A Meaning-centered spiritual care training program for hospice palliative care team in South Korea: development and preliminary evaluation

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Abstract

Background

Spirituality is a fundamental and intrinsic aspect of human beings and should be a core component of quality palliative care. There is an urgent need for training of hospice palliative care teams (HPCTs) to enhance their competency to provide spiritual care. The purpose of this study was to develop and evaluate a meaning-centered spiritual care training program for hospice palliative care teams (McSCTP-HPCT).

Methods

In this methodological study we developed a training program for HPCTs, using the ADDIE educational content developmental model. The final training program comprised five modules. The modules' content was informed by Viktor Frankl's meaning-centered logotherapy with its emphasis on spiritual resources as well as the spiritual care model of ISPEC (Interprofessional Spiritual Care Education Curriculum). Following development, a pilot test was conducted with four nurses. The results of the pilot were used to inform the final program. The final program was tested in an intervention involving 13 hospice palliative care nurses. Measurements using self-administered questionnaires were taken at three points before and after the intervention. Participants' demographic and career-related characteristics and the degree of variance between outcome variables (compassion fatigue [CF], spiritual care competency [SCC], and spiritual care therapeutics [SCT]) were analyzed using descriptive statistics, t-test, and one-way ANOVA.

Results

The MCTP-HPCT was developed into five modules. Module I: The HPCT's SCC evaluation, understanding the major concepts of spiritual care and logotherapy, Module II-IV: Meaning-centered intervention related to the spiritual needs (existential, relational, and transcendental/religious), Module V: The process of meaning-centered spiritual care. The preliminary evaluation showed a significant differences in all three outcome variables at the first measure point (CF, $p = 0.037$; SCC, $p = 0.005$; SCT, $p = 0.002$). At the second measure point statistical significance was found only with SCC ($p = 0.006$).

Conclusions

The MCTP-HPCT developed in this study is suitable for use in clinical settings and provides evidence for evaluating the spiritual care competency of HPCTs.

Background

Across the world, interest regarding spiritual care in hospice palliative care (HPC) is increasing. HPC is a professional medical service provided by multidisciplinary teams comprising doctors, nurses, social workers, clergy, and volunteers. HPC aims to relieve physical, psychological, social, and spiritual suffering and to improve the quality of life (QoL) of patients with life-threatening illness and their family caregivers [1]. Since 2018, in South Korea the scope of HPC recipients has expanded to include non-cancerous diseases, including non-terminal cancer, in which more systematic care services and quality management are required [2]. In particular, spiritual care is a fundamental component of quality palliative care [3, 4]. According to an Interprofessional Spiritual Care Education Curriculum (ISPEC) report [5], the spiritual well-being of patients and their family caregivers is a major factor influencing health-care outcomes such as QoL, positive coping, satisfaction with caring, and decision making at the end of life [6, 7].

Hospice palliative care team (HPCT) nurses, who are specialists taking care of terminally ill patients 24 hours a day, are increasingly required to initiate discussions with terminally ill patients and their family caregivers concerning spirituality as the essence of their existence [1]. Understanding that humans are spiritual beings regardless of whether they are religious or not may be one of the strongest predictors for HPCT members providing spiritual care for patients with life threatening illness [8]. There is an urgent need for training to enhance the competencies of HPCT members to satisfy patients' spiritual care needs. Therefore, to provide meaning-centered spiritual care focused on spirituality that can take care of one of the most essential needs of human existence, systematic educational training for HPCTs is needed.

Previous studies have shown that HPCT members often have difficulties regarding spiritual care, thus they are unable to satisfy patients' spiritual care needs. It is reported that, because spiritual care has been confused with religious care, it is referred to the clergy [9, 10]. In one study targeting doctors and nurses who take care of advanced cancer patients [11], only 12% of nurses and 14% of physicians reported that they received spiritual care training. A group intervention study was conducted in the United States [12, 13] to improve HPCT nurses' job

satisfaction and QoL, and another study that developed the spiritual care training protocol for oncology nurses as a comprehensive concept of spiritual care was conducted in China [8]. However, a training program to enhance the spiritual care competency of HPCT members in Korea has not yet been done.

Currently, there are 87 hospice palliative care institutions that have formal approval by the Korean government in 2020 [14], but hospice palliative care services provided in Korea are still focused on physical symptom management, and no systematic training programs have been developed for the spiritual well-being of terminal patients. Moreover, there is no specified curriculum for spiritual care training for HPCT members. In order to promote the QoL of patients with life-threatening disease, spiritual care interventions grounded in human spirituality need to be established. In addition, in order to establish spiritual care as a core component of hospice palliative care and quality control service not limited to religious support, education and training of HPCT members should be implemented as a priority. The purpose of this study was to develop and evaluate a spiritual care training program for HPCTs using Victor Frankl's meaning-centered logotherapy approach to addressing the resources of spirituality. The training program will from here on be referred to as McSCTP-HPCT (meaning-centered spiritual care training program for hospice palliative care teams).

Methods

Study Design

This is a methodological study employing a one-group pretest posttest design. The developmental process used follows the ADDIE model of Seels and Richey [15] (Fig. 1).

Theoretical Foundation

A McSCTP-HPCT was developed incorporating the spiritual care guideline formulated by ISPEC [5], and concepts from Viktor Frankl's logotherapy conceived by experiences in the concentration camps in World War 2 and established as the meaning centered theory were used to focus on and enhance the resources of spirituality (Fig. 2).

"Spirituality" refers to a dynamic and intrinsic aspect of humanity that has an important influence on the status of body and mind [7]. The main attributes of spirituality are meaning, interconnectedness, and transcendence [16–18]. That the attitude of patients in the terminal stage of their illness developed from "pain" to "meaning" (such as the meaning of suffering, life, and death) confirms that the attributes of spirituality are related to meaning in life. In addition, 12 primary spiritual issues (e.g., despair/hopelessness, grief/loss, guilt/shame, reconciliation, isolation etc.) suggested by the National Consensus Project for Quality Palliative Care in the United States are related to the nature of spirituality [18]. Therefore, spiritual care should be focused on recognizing and responding to the needs of the human spirit including the attributes of spirituality with compassionate relationship [19]. ISPEC suggested an Interprofessional Special Care Model to improve the quality of spiritual care in the hospice palliative care area, and, in this model, the need for a multidisciplinary team approach was proposed as well as three levels for spiritual assessment (spiritual screening, history-taking, and assessment).

Viktor Frankl described the spiritual dimension of human beings as a "healthy core" or "the defiant power of human spirit" that affects the body and mind. In addition, the will to meaning in human spirituality is a motivating force to overcome the inevitable pain and live actively [20]. He developed "logotherapy", a theoretical system and psychotherapeutic intervention that advocates using spiritual resources to overcome unavoidable suffering. The main assumptions of logotherapy are that awareness of responsibility (being responsible for one's own existence), finding meaning (as the motivational and driving force of relieving suffering), and self-transcendence (dedication to something beyond themselves) within an authentic encounter are the essence of human existence. Recovery from suffering and spiritual well-being can be achieved through attitudinal modification towards optimism in situations where pain is inevitable [20–22].

Procedure

The flow of the McSCTP-HPCT development process is presented in Fig. 2. The development period was from March 2017 to April 2019, and the preliminary evaluation period was from May to July 2019.

Stage I: Development

Analysis

- **Review of literature.** We searched literature published from the earliest available subscription date to May 2017 that applied the meaning-centered intervention (MCI) to patients with advanced and life-threatening disease and caregivers. The contents of MCIs were

analyzed by means of a systematic review [23] and two meta-analyses [24, 25]. Besides the MCI study, which was designed to prevent burnout among and provide support for nurses who provide palliative care [12, 13], only one study on spiritual care training protocols was conducted regarding the general educational contents of spiritual care training for oncology nurses [8]. To the best of our knowledge, no meaning-centered spiritual care training program for hospice palliative care teams has been developed yet.

- **Identification of spiritual care guidelines.** Through searching for protocols or guidelines regarding spiritual care, we identified the ISPEC guideline [5] which have been developed by the National Consensus Project as an evidence-based training program for multidisciplinary teams [18], and which includes specific models regarding the process of spiritual care. Therefore, it is appropriate as a guideline to develop a training program suitable for Korean culture.
- **Needs assessment.** A needs assessment was conducted as follows. First, we identified the spiritual care needs of patients with life-threatening illness and their families who were admitted to hospice palliative care institutions in Korea [26]. Among their spiritual care needs, the desire for love and connection, finding meaning, and hope and peace were found to be higher than religious beliefs. As a result, we understand that spirituality (rather than religion) is a universal, intrinsic aspects of being human. Second, 282 nurses working at hospice palliative care institutions (n = 282) were surveyed on the meaning of spiritual care and their capacity for spiritual care. In response to the open question “What do you think special care is?”, 33.7% recognized spiritual care as “Helping prepare for a dignified death including religious support.” On the other hand, a survey conducted using the spiritual care competency (SCC) tool [27] showed that the lowest-scored SCC items were “assessment and evaluation of special care” and “professionalization and impacting the quality of special care”. Finally, the researchers collected opinions regarding spiritual care needs from a panel comprising seven experts on hospice palliative care practice, education, and officials responsible for hospice policy.

The analysis process confirmed the necessity that the McSCTP-HPCT be developed with due regard to the attributes of spirituality.

Design

- **Specification of contents, sessions, and modules.** The major contents of the McSCTP-HPCT, composed through previous research analysis, are the SCC evaluation of HPCT, the concepts of spiritual care and logotherapy, and meaning-centered care linked to the three attributes of spirituality (meaning, interconnectedness, and transcendence). The program consists of five sessions, and a total of 20 hours.
- **Educational methods.** As main educational methods for meaning-centered intervention, logotherapy counseling technique were applied, with logo-analysis and Socratic dialogue as the main techniques, and Medicine Chest and Appealing Technique as complementary methods. Logo-analysis [28] is the process of discovering potential spiritual resources in one’s spirit and analyzing them to find the meaning and purpose of life. The specific analytic processes are as follows: Self-evaluation, Acting as if…, Establishing an encounter, Finding values in creativity, experience, attitude, and commitment (Table 1). Socratic dialogue is a way of helping people recognize the latent “logohints” in their minds through an authentic conversation with a counselor. Medicine Chest is a way of helping patients recognize that there is a healthy core (the defiant power of the human spirit) in their spiritual dimension. Appealing Technique is a self-training meditation method that consists of positive content to help strengthen the use of one’s spiritual resources.

Table 1

Meaning-centered Spiritual Care Training Program for Hospice Palliative Care Team (McSCTP-HPCT)

Goal: The meaning-centered spiritual care training program (McSCTP) was developed to promote the spiritual well-being of patients by hospice palliative care teams (HPCT) who take care of patients with life-threatening illness. McSCTP is premised on the spiritual attribute of human beings. **Caring principle based on McSCTP: HPCTs act as assistants to help patients with life-threatening illness find their own meanings.**					
	Topic	**Objectives**	**Contents**	**Workbook**	**Methods**
Module I	Evaluation of spiritual care competency of HPCT and understanding of logotherapy concept	• Identify their spiritual care competency as a HPCT • Understand major concepts of spiritual care • Understand major concepts of logo therapy • Apply meaning-centered intervention to oneself	• Self-evaluation of spiritual care competency (compassion, compassion fatigue, and spiritual care competency) • Major concepts of spiritual care • Major concepts of logotherapy	• Evaluation of self-assessment regarding compassion, compassion fatigue, and spiritual care competency Identify of case-based attributes of spirituality, spiritual needs, spiritual issues, spiritual resources /communication practice • Meaning-based perspective training with real case • The practice of meaning-centered intervention for HPCT	• Self-evaluation • Lecture • Discussion • Case study • Presentation
Module II	Meaning-centered care related to existential needs	• Understand the meaning-centered care process related to existential needs • Identify spiritual needs, spiritual issues, and spiritual resources with real cases. • Implement meaning-centered care related to existential needs	• The process of meaning-centered care related to existential needs (Sp 1) • Meaning-centered care (Sp 2)	• Identification of spiritual needs, spiritual issues, and spiritual resources based on cases • Implement meaning-centered care	• Lecture • Discussion • Case study • Practice: Meaning-centered counseling technique • Presentation
Module III	Meaning-centered care related to relational needs	• Understand the meaning-centered care process related to relational needs Identify spiritual needs, spiritual issues, and spiritual resources with real cases. • Implement meaning-centered care related to existential needs	• The process of meaning-centered care related to relational needs (Sp 1) • Meaning-centered care (Sp 2)	• Identification of spiritual needs, spiritual issues, and spiritual resources based on cases • Implement meaning-centered care	• Lecture • Discussion • Case study • Practice: Meaning-centered counseling technique • Presentation

HPCT: hospice palliative care team; McSCTP-HPCT: meaning-centered spiritual care training program; Sp: supplementary file

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Module IV	Meaning-centered care related to transcendental/ Religious needs	• Understand the meaning-centered care process related to transcendental/Religious needs • Identify spiritual needs, spiritual issues, and spiritual resources with real cases. • Implement meaning-centered care related to transcendental/Religious needs • If they have a religious need, refer the patient to the priest they want	• The process of meaning-centered care related to transcendental/Religious (Sp 1) • Meaning-centered care (Sp 2)	• Identification of spiritual needs, spiritual issues, and spiritual resources based on cases • Implement meaning-centered care	• Lecture • Discussion • Case study • Practice: Meaning-centered counseling technique • Presentation
Module V	Meaning-based care implementation model and caring process for spiritual well-being	• Understand the meaning-centered spiritual care model for spiritual well-being of patients with life-threatening illness. • Identify the implementation process of meaning-centered spiritual care for spiritual well-being of patients with life-threatening illness.	• Spiritual care implementation model • Spiritual care decision pathway • The principle of spiritual care • Assessment of spiritual needs and spiritual resource • Meaning-centered spiritual care process based on spirituality (Sp 1)	• Spiritual needs assessment based on meaning-centered perspective	• Lecture • Discussion • Practice

HPCT: hospice palliative care team; McSCTP-HPCT: meaning-centered spiritual care training program; Sp: supplementary file

Development

- **Development of initial program**. To ensure effective outcomes for both patients and health care professionals, the program had to address both the importance of spiritual care based on the attributes of spirituality and the hospice palliative care provider's compassion [7, 29–32]. These issues were reflected in the evaluation of compassion fatigue (CF) and SCC of HPCTs. The initial program also addressed the spirituality of ISPEC guideline, the meaning and standard of spirituality care, spiritual assessment and diagnosis based on the three attributes of spirituality, and basic concepts of spirituality implementation. To facilitate the efficient progress of education, McSCTP was organized as a group intervention. It included a mix of didactic presentations, case sharing, experiential exercises with main logotherapeutic counselling techniques including logo-analysis, Socratic dialogue, group discussions with reflection, and home exercises.
- **Critical review by professionals and modification process**. At a workshop with spiritual care experts in the HPC field, it was agreed that five sessions, five hours per week, for four weeks, and a total of 20 hours of training programs would be appropriate for the education component of the McSCTP-HPCT. In addition, it was agreed that in order to strengthen case-oriented education, the 12 spiritual issues presented in the ISPEC guideline have been adjusted to nine issues that are suitable for Korean culture. The McSCTP-HPCT is an approach based on the universal spiritual attributes of human beings, and the three levels of spiritual assessment were modified to be appropriate for the Korean situation. It was agreed that religious needs expressed by the subject should be referred to the clergy.
- **Establishment of an intervention team**. To ensure consistency of education, the first author of this study and one of the coauthors, who is an expert (a trained chaplain) in the field of HPC, were designated as both educator and facilitator.

- **Pilot test**. To check the suitability of the MCTP-HPCT, the problem and satisfaction level of the progress procedure and the content validity were tested by four nurses working in the tumor and HPC area. The content validity index score showed over 80% in all 10 items tested. These results were used to complete the final McSCTP-HPCT.

Stage II: Preliminary evaluation

Implementation

- **Participants.** Participants for the preliminary evaluation were HPCT members who works at a nationally administered hospice care institution. The inclusion criterion was that HPCT members must have been engaged in a hospice palliative care unit or center for more than five years. Initially, 15 people participated in the study, but two dropped out, leaving a total of 13 (eight nurses, two social workers, and three related professions).
- **Intervention procedure.** The McSCTP-HPCT was presented at four weekly training sessions (a total of five hours per week, 20 hours in total) by two educators who acted as facilitators for lectures and discussions. Application and group discussion were conducted with real cases, and tasks for reflection were given to prepare for the next session. For data collection, the research assistant explained the purpose of the study and distributed the self-administered questionnaire. The McSCTP-HPCT measurements were made over three time periods. The pretest measurement (Measure 1, M 1) was conducted before McSCTP-HPCT was presented, the posttest measurement (Measure 2, M 2) was conducted after the completion of the training, and the follow-up test (Measure 3, M 3) took place four weeks after the completion of the posttest by mail.

Evaluation

- **Measures.** Socio-demographic and career-related background information were collected at M 1. The three outcome variables (compassion fatigue, spiritual care competence [SCC] and spiritual care therapeutics [SCT]) were measured at M 2 and M 3. SCC was measured using the Spiritual Care Competence Scale (SCCS)[27] with a 5-point Likert scale (1 = completely disagree to 5 = fully agree). It assessed six sub-dimensions (implementation of spiritual care, professionalization and improvement of the quality of spiritual care, personal support and patient counselling, communication, attitude towards the patient spirituality, and referral to professionals) with 27 items. The Cronbach alpha was .94. SCT [33] evaluates the frequency of HPCT-provided spiritual care. It consisted of 17 items rated using a 5-point Likert scale (1 = never, 2 = rarely, 3 = occasionally, 4 = often, 5 = very often). The Cronbach's alpha was .97. Compassion fatigue (CF, Supplementary 3) refers to the silencing response experienced by HPCs in the early stages [34, 35] It was measured by means of 16 items using a 5-point Likert scale (1 = never, 2 = rarely, 3 = occasionally, 4 = often, 5 = very often). The scale exhibits internal reliability with an alpha coefficient of 0.85. After the translation-reverse translation process, both SCT and CF were validated by five experts, and content validity index showed more than 80% over all items.
- **Data analysis.** Data were analyzed using the Statistical Package for Social Sciences (IBM SPSS, version 25.0). Participants' demographic and career-related characteristics and the degree of variance between outcome variables were analyzed using descriptive statistics, t-test, and one-way ANOVA. The preliminary effects of McSCTP were tested with paired t-test to determine the change in the score between the measurement points.

Results

Development of McSCTP-HPCT

The MCTP-HPCT was developed into five modules as described briefly below and in more detail in Table 1. Each module consists of learning objectives, key training contents, and workbooks and consists of case-based discussions and exercises for effective practical application.

Module I. This module consists of the HPCT's SCC evaluation, understanding the major concepts of spiritual care and logotherapy, and the application of meaning-centered intervention directly to HPCT. In particular, to enhance the competency of HPCT members to provide meaning-centered intervention, they practiced self-evaluation to find meaning in their own job.

Module II. This module consists of a meaning-centered intervention process that presents two spiritual issues ("despair/hopelessness" and "lack of meaning and purpose") related to the existential needs of patients.

Module III. Module III contains a meaning-centered intervention process that presents five spiritual issues ("anger at God or others", "guilt/shame", "grief/loss", "abandonment by God or others/isolation", and "reconciliation") related to the relational needs experienced by

patients and their families.

Module IV. The contents of this module are related to the transcendental/religious needs, with two spiritual issues focused on (“concerns about relationship with deity”, “conflicted or challenged belief systems”).

Module V. This final module reconstructs the process of meaning-centered spiritual care in the context of the Spiritual Care Implementation Model presented by ISPEC and consists of two parts. The first part comprises a meaning-centered spiritual care model including a) spiritual implementation model, b) decision pathways, and c) caring principle for spiritual well-being. In the second part, we presented a spiritual care matrix (spiritual assessment with three levels: screening, history, and assessment/spiritual resources, and needs based on spiritual attributes, spiritual issues, and meaning-centered intervention evaluation).

The workbooks for modules II, III, and IV presented practical exercises to identify spiritual needs (existential, relational, and transcendental) and how to satisfy these with spiritual resources, and other spiritual issues based on actual cases.

Preliminary Evaluation

Participants’ Background Characteristics and Differences in Outcome Variables. The characteristics of the participants are presented in Table 2. The item that differed most in the outcome variables according to the characteristics of the participants was religious status (p = .041) in CF. In the results of a post-hoc Scheffe test, none of the items showed significant differences in the mean scores of the three outcome variables.

Table 2
Participants Background Characteristics and Differences in Outcome Variables (N = 13)

			CF[a,d]		SCC[b,d]		SCT[c,d]	
Characteristics	**Categories**	**M (SD)/N (%)**	**M (SD)**	**t/F (p)**	**M (SD)**	**t/F (p)**	**M (SD)**	**t/F (p)**
Age (years)		44.69 (9.69)	-	-	-	-	-	-
	< 39	6 (46.2)	2.26 (0.42)	0.75 (.468)	3.12 (0.69)	-1.23 (.266)	3.07 (0.75)	-0.92 (.378)
	> 40	7 (53.8)	2.11 (0.31)		3.48 (0.24)		3.35 (0.32)	
Marital status	Not married	6 (46.2)	2.27 (0.34)	0.86 (.412)	3.44 (0.42)	0.76 (.461)	3.25 (0.58)	0.63 (.851)
	Married	7 (53.8)	2.10 (0.38)		3.22 (0.59)		3.19 (0.57)	
Educational level	Undergraduate	9 (69.2)	2.09 (0.39)	-1.78 (.103)	3.33 (0.57)	0.14 (.888)	3.25 (0.59)	0.25 (.807)
	Graduate	4 (30.8)	2.37 (0.18)		3.29 (0.41)		3.16 (0.53)	
Religion	Have	11 (84.6)	2.13 (0.37)	-2.39 (.041)	3.31 (0.56)	-0.20 (.844)	3.26 (0.57)	0.52 (.615)
	None	2 (15.4)	2.44 (0.09)		3.39 (0.18)		3.03 (0.54)	
Type of job	Nurse	8 (61.5)	2.34 (0.32)	3.57 (.068)	3.38 (0.41)	0.66 (.536)	3.26 (0.50)	0.51 (.616)
	Social worker	2 (15.4)	2.06 (0.35)		2.93 (1.26)		2.85 (1.21)	
	Others	3 (23.1)	1.81 (0.17)		3.42 (0.15)		3.35 (0.27)	
Experience of hospice care education	Have	9 (69.2)	2.28 (0.35)	1.74 (.111)	3.25 (0.61)	-0.70 (.496)	3.18 (0.66)	-0.37 (.722)
	None	4 (30.8)	1.94 (0.28)		3.47 (0.16)		3.31 (0.24)	
Length of clinical career (years)		153.38 ± 94.40	-	-	-	-	-	-
	Under 5	2 (15.4)	1.66 (0.04)	3.82 (.058)	3.61 (0.39)	0.93 (.426)	3.56 (0.71)	1.05 (.387)
	5–10	3 (23.1)	2.19 (0.22)		3.00 (0.85)		2.86 (0.76)	
	Above 10	8 (61.5)	2.31 (0.33)		3.37 (0.39)		3.27(0.45)	
Length of hospice care career (years)		84.92 (54.51)	-	-	-	-	-	-
	Under 5	5 (38.5)	2.04 (0.36)	1.13 (.363)	3.13 (0.68)	0.49 (.627)	2.94 (0.75)	1.14 (.358)

[a]CF: compassion fatigue

[b]SCC: spiritual care competency

[c]SCT: spiritual care therapeutics

[d]5-point Likert scale

			CF[a,d]		SCC[b,d]		SCT[c,d]	
	5–10	5 (38.5)	2.36 (0.30)		3.44 (0.38)		3.34 (0.39)	
	Above 10	3 (23.1)	2.10 (0.45)		3.43 (0.48)		3.49 (0.28)	
Educational needs for spiritual caring	Have	12 (92.3)	-	-	-	-	-	-
	None	1 (7.7)	-	-	-	-	-	-

[a]CF: compassion fatigue

[b]SCC: spiritual care competency

[c]SCT: spiritual care therapeutics

[d]5-point Likert scale

Table 3
Changes in CF, SCC, and SCT from Baseline through Follow-up (N = 13)

Variables (items)	Measure 1 (M1[d]-M2[e])		Measure 2 (M1-M3[f])	
	Diff (SD)	t (p)	Diff (SD)	t (p)
CF (16)[a]	0.21 (0.32)	2.35 (.037)	0.16 (0.35)	1.66 (.123)
SCC (27)[b]	-0.48 (0.50)	-3.50 (.005)	-0.45 (0.48)	-3.38 (.006)
SCC-A (6)[g]	-0.60 (0.64)	-3.40 (.005)	-0.54 (0.67)	-2.90 (.013)
SCC-PI (6)[h]	-0.54 (0.70)	-2.77 (.017)	-0.53 (0.61)	-3.12 (.009)
SCC-PP (6)[i]	-0.44 (0.66)	-2.39 (.034)	-0.38 (0.70)	-1.98 (.072)
SCC-R (3)[j]	-0.49 (0.50)	-3.50 (.004)	-0.44 (0.60)	-2.62 (.022)
SCC-At (4)[k]	-0.38 (0.54)	-2.59 (.024)	-0.38 (0.44)	-3.15 (.008)
SCC-C (2)[l]	-0.27 (0.81)	-1.20 (.252)	-0.31 (0.69)	-1.60 (.136)
SCT (17)[c]	-0.35 (0.31)	-4.04 (.002)	-0.09 (0.41)	-0.76 (.464)
[a]CF: compassion fatigue				
[b]SCC: spiritual care competency				
[c]SCT: spiritual care therapeutics				
[d]M1: pretest				
[e]M2: posttest				
[f]M3: follow up (after 4 weeks)				
[g]SCC-A: assessment of implementation of spiritual care				
[h]SCC-PI: professionalization and improvement of the quality of spiritual care				
[i]SCC-PP: personal support and patient counseling				
[j]SCC-R: referral to professionals				
[k]SCC-At: attitude towards the patient spirituality				
[l]SCC-C: communication				

Comparison of Changes in Outcome Variables. In the difference of mean score by measurement points, Measure I (M1-M2) showed significant differences in all three outcome variables (CF, $p = 0.037$; SCC, $p = 0.005$; SCT, $p = 0.002$). There was no significant difference only in communication among the sub-dimensions of SCC (SCC-C, $p = 0.252$). In Measure II (M1–M3), statistical significance was found only in the SCC ($p = 0.006$), and no significant differences were found in CF ($p = 0.123$) or SCT ($p = 0.464$).

Discussion

Principal findings

The McSCTP-HPCT was developed to allow HPCT members to maximize the patient's spiritual resources. It addressed itself to human spirituality rather than religious aspects [20–22]. The theoretical background was rooted in the spiritual care model presented by ISPEC's guidelines and the logotherapy approach which is a meaning-centered approach rather than a pathos-centered approach [20, 21]. In previous studies, meaning in life was reported as a stable intrapersonal resource that can be used to maintain the spiritual well-being of patients with chronic or life-threatening illness [36, 37]. The main characteristics of McSCTP-HPCT are as follows: First, it is linked to

spiritual needs with expressions, spiritual issues, and meaning-centered interventions based on the attributes of spirituality. Second, it is designed to meet the existential needs of terminally ill patients and promote spiritual well-being. Finally, it was based on the spirituality concept presented by ISPEC and an interdisciplinary approach to spiritual assessment, implementation model, and spiritual issues. Researchers have shown that personnel who undergo spiritual care training are more likely to meet patients' spiritual needs [38–40]. Through the spiritual care training program, the HPCTs can more effectively assist patients to find meaning in life and overcome the spiritual suffering experienced during their illness.

Development of McSCTP-HPCT

A feature of Module I was that the medical personnel's own spirituality and compassion skills were dealt with for spiritual care. Their spirituality affects health care outcomes including QoL [18]. Compassion is a spiritual practice, a way of being, a way of service to others, and an act of love. Thus, spirituality is intrinsically linked to compassion [7, 41]. HPCT members' compassion and SCC were assessed before providing spiritual care, and compassion training was also emphasized. In order to effectively provide spiritual care, the compassion of HPCT has been reported as an important factor [41] In addition, the self-reflection process of HPCT enabled the HPCT members to discover meaning in their own profession as a prior education for spiritual care [6]. Riahi et al. [42] also emphasized the importance of the nurses' own professional meaning and commitment to spiritual care.

The differentiation of modules II, III, IV is the linking of spiritual needs based on the attributes of spirituality, spiritual issues, meaning-centered intervention, and objectives of intervention with evaluation using patient-reported outcomes (Supplementary 2). In addition, the implementation result was evaluated with one item (5-point scale) per initial issue, and finally, the effects of the meaning-centered spiritual care was evaluated with spiritual well-being (8 items, 5-point scale). Spiritual well-being is an important outcome criterion and is a core component of quality in oncology and palliative care [37].

For the composition of the main contents of meaning-centered intervention, systematic reviews, meta-analyses, and clinical trial literature published in the last five years were analyzed [8, 10, 12–13, 23–25, 42]. The common purpose of MCI identified through analysis was to improve spiritual well-being by finding meaning in life even in painful situations including incurable diseases. The major contents of intervention were confirmed to be the essential characteristics of human existence (meaning of life, will to meaning, freedom of will, choice and responsibility, self-transcendence), and how to find meaning (creativity, experience, attitude). Based on previous studies, the McSCTP-HPCT was composed to help patients find the meaning of life through their own strengths, creativity, positive experiences, and attitude modification based on four main theoretical concepts (finding meaning, attitudinal modification, awareness of responsibility, self-transcendence) proposed in logotherapy

Most previous studies which applied MCI to patients with an advanced or terminal illness or in an unavoidable suffering situation were designed as group interventions, with eight sessions lasting 90–120 minutes per session with lectures, discussion, reading and self-reflection as individual tasks [23–25] Two studies, which applied MCI to improve job satisfaction and QoL among palliative care nurses [12–13], were designed with four sessions of group intervention, lasting 120180 minutes per session. The teaching methods were didactic presentations, discussions, experiential exercises, and home exercises, similar to those of McSCTP-HPCT in this study. The educational methods of these previous studies were planned around five sessions, 240 minutes per session, and group intervention.

In Module V, the overall implementation process of meaning-centered care by HPCTs was presented. Puchalski et al. [18] pointed out the importance of spiritual care in palliative care settings and provided clarification about who should provide spiritual care and the role of health care team providers in spiritual caring. To date, although the importance of spiritual care was emphasized by some researchers, spiritual care was not provided systematically especially for the patients with life threatening conditions because of the insufficient preparedness of the HPCT [7]. The spiritual assessment, the third stage of spiritual assessment presented by ISPEC, included a question that could confirm the spiritual resources of patients (Supplementary 1) [29]. These are questions that can lead to spiritual resources shown in the Medicine Chest, one of the logotherapy counseling techniques [29]. Therefore, HPCTs must pay attention to and care for their patients' spirituality carefully. Part of their role is to safeguard patients' spirituality. Accordingly, they are able to help patients cope with their terminal illness and treatment using the defiant power in spirituality [10]. Lewis et al [43] also reported that patients' spirituality helps them make sense of their lives and feel whole, hopeful, and peaceful even in the midst of a serious illness. In addition, it also helps clinicians to conceptualize and plan subsequent treatment.

Furthermore, the 12 spiritual issues presented in the ISPEC guidelines [5] were adjusted as follows to nine issues suitable for Korean culture: meaning ("despair/hopelessness" and "lack of meaning and purpose [existential]"), interconnectedness ("anger at God or others", "guilt/shame", "grief/loss", "reconciliation", and "abandonment by God or others/isolation"), transcendence ("concerns about relationship with deity" and "conflicted or challenged belief systems"). This imply that the frameworks and contents of spiritual care training should consider variations according to cultural differences, although still following the global standard guideline [44–46].

Preliminary Evaluation

In the preliminary evaluation, three outcomes (CF, SCC, and SCT) were chosen to measure the changes in the spiritual care competencies of HPCTs. CF was tested to identify HPCTs' own self-preparedness, SCC was used to evaluate their ability [27], and SCT was used to measure the frequencies of HPCT-provided spiritual care [33]. In Iran, a study regarding the effects of spiritual intelligence training for critical care nurses showed no significant effects on SCC until four weeks after the intervention [42]. On the other hand, in this study, in the first post-measurement, all three variables (CF, SCC, and SCT) showed significant differences compared to the pretest scores, but in the measurements after four weeks, only SCC was maintained significantly. The reason that the maintenance effect in CF and SCT was short-lived may be speculatively attributed to the fact that it was difficult to apply the contents of McSCTP-HPCT continuously after training because only one or two people per institution participated. Therefore, we recommend that all HPCTs at the institution participate in the McSCTP-HPCT, and continuous application and evaluation should be established at the same time [42, 47].

Clinical Implications

Spiritual care education is one of the core categories of interprofessional team training in hospice/palliative care settings [18, 42–47]. We, the authors, expect that the spiritual training program will help HPCTs understand the techniques they can use to provide effective spiritual care for their patients. Therefore, McSCTP-HPCT may facilitate the development and improvement of HPCT members' competence at providing spiritual care to diverse patients and their families with life-limiting illnesses or conditions.

In addition, we expect this study will highlight the importance of spiritual care training which can impact on spiritual well-being in patients with life-threatening illness. Considering that the purpose of spiritual care is to ease patients' difficulties and help them to find meaning in life and to improve their spiritual well-being [8], the McSCTP-HPCT developed in this study will help patients' understand their own sense of value, find meaning in their life, and provide them with spiritual well-being.

Limitations

The limitations of this study should be acknowledged. First, the McSCTP-HPCT is a training program to help HPCTs provide spiritual care with a focus on meeting the existential needs of patients. Communication, ethics, and religious care were not included in the educational content. Regarding communication, only the part of compassion training through reflective listening was dealt with, and the overall concept and domain of communication were not included. Second, McSCTP-HPCT was developed with a focus on the inpatient spiritual care implementation model of ISPEC, and, when considering the outpatient situation, program modification and further testing are required. Finally, a tool used to measure the CF of HPCT is necessary to verify objective validity for conceptualization. This tool should consist of themes (e.g., belief and attitudes around spirituality, knowledge, ability, and frequency about spiritual care) suggested by Harrad et al. [11] as an early sign of CF.

Conclusions

To better integrate spiritual care in clinical practice, it is necessary to create and increase the importance of spiritual care among HPCTs through effective training programs. Using ISPEC guidelines and logotherapy, a spiritual care training program for HPCTs (McSCTP-HPCT) was developed consisting of five modules. The preliminary test showed that this study may be used as evidence for further research to test the effectiveness of McSCTP-HPCT by evaluating the spiritual care competency of HPCTs.

Abbreviations

CF
compassion fatigue
HPC
hospice palliative care
HPCT
hospice palliative care team
ISPEC
Interprofessional Spiritual Care Education Curriculum
MCI
meaning-centered intervention
McSCTP-HPCT
meaning-centered spiritual care training program for hospice palliative care team

SCC
spiritual care competency
SCCS
spiritual Care Competence Scale
SCT
spiritual care therapeutics
QoL
quality of life

Declarations

Ethics Approval and Consent to Participate

For this study, a research proposal with the purpose, content, scope, method, and data analysis was submitted to the Research Ethics Committee. The ethical aspects were considered in the entire research process. IRB approval was obtained from Sahmyook University (2019017HR). The purpose and procedure of this study were fully explained to the team members working in the hospice palliative care field who participated in the pilot test. The consent form was signed by the subjects who voluntarily agreed after it was explained that anonymity was guaranteed and participation could be withdrawn at any time according to the person's intention, and the surveyed data would never be used for any purpose other than research.

Consent for publication

Not applicable

Availability of Data and Materials

The data of this study can be obtained by any reasonable request from authors with permission of the National Research Foundation of Korea. If needed, please contact the author of this article.

Competing interests

The authors declare that they have no competing interests

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Authors' contributions

KKA was the primary author and conceived the idea, developed the program, collected the data, analyzed the data, and did the manuscript writing, KSJ was the corresponding author and prepared the conceptual framework, developed the program, and assisted in data analysis and manuscript writing, while YYS contributed to the design and data collection. KDB, CYS, PMH, YSJ, KSJ, and CSE contributed to the design and developed the contents of program. All authors reviewed and approved the final manuscript.

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Figures

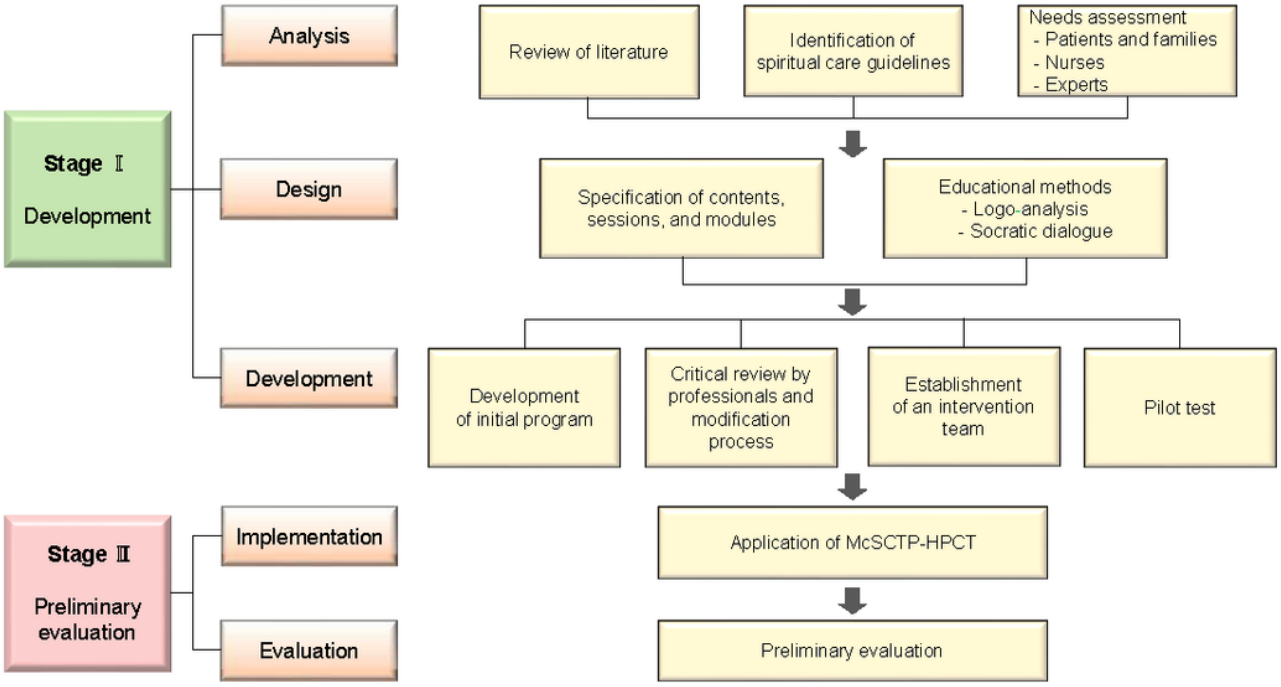

Fig. 1 The process of this study

McSCTP-HPCT: Meaning-centered spiritual care training program for hospice palliative care team

Figure 1

The process of this study

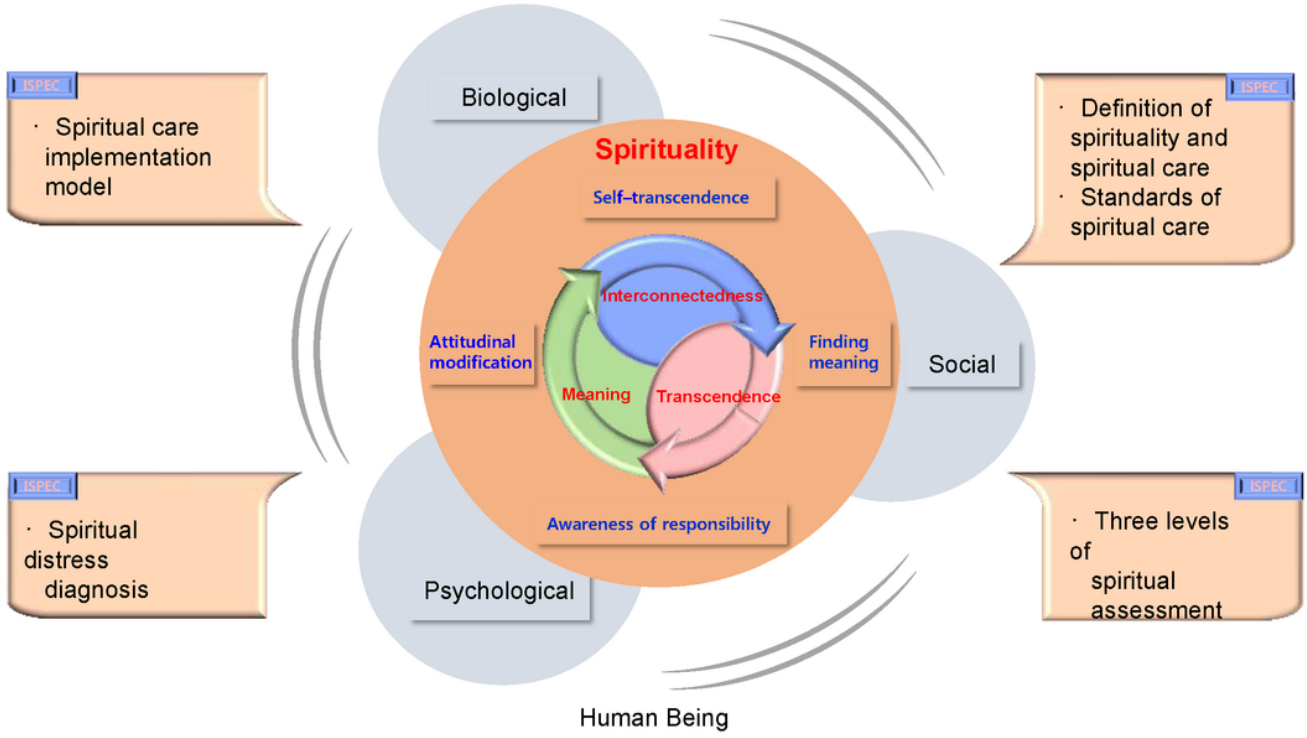

Fig. 2 Conceptual framework of this study

ISPEC=Interprofessional Spiritual Care Education Curriculum

Figure 2

Conceptual framework of this study

Supplementary Files

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