers reflect their observations and perceived understandings of practice together with actors embedded in practice (Kildedal and Laursen 2014). The focus for this study was how a training course could reduce barriers towards spiritual care. Based on the knowledge and understanding gained from the reflection-on-praxis, the researcher implemented an action-in-praxis with the hospice staff. Action-in-praxis is an experiment or intervention where praxis-oriented knowledge and change are facilitated (Laursen 2014).

2.2. Participants

The project began with the first author being a participating observer at hospice: for two months (April and May 2017) with 20 h per week she participated in the everyday life at the hospice, being in dialogue with the research field; patients, relatives, staff, and different situations with patients. She made different observations and wrote fieldnotes on her reflections about spiritual care in practice at the hospice.

Hospice staff were strategically selected based on desire to obtain variation within age and experience, as they were they were a homogeneous group in terms of gender and disciplines. Based on ethical concerns, patients should fulfil inclusion and exclusion criteria. Patients characteristics are presented in Table 1. The inclusion criteria were: patients at the hospice. They should volunteer freely to participate after receiving thorough information about the study. The exclusion criteria were: persons suffering from a distorted perception of reality, severe cognitive or memory problems, or people who recently (i.e., within the past 0–4 weeks) had been suicidal.

Table 1. Patient characteristics.

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Gender</th>
<th>Dominating Cancer Type</th>
<th>Marital Status</th>
<th>Time Since Terminal Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>65</td>
<td>Female</td>
<td>Kidneys, liver</td>
<td>Single</td>
<td>3–4 months ago</td>
</tr>
<tr>
<td>2.</td>
<td>67</td>
<td>Male</td>
<td>Leukemia</td>
<td>Married</td>
<td>6–8 weeks ago</td>
</tr>
<tr>
<td>3.</td>
<td>75</td>
<td>Female</td>
<td>Stomach</td>
<td>Widowed</td>
<td>3 months ago</td>
</tr>
<tr>
<td>4.</td>
<td>72</td>
<td>Female</td>
<td>Lungs/breast</td>
<td>Widowed</td>
<td>2.5 months ago</td>
</tr>
<tr>
<td>5.</td>
<td>65</td>
<td>Male</td>
<td>Leukemia</td>
<td>Single</td>
<td>3 weeks ago</td>
</tr>
<tr>
<td>6.</td>
<td>69</td>
<td>Male</td>
<td>Lung cancer</td>
<td>Married</td>
<td>8–9 weeks ago</td>
</tr>
<tr>
<td>7.</td>
<td>62</td>
<td>Male</td>
<td>Lung cancer</td>
<td>Widowed</td>
<td>6–8 months ago</td>
</tr>
<tr>
<td>8.</td>
<td>69</td>
<td>Female</td>
<td>Breast cancer</td>
<td>Cohabitating</td>
<td>Approx. 2 years ago</td>
</tr>
<tr>
<td>9.</td>
<td>66</td>
<td>Female</td>
<td>Stomach cancer</td>
<td>Married</td>
<td>6 weeks ago</td>
</tr>
<tr>
<td>10.</td>
<td>71</td>
<td>Female</td>
<td>Leukemia</td>
<td>Divorced</td>
<td>2–3 months ago</td>
</tr>
<tr>
<td>11.</td>
<td>32</td>
<td>Female</td>
<td>Bones, lungs</td>
<td>Married</td>
<td>6–8 Months</td>
</tr>
<tr>
<td>12.</td>
<td>29</td>
<td>Female</td>
<td>Bones, blood</td>
<td>Single</td>
<td>3–4 Months</td>
</tr>
</tbody>
</table>

2.3. Interviews

The first author conducted 12 semi-structured interviews with patients and three focus-group interviews with staff as a reflection-on-praxis based on her observations and field notes. The action-in-praxis was structured as six focus-group interviews with the
hospice staff over a period of six months, where the researcher facilitated discussions and initiatives on how to improve spiritual care at the hospice and involved the staff in developing and testing a training course in spiritual care. Interviews topics and examples of questions are presented on Table 2. She conducted the individual interviews with 12 patients using a semi-structured interview-guide. These interviews took place in the patients’ own rooms at the hospice and lasted between 19 min and 56 min (36 min on average). All in all, nine focus-group interviews with hospice staff with 6–10 participants in each group were conducted (three reflection-on-praxis and six action-in-praxis). The length of each focus-group interview ranged from fifty-seven minutes to one hour and forty-five minutes (one hour and twenty-two minutes on average). We applied a selection strategy for attaining ‘maximum variety’ and group sizes where the participants would feel comfortable sharing their perceptions and experiences of spiritual care, as well as engaging in interactions and discussions with other participants (Halkier 2016). The first author moderated the focus groups using a moderator guide.

Table 2. Interview topics and examples of questions.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The spiritual care needs of patients</td>
<td>Will you explain to me what concerns you the most these days?</td>
<td>Spiritual self-reflection</td>
<td>Would you consider personal spirituality important?</td>
<td>Participating in spiritual self-reflection exercise</td>
<td>How did you experience the spiritual self-reflection exercise?</td>
</tr>
<tr>
<td>What does it feel like, for you, to be in your situation (here at the end of life)?</td>
<td></td>
<td></td>
<td>Do you often think about your own spiritual needs, thoughts, beliefs, and values?</td>
<td></td>
<td>Did the spiritual self-reflection exercise affect your spiritual care practice? (Follow up: How?)</td>
</tr>
<tr>
<td>How can the staff best care for you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Do you think those thoughts affect your spiritual care practice? (Follow up: How?)</td>
</tr>
</tbody>
</table>

2.4. Subsequent Process

All interviews were recorded and transcribed verbatim in an anonymized way, with only gender appearing, after which audio files were deleted. The content of the sentences was weighted in the transcripts; speech sounds and repetitions emanated, while pauses and expressions of emotion were included, so that interviews emerged with an understanding of participants’ experiences and meanings about spiritual care. The first and last author was involved in establishing relationships with the research field, designing the study, and coding and discussing the data. Furthermore, the staff at the hospice participated in validating and interpreting data. In an action research study with multiple stakeholders, it is important to keep awareness of the different motivations, interests, and goals of researchers and practice field for conducting the study, as well as personal beliefs, values, and preconceptions. These were written in notes during the different aspects of the research process and discussed between the authors.

2.5. Ethical Considerations

Before giving their consent to participate in the study, patients and staff were informed about the purpose of the study both orally and in writing. They were informed that participation was voluntary, and they could withdraw from the study at any time, just
as all personal data would be made anonymous. Only the name and location of the two hospices have not been anonymous. The ethical implications of the different aspects of the research process were regularly discussed between the authors, particularly the distinctive ethical implications for patients at a hospice. The study follows the standards for good research practice of the Danish Cancer Society, version 12.12.2011 (Danish Cancer Society 2011) and meets the criteria for ethical guidelines for nursing research of the Nordic Nurses’ Federation (Northern Nurses’ Federation 2003). The project was registered at SDU Research & Innovation Organisation (RIO) (registration number 10.467) and carried out in accordance with the instructions of the RIO and Danish legislation on personal data.

2.6. Rigor and Trustworthiness

During the data generation process, the researchers evaluated the rigor and trustworthiness of the study by Lincoln and Guba’s criteria for qualitative research (Lincoln and Guba 1985). Credibility was established through prolonged engagement, persistent observation, peer debriefing, and member-checking, which are techniques that are embedded in the present action study design. Transferability was established through thick descriptions of data. Dependability and confirmability were upheld by reflexivity, as well as involving external audits of authors not involved in the research process. Furthermore, the editors of The Handbook of Action Research, Reason and Bradbury (2001), describe six underlying principles for action research: (1) Grounded in lived experience? (2) Developed in partnership? (3) Addressing significant problems? (4) Working with, rather than simply studying, people? (5) Developing new ways of seeing/theorizing the world? (6) Leaving infrastructure in its wake? (Cf. 1) This was sought throughout the study by keeping the lived experience of the participants central. (Cf. 2) The understandings and knowledge were gained from close collaboration between research and practice at hospice. (Cf. 3) The problem addressed in the study concerned optimizing care for dying patients. (Cf. 4) This was kept by close collaboration with participants as well as involving them in all facets of the study. (Cf. 5) Knowledge gained from the study was applied in praxis by the staff. (Cf. 6) The present study aimed at implementing lasting change at the hospices involved as well as influencing future policies for spiritual care (Bradbury and Reason 2003; Reason and Bradbury 2001).

2.7. Data

When analyzing the data, the methods of action research were combined with philosophical hermeneutics (Gadamer [1960] 2004; Heidegger [1927] 1962) and existential phenomenology (Løgstrup 1997; Merleau-Ponty 1968) and a thematic analysis was applied (Braun and Clarke 2006). This analytic approach has been positively applied together with action research in other studies concerning death and dying (Hansen 2016). The process from initial themes to the three topics is presented in Table 3. Initially, the first and last author would thematically analyze the interviews stemming from the reflections-of-praxis (12 interviews with patients and three focus-group interviews with staff): the researchers would read and reread the interview transcripts in order to become familiar with the dataset. The researchers wrote comments attempting to summarize or paraphrase, make associations or connections, and make preliminary interpretations. Each researcher did this individually. Then transcripts were closely read, while we wrote comments in the text where the participants expressed particular experiences and meanings about spiritual care. Hereafter, transcripts were reread and comments from each interview reworded into initial themes across all interviews. These initial themes were presented to the staff during action-in-praxis where they were interpreted and validated. Furthermore, during action-in-praxis with the hospice staff, different aspects of a training course in spiritual care were discussed, elaborated, and developed. The training course in spiritual care compounded different aspects that were tested with the staff at both hospices after which action-in-praxis again were performed. Thereby, analyzing and interpretation of data was an ongoing process in close collaboration between researcher and hospice practice. This
data-generating process resulted in a training course which will be presented after the analysis.

Table 3. The action research process: from initial themes to the three topics.

<table>
<thead>
<tr>
<th>Phases</th>
<th>Action Research Activity</th>
<th>Examples of Different Initial Themes/Three Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Observations + field notes</td>
<td>Medical paradigm, dignity, medical vs. spiritual language, spiritual needs, religious beliefs, relational aspects of care, self-care, relatives-care, etc.</td>
</tr>
<tr>
<td>2.</td>
<td>Reflection-of-praxis: 12 interviews with patients + 3 focus-group interviews with staff at hospice</td>
<td>Individual spiritual concerns, patients’ meaning-making, patients’ perspective on dignity and care, spiritual loneliness, embodied vs. verbal spiritual care, etc.</td>
</tr>
<tr>
<td>3.</td>
<td>Authors analyze data</td>
<td>Authors analyze data</td>
</tr>
<tr>
<td>4.</td>
<td>Action-in-praxis: Testing of course material + six interactive focus-group interviews with staff at hospice</td>
<td>Patients and staff both feeling vulnerable, personal spirituality of both patients and staff, multiple spiritual care, training spiritual dialogue.</td>
</tr>
<tr>
<td>5.</td>
<td>Authors analyze data</td>
<td>Validation and interpretation of themes with staff at hospice + discussing the framework for a flexible course design</td>
</tr>
<tr>
<td>6.</td>
<td>(1) The vulnerable encounter, (2) self-reflection concerning spiritual needs, thoughts, beliefs, and values, and (3) shared professional language for spiritual care.</td>
<td></td>
</tr>
</tbody>
</table>

3. Results

The action research process enabled the division into three topics, on how a training course can reduce barriers towards spiritual care among the healthcare professionals. These three topics functioned as a framework for a flexible course design for improving spiritual care at hospices in Denmark. These topics were developed and validated in close collaboration with patients and staff at the two hospices involved in study. The three topics comprised: (1) the vulnerable encounter; (2) self-reflection concerning spiritual needs, thoughts, beliefs, and values; and (3) shared professional language for spiritual care. First, we present the analysis of the three topics of the framework. Then, secondly, we present how the action research process led to a notion about a flexible framework for the course design, and thirdly, we present the curriculum developed in collaboration with the staff at hospices.

3.1. Topic 1: The Vulnerable Encounter

The topic of the vulnerable encounter is about how patients’ needs for spiritual care involve a high degree of relational vulnerability. The patients are in a vulnerable situation, but staff may also feel vulnerable when relating to patients. During the interviews with patients during the second phase, we found addressing patients’ spiritual needs and issues often involve a high degree of sensitivity from the healthcare professionals. When discussing this during action-in-praxis in the fourth phase, staff explained how it often is unclear when and whether the spiritual care provided is sufficient and effective. They compared this vulnerability to providing physical care. One staff member for example said: “When providing pain relief, I can tell that it works . . . patient feels better right away . . . I feel more insecure when it comes to this (spiritual care)”. Another staff member explained how
her feelings of vulnerability were caused by wanting to give the right care: “... But I am worried that I might hurt the patient ... if I ask the wrong question or take his hand and he doesn’t want that [ ... ] I need to know that I am doing the right thing”. It seemed that the vulnerability of the encounter between patients and healthcare professionals is experienced both ways when it comes to spiritual care.

During this fourth phase of action-in-praxis it was discussed how healthcare professionals must train being relationally present in the vulnerable encounter if they are to provide spiritual care for patients, as it is much harder for staff to handle their own vulnerability than the patients’.

The importance of strengthening the staff’s relational abilities to be present in the vulnerable encounter is a good example of how the training courses in spiritual care should have a different character than many other kinds of healthcare courses. When training the vulnerable encounter, the focus is not on providing a solution to the patient’s spiritual pain and suffering, because there is no medical treatment for that. Instead, the vulnerable encounter is about being present with the patient in his or her situation, together with the patient, and often without “fixing” things. During the action-in-praxis of the fourth phase it was discussed how being relationally present actually relieves patients’ pain and increases quality of life. The healthcare professional should be present in this two-way vulnerable relationship while caring and listening for the patient’s spiritual needs. However, these relational qualities do not stem from a medical and solution-focused paradigm, in which healthcare professionals are primarily trained. During action-in-praxis, the hospice staff pointed out that healthcare professionalism and a ‘relational compassion’ have to go hand in hand if they are to succeed in relieving the patients’ spiritual suffering and needs. A staff member explained: “To be professional in that situation (when caring for patients’ spiritual needs) means to be both medically trained and to be a human being, a fellow human being ... ”.

During this action research process where staff were involved in developing and implementing a training course in spiritual care, staff also changed their personal understanding of the vulnerable encounter from being a barrier for providing spiritual care to a condition for spiritual care practice which they believed they could handle if trained.

3.2. Topic 2: Self-Reflection Concerning Spiritual Needs, Thoughts, Beliefs, and Values

Topic 2 is related to the vulnerable encounter. During the second phase of the research process, we found that staff’s self-reflection on their own spiritual needs, thoughts, beliefs, and values would positively affect their ability to be relationally present in the vulnerable encounter with patients. Conversely, it also became clear how a lack of self-reflection on spiritual topics in one’s own life made it difficult to be a caring, present, and listening fellow human being when encountering another person’s spiritual suffering. For example, a staff said: “You cannot talk about death if you have not processed the concept of your own death”. The staff reported that entering sensitive conversations with patients in spiritual distress required a lot of introspection, vulnerability, and honesty on their part. Others pointed to the importance of addressing their own spiritual concerns during the training course for practicing and bettering spiritual care. However, several staff members also expressed a hesitation about implementing self-reflective practice into the workplace. One staff said: “My way of regarding the world and other people is also rooted in who I am as a person, but I’m not sure I want to work with my own spiritual concerns at my workplace”. Despite these worries, the importance of being aware of their own spiritual considerations was held important by all participants.

We therefore implemented self-reflection training in all the courses that were tested with the staff at the two hospices. During the subsequent action-in-praxis of the fourth phase, it became clear how the staff appreciated the self-reflection training, and it facilitated feelings of being comfortable in the vulnerable encounter. However, staff emphasized how these self-reflection exercises also opened a vulnerability in each person during the exercises and that facing personal spiritual needs, thoughts, beliefs, and values could be a painful process. It became significant that when participating in the training course, each
individual felt that his or her vulnerability was cared for and safeguarded in the teaching situation with colleagues. It seemed that during the training course, staff felt the same kind of vulnerability as patients facing spiritual distress. One staff member expressed: “It was good but also very hard for me [...]. I don’t know if I could think about that (personal spiritual needs, thoughts, beliefs, and values) if it wasn’t for X (name of a co-worker) who sat there next to me [...].”

It is therefore central for the training course that every participant is met with an understanding, that this self-reflection process can be vulnerable, painful, and difficult, and that this is normal and acceptable. Another focus of the course is to increase collegial care between the employees, where co-workers secure an environment at the workplace where both staffs’ and patients’ spiritual needs, thoughts, beliefs, and values can safely be faced and openly talked about. This is facilitated at the training course by providing space for the individual’s vulnerability in relation to spiritual issues, both in plenary and in small groups, as well as making sure that the sessions are undisturbed and that the program involves time for small walks with colleagues.

3.3. Topic 3: Shared Professional Language for Spiritual Care

Topic 3, shared professional language for spiritual care, involves the importance of being able to share reflections on spiritual care with colleagues to strengthen spiritual vernacular in relation to patients. Developing and applying a shared professional language for spiritual care in practice is also expected to decrease barriers for providing spiritual care.

In the beginning of the action research process during phase 1, it was evident that although the staff at the hospice wanted to provide and improve spiritual care for patients, their embeddedness within a medical and solution-focused paradigm facilitated certain perspectives on both the barriers and solutions for providing spiritual care. Staff made different statements in this regard during reflection-of-praxis and action-in-praxis of both phase 2 and 4, for example: “... I am worried that I might hurt the patient ... if I ask the wrong question [...]. I need to know that I am doing the right thing”, “can’t you (the researcher) write a list or a book with sentences on what to say to patients”, “we need to decide what is the right or wrong thing to say when (providing spiritual care)”, or “just tell us what to say ... Then we practice ... So we say the right things to patients”. A solution-focused notion of the ‘right or wrong spiritual care treatment’ was predominant among the staff in the beginning of the action research process; however, as the process progressed and the staff participated in developing the training course during the fourth phase, they began to express themselves differently. For example: “It (being afraid of doing something wrong) really is a great hindrance ... but when you step away from your professionalism and just say, here I am, and I’m just going to ask (the patient) ... that facilitate better spiritual dialogue”, “You can’t say anything wrong. The worst thing you can do is to say nothing, or to avoid people” and “Is it even possible to define the spiritual relational encounter as being right or wrong?”

During the action research process, it became apparent that shared professional language for spiritual care was primarily intended for improving the professional dialogue between staff about the patients’ spiritual needs: how to provide best care for these, and to talk about the challenges the staff experienced when providing spiritual care. A shared professional language for spiritual care was not about finding solutions or providing the right treatment, instead it was about sharing one’s reflections, difficulties, and positive experiences of spiritual care with one’s co-workers. The shared professional language for spiritual care equips the staff for spiritual dialogue with patients. Furthermore, health professionals use themselves when providing spiritual care for patients in distressful life circumstances. Therefore, having a shared professional language for spiritual care at a hospice will improve collegial care and recognition, which is crucial for reducing care fatigue.

A training course should focus on shared professional language for spiritual care, in order to improve spiritual care for the patients as well as collegial care. However, this
form of learning, which is highly embedded in specific healthcare contexts with different groups of staff (e.g., a hospice or hospital ward), is often difficult to maintain. Therefore, a shared professional language for spiritual care must be continuously maintained and developed. The present action research study has, for example, contributed to Hospice Sydfyn deciding to work purposefully with the three topics in their healthcare practice.

### 3.4. Framework for a Flexible Course Design

The notion of a flexible framework for the course design emerged on a basis of several discussions on the practical considerations of the hospice setting during the action-in-praxis of the fourth phase. It became apparent how the training course should be adaptable to the needs and wishes of the individual hospice as well as their practical possibilities and limitations. The first time we tested the training course with the two hospices, we organized it as a 24 h overnight course. The idea was to take the staff out of their work-related environment and provide more caring and exquisite surroundings which should facilitate relaxation, reflections, and dialogue. The feedback of the staff during the fourth phase on these courses was overly positive with several comments on the conference facilities. However, we also tested the course as a 7 h day course, where one hospice situated the course at a conference facility and the other hospice inhouse at their own location. When the participants subsequently evaluated the different courses in an action-in-praxis of the fourth phase, they reported experiencing similar professional benefits from the 24 h and 7 h courses, respectively, at the conference facility and inhouse. However, the staff participating in the inhouse course at the hospice location reported extra professional benefits on sharing the insights of the course with colleagues at work during breaks or when talking with them after the course.

Both the 24 h overnight course as well as the 7 h day course were arranged two times with each hospice where half of the staff participated the first time, and the other half of the staff participated the second time. Thereby, all the staff at each hospice completed the same course. While testing the course material, small groups of staff also participated in 2 h teaching on spiritual care; however, even though staff experienced these teaching sessions positively, they reported less professional benefit from these than the 24 h and 7 h courses, and they explained how this was primarily caused by (1) all of the staff not completing the same teaching and therefore not being able to share the experienced insights, and (2) these 2 h teaching sessions were often interrupted by work-related concerns that the staff also should attend to while participating in the teaching.

The staff explained how they experienced the most benefit from the course if they could share their newly gained understandings with each other immediately at work. For example, a staff member explained in an action-in-praxis: “It was really nice to talk with your colleagues about what you’ve learned . . . [ . . . ] now we also talk about how we do it (practice spiritual care) while working together or at our daily conference . . . ”. The staff also explained how they could not remember the teaching afterwards if they had encountered several interruptions during the teaching session. Therefore, it was important that the training course in spiritual care was kept uninterrupted.

The training course can be organized in different ways, with different durations and in different locations, but we always arrange these training courses for the entire group of staff to participate (usually divided into two groups with two similar training courses). This facilitates shared experiences of the insights gained during the courses as well as facilitating a shared language of the staff for practicing spiritual care. We also structure the course with full participation of each staff member with no work-related interruptions. Each training course is organized in close dialogue and cooperation with the hospice management with an understanding for their needs, wishes, and practical possibilities and limitations. The training course is structured around the three topics.
3.5. Flexible Curriculum for Training Course

When developing a curriculum for the training course in spiritual care, we, together with the staff during phase 6, operationalized the three topics into a framework for a flexible course design which could be adaptable to the needs, wishes, and practical possibilities and limitations of the individual hospice. An overview of the curriculum is presented in Table 4. The curriculum includes theoretical teaching, reflection exercises, and an improvisation theater workshop with professional actors. All different parts of the curriculum seek to improve the staff’s ability to be relationally present in the vulnerable encounter, self-reflection, and shared professional language for spiritual care. The different parts of the curriculum comprised the flexible course design, and each training course can be organized in different ways and with different durations and budgets in close dialogue with hospice management, appreciating their needs, wishes, and practical possibilities.

Table 4. Overview of the curriculum.

<table>
<thead>
<tr>
<th>Theoretical Teaching</th>
<th>Reflection Exercises</th>
<th>Improvisation Theater Workshop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity in spiritual care (from patients’ perspectives)</td>
<td>Individual reflection exercises</td>
<td>Training spiritual care with actors in small groups of 5–6 persons</td>
</tr>
<tr>
<td>Spiritual care begins by entering the door to patients’ room</td>
<td>Reflection exercises in small groups of 3–5 persons</td>
<td>Actors playing cases on spiritual care from hospice—participants comment and discuss</td>
</tr>
<tr>
<td>Three areas of spiritual care (patient care, self-care, and collegial care)</td>
<td>Reflection exercises in groups of 8–10 led by facilitator</td>
<td>Actors playing cases on spiritual care from hospice—participants ‘go on stage’</td>
</tr>
<tr>
<td>Spiritual meaning-making</td>
<td>Reflection exercises in plenum of big groups involving discussions</td>
<td>Participants are involved in informing actors about cases prior to teaching course → they play scenes on spiritual care with actors</td>
</tr>
<tr>
<td>Medical vs. spiritual vernacular</td>
<td>Homework reflection exercises before or after teaching course</td>
<td></td>
</tr>
<tr>
<td>Concrete vs. absolute hope</td>
<td>Different reflection exercises from the material of the “Existence Laboratory”</td>
<td></td>
</tr>
<tr>
<td>Four aspects of spiritual care (relational, individual, embodied, and verbal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients’ perspectives on death, dying, and afterlife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relational spiritual care for patients</td>
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</tbody>
</table>

The theoretical teaching comprises an introduction to an overall understanding of spiritual care as well as the three topics for the teaching course. It also includes results and statements of the action research process, where we found notions that were relevant for spiritual care practice at the hospice. These notions were: dignity in spiritual care (patients’ perspectives) (Viftrup et al. 2021); spiritual care begins by entering the door to the patients’ room; three areas of spiritual care (patient care, self-care, and collegial care) (Viftrup et al. 2020b); spiritual meaning-making; medical vs. spiritual vernacular; concrete vs. absolute hope (Viftrup et al. 2020a); four aspects of spiritual care (relational, individual, embodied,
and verbal); patient perspectives on death, dying, and afterlife (Viftrup et al. 2020a); and relational spiritual care for patients (Viftrup and Langdahl 2019).

The reflection exercises could also involve statements about these notions with the aim of facilitating discussions, reflections, and small exercises in plenary and small groups leading to self-reflection and self-awareness about personal spiritual needs, thoughts, beliefs, and values, as well as shared professional language for spiritual care. We also use and recommend the developed and documented material of the “Existence Laboratory” (Eksistenslaboratorium) (Jørgensen et al. 2016) for sparking staff’s self-reflection and self-awareness about spiritual concerns. This material focuses on topics such as: faith, doubt, hope, meaning, dignity, presence, and suffering.

During the improvisation theater workshop with professional actors, the actors play authentic scenes from practice at the hospice with patients, relatives, and staff. Staff can attend the scene and practice together with the actors or they can provide thoughts and reflections on the process together with their co-workers. A safe space is facilitated where staff can practice spiritual care: being relationally present in the vulnerable encounter, addressing patients’ spiritual needs and issues, caring and listening for the patient’s spiritual needs, being able to be both professional and a fellow human being, and be a caring, present, and listening fellow human being. During the improvisation theater workshop, the participants work either in plenary or in small groups.

4. Discussion

This study also indicates that a training course in spiritual care may reduce the barriers of hospice staff for providing spiritual care, which has also been found in several other studies (Paal et al. 2015; Jones et al. 2021).

4.1. Topic 1: The Vulnerable Encounter

This study found that spiritual care is difficult to integrate as a part of daily health care, which international studies also indicate (Straßner et al. 2019). The study points to addressing patients’ spiritual needs and issues often involves a high degree of sensitivity from the healthcare professionals. This could be related to why other studies have found confusion about the role of nurses in relation to spiritual care (Narayanasamy and Owens 2001), as these sensitivity caring competencies usually are not a part of nurses’ training. It seemed that the vulnerability of the encounter between patients and healthcare professionals is experienced both ways when it comes to spiritual care. This could reflect the barriers of ‘professional shyness’ when facing spiritual themes in conversations with patients, which has been found in other studies (Boston et al. 2011; Lundmark 2006; Assing Hvidt et al. 2016; Assing Hvidt et al. 2017). The importance of strengthening the staff’s relational abilities to be present in the vulnerable encounter became clear during the action research study, and it was discussed how being relationally present actually relieves patients’ pain and increases their quality of life. This points to both the aspects of skills (functional) and attitudes (behavioral) in spiritual care competencies of the ‘EPICC Standard’. Particularly, the interpersonal spirituality where health care professionals engage with patients’ spirituality seems highly relevant (McSherry et al. 2021). However, for the staff of this study to engage with patients’ spirituality, they also needed to change their understanding of the vulnerable encounter from being a barrier to a positive condition for spiritual care practice that they believed they could handle if trained.

4.2. Topic 2: Self-Reflection Concerning Spiritual Needs, Thoughts, Beliefs, and Values

During the action research study, we found that staff’s self-reflections on their own spiritual needs, thoughts, beliefs, and values would positively affect their ability to be relationally present in the vulnerable encounter with patients. In this study, self-reflection also seemed an important competency if the health care professionals were to engage with patients’ spirituality (McSherry et al. 2021). Several studies suggest that the barriers for providing spiritual care among the healthcare professionals stem from lack of self-reflection.
(Boston et al. 2011; Lundmark 2006; Assing Hvidt et al. 2016; Assing Hvidt et al. 2017), and self-awareness has also been described within the domains of nursing competencies for spiritual care (Van Leeuwen and Cusveller 2004). Perhaps, this being even more the case in highly secularized countries as Denmark, where health care professionals in general lack spiritual vernacular for caring for patients’ spiritual needs (Vittrup et al. 2020a).

4.3. Shared Professional Language for Spiritual Care

In the beginning of the action research study, the staff’s perspectives on solutions and barriers for providing spiritual care were embedded within a medical and solution-focused paradigm with a clear distinction about ‘right and wrong treatment’. During the action research process, they developed a shared professional language where they began to express themselves differently about spiritual care. It seemed that the development of a shared professional language equipped the health care professionals for spiritual dialogue with patients and reduced barriers among the staff. Studies have found that education and training in spiritual care lead to increased competencies for providing spiritual care (Paal et al. 2015; Jones et al. 2021), and a Danish study found how spiritual care training increased the participants’ assessed self-efficacy in relation to communicating about spiritual issues and concerns with their patients (Assing Hvidt et al. 2018). Van Leeuwen and Cusveller (2004) describe the competencies of self-awareness and communication, and the ‘EPICC Standard’ points to spiritual care involving responding to patients’ spiritual needs and resources within a caring, compassionate relationship (McSherry et al. 2021). However, these competencies do not specifically address how nurses develop a spiritual vernacular if they in general lack specific words and conceptions for talking about spiritual concerns. This study points to the importance of developing a shared professional language for spiritual care among the staff if we are to increase spiritual care.

4.4. The Flexible Course Design

Due to the flexibility of the framework and curriculum of the training course, it is possible to organize the course in different ways depending on the possibilities and resources available at the individual hospice.

The study found that staff who participated in the inhouse course appreciated the possibility (e.g., during breaks) to talk to colleagues who are at work without participating in the course, which seem to diverge with the need for no work-related interruptions. The difference between these two types of interruptions during the spiritual care training course may lay in the importance of shared professional language for spiritual care and collegial support when facing one’s own vulnerability. This could indicate how the spiritual dimensions in the nursing process (Van Leeuwen and Cusveller 2004) may positively affect the development of shared professional language for spiritual care.

4.5. Limitations

This study was carried out as an action research study aiming at improving practice through collaborative research processes. Action research seeks to empower research subjects to influence decision making for their own aspirations (Bradbury and Reason 2003) but as all the patients involved in the study will have died by the time of publication of the data, the ideal of action research does not favor them individually. However, their voices were considered very important for improving spiritual care for future patients.

The twelve patients interviewed for the study were selected based on their energy and interest in the study and therefore they may not be representative for patients at a hospice in general. However, variation within age, gender, and type of illness was attempted.

The themes identified in the data reflected the authors’ interpretation, and aspects of the participants’ experience could have been omitted. However, the staff were involved in verifying and interpreting data, just as we attempted to involve participants throughout the research process and keep their experiences and expressions central in the analysis. Furthermore, all findings of this study have been presented for the staff and they have also
verified their quotes. Unfortunately, this was not possible for patients’ perspectives, which clearly is a limitation of the study.

5. Conclusions

Based on an action research study in collaboration with two Danish hospices, the purpose of this study was to improve spiritual care in palliative care.

We found that educating staff in spiritual care at two hospices in Denmark led to the development and improvement of spiritual care for patients in palliative care. By educating staff at a hospice in relation to three main topics embedded in a course design with a flexible and adaptable curriculum, staff can become more comfortable talking about personal values and vulnerability in general, and thereby feeling more comfortable in the vulnerable encounter with patients and providing spiritual care. This is achieved by self-reflection and discussions in a safe environment where the staff also may develop and improve a shared professional spiritual language, which seemed particularly relevant in a highly secularized context.

One of the hospices involved in the study, Hospice Sydfyn, has already taken the course actively in use and decided to work purposefully and intensively with the three main topics.

Author Contributions: D.T.V. and N.C.H. was involved in establishing relationships with the research field, designing the study, and coding and discussing the data. Furthermore, the staff at the hospices participated in validating and interpreting data. All three authors revised, discussed, and wrote the article. All authors have read and agreed to the published version of the manuscript.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study, and written informed consent has been obtained from the participants to publish this paper.

Data Availability Statement: Data can be made available on request to the first author.

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