SpECi – An interprofessional training program for Spiritual and Existential Care

Univ.-Prof. Dr. med. Arndt Büssing
Professorship Quality of Life, Spirituality and Coping
University Witten/Herdecke

universität Witten/Herdecke

WHO Definition of Palliative Care

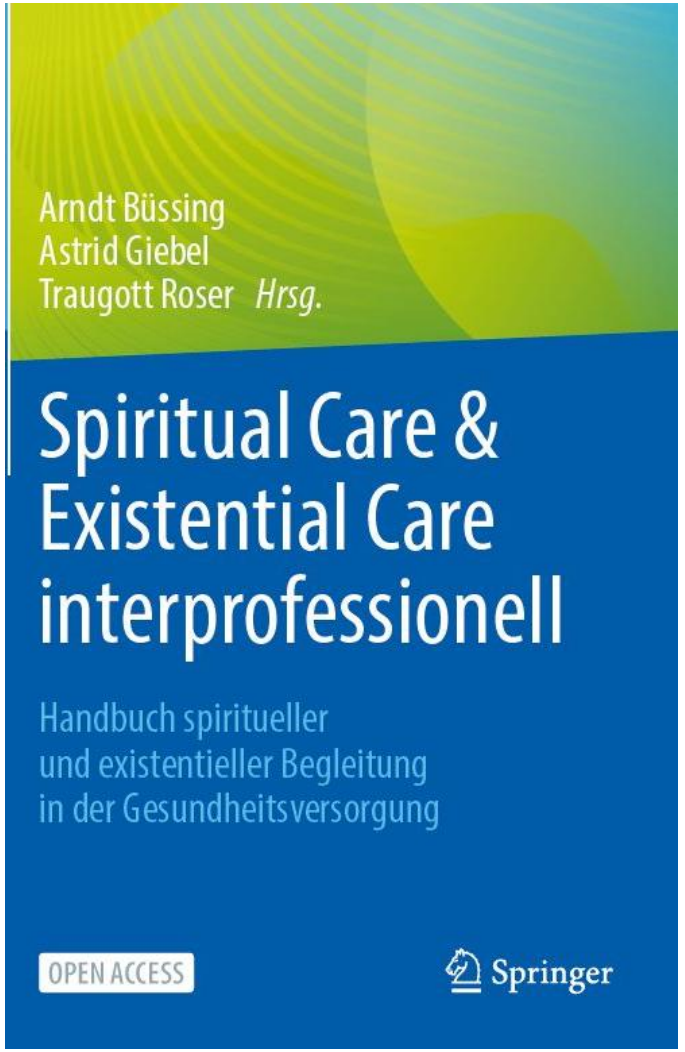
The prevention and relief of physical, psychological, social or spiritual suffering is “an ethical responsibility of health systems”.

It is an “ethical duty of health care professionals to alleviate pain and suffering, whether physical, psychosocial or **spiritual**, irrespective of whether the disease or condition can be cured“.

WHO: World Health Assembly Resolution 67.19 (2014)

This challenge contributed to the **emergence of Spiritual Care**
→ Concerns of all health professionals to take care of the existential/spiritual needs, worries, and distress of sick, old, and burdened people – and their relatives.

➢ Yet many HCPs lack the time, lack of expertise, or to unclear assignment of responsibility. Curlin et al. (2006), Frick et al. (2021)



We do not ask what our patients need

Thus: Recording and Documentation → Justified Reactions

- Many patients experience existential and spiritual concerns that remain unnoticed in everyday clinical care.

Balboni *et al.*, *J Clin Oncol* 2007; Büssing et al., *Pain Medicine* 2009, 2013; Höcker et al., *Eur J Cancer Care* 2014; Moeini et al., *J Pain Symptom Manage* 2018; Riklikiene et al., *Eur J Oncol Nursing* 2019; Sastra et al., J Transcult Nursing 2020

- Spiritual well-being and corresponding needs are usually not recorded during the anamnesis and therefore remain "hidden".
- Although healthcare professionals often recognize the importance of these issues, they do not address these underlying needs for various reasons.

➢ **What is not assessed and documented remains invisible in clinical practice.**

Competent Spiritual Care, therefore, requires…

1) systematic assessment and documentation of patients´ existential/spiritual needs
2) caring attitude of the health care professionals,
3) And an interprofessional collaboration to respond to these needs.

Patients Want Professionals to Address Spiritual Concerns

Many German cancer patients would like their physicians to show interest in their spiritual orientation. Frick et al., *Eur J Cancer Care* (2006)

An empirical study investigated with whom (outpatient) pain patients would like to talk about their spiritual needs:

- with chaplain/pastor: 23%
- no contact person: 20%
- important to talk to my doctor about it: 37%

Büssing et al., *Pain Medicine* (2009)

→ Yet many physicians still do not perceive this area as part of their professional role.

Main Barriers to Addressing Spirituality in Clinical Care

US physicians:

Professional neutrality:	40%
Lack of time:	48%
Lack of knowledge:	26%
Unease:	23%

Curlin et al., *Medical Care* (2006)

German HCP:

No responsibility:	39%
Lack of time:	40%
Lack of knowledge:	42%
Unease:	18%
No suitable space/room:	39%

Frick et al., Nervenarzt (2021)

- The barriers are manifold and differ only partially among physicians, nurses, and other HCPs.
- In Germany, 40% stated that they lacked the time, and only 38% would have liked to have more time to discuss these topics…

Assessment makes Spiritual Needs visible

- To provide Spiritual Care reliably in an interdisciplinary manner, these needs must be assessed and documented.
- Assessment allows interprofessional teams to respond appropriately and consistently.

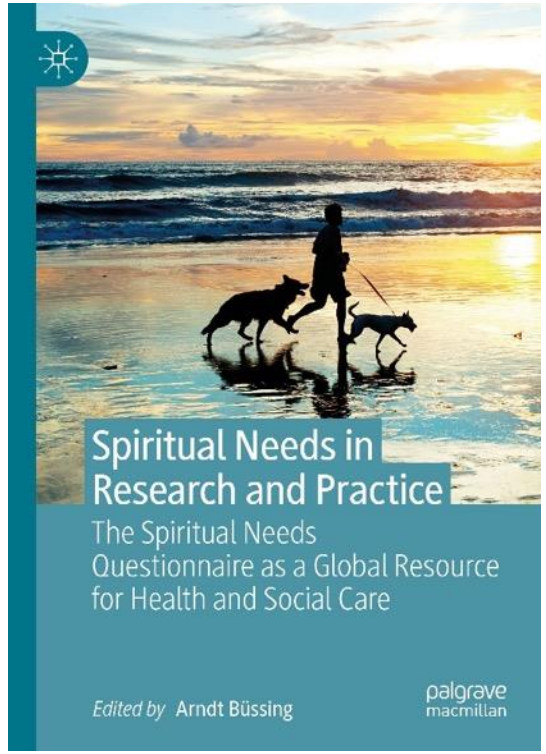
For that purpose the following tools are available

- *Spiritual Needs Questionnaire* (SpNQ) with 20 (+7) Items
- *Spiritual Needs Screener* with 10 Items
- *Spiritual Distress Screener* with 10 Items

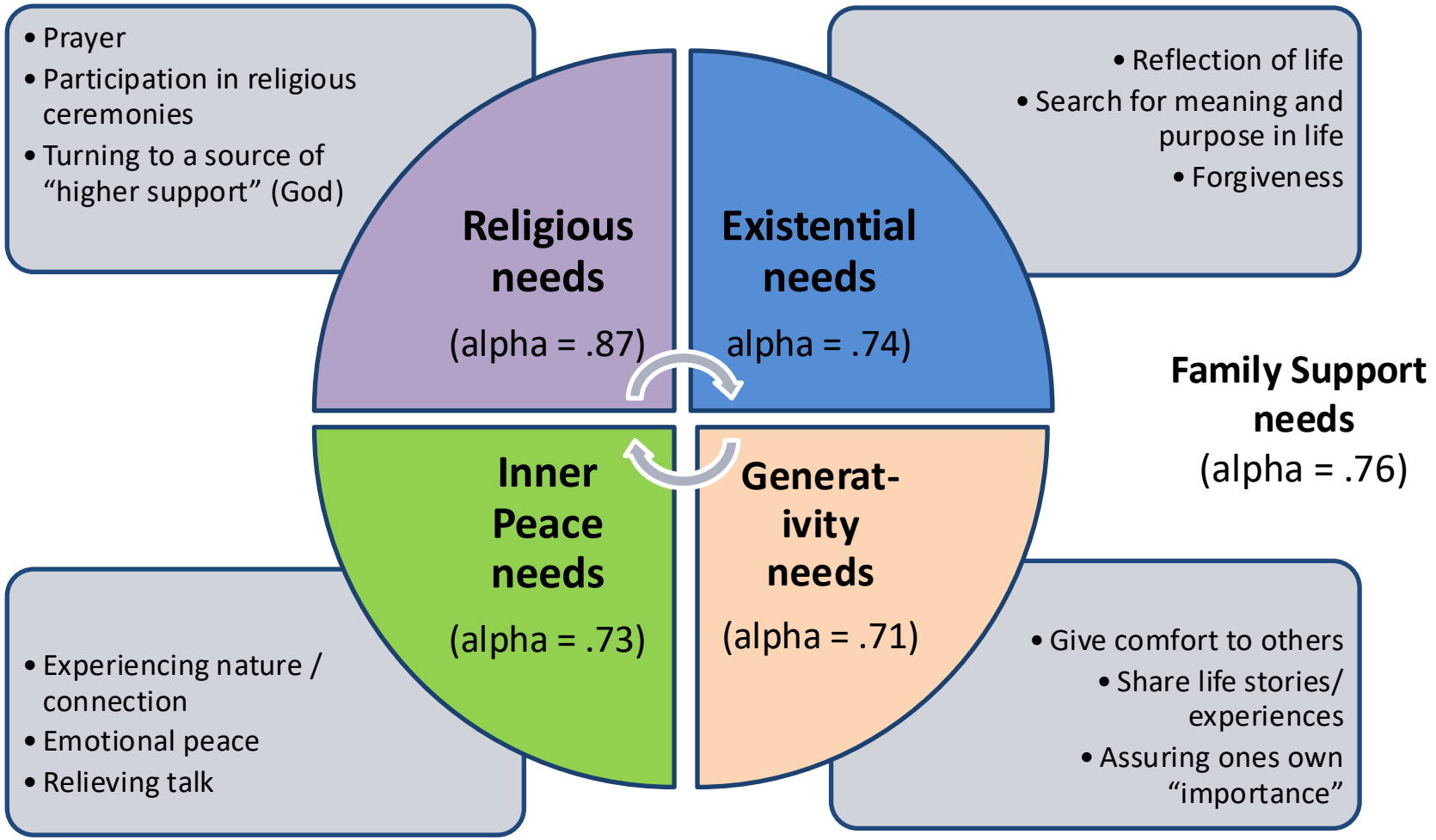
→ Both instruments are freely available

www.spiritualneeds.net

  - Empirical studies on the intensity of these needs in different groups are available from different cultures →

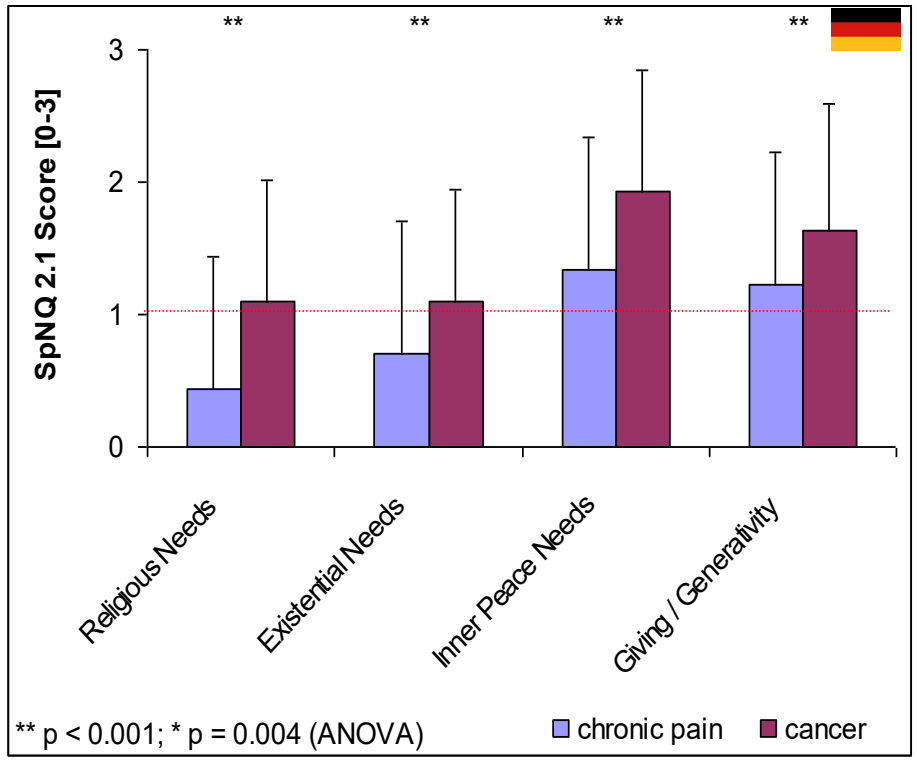


Main dimensions of Spiritual Needs



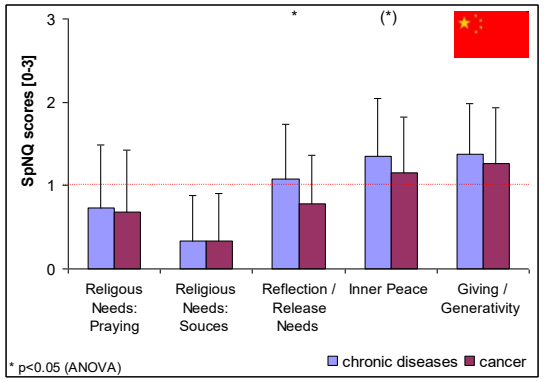
Arndt Büssing: *Spiritual Needs in Research and Practice* (2021)

Spiritual Needs Across Cultures and Diseases



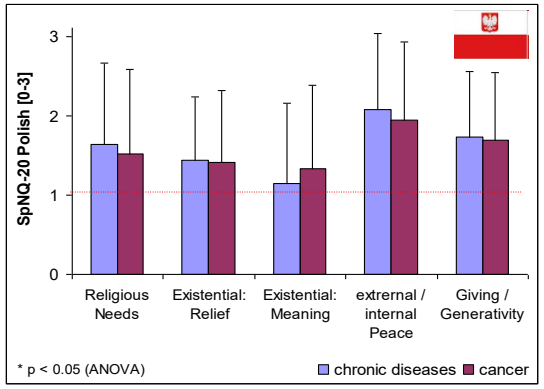
N = 392
67% women, 33% men
age 56 ± 14 years
68% living with partner
61% Christian denomination, 36% none
86% chronic pain disorders, 14% cancer

Büssing et al., *Pain Medicine* (2013)



N=168
39% women, 61% men
age 51 ± 16 y
93% living with a partner
77% no religious affiliation, 34% various Religions
66% cancer, 34% other chronic conditions

Büssing et al., *J Integr Med* (2013)



N=275
74% women, 26% men
age 56 ± 16 y
54% living with a partner
100% Catholics
35% cancer, 66% other chronic conditions

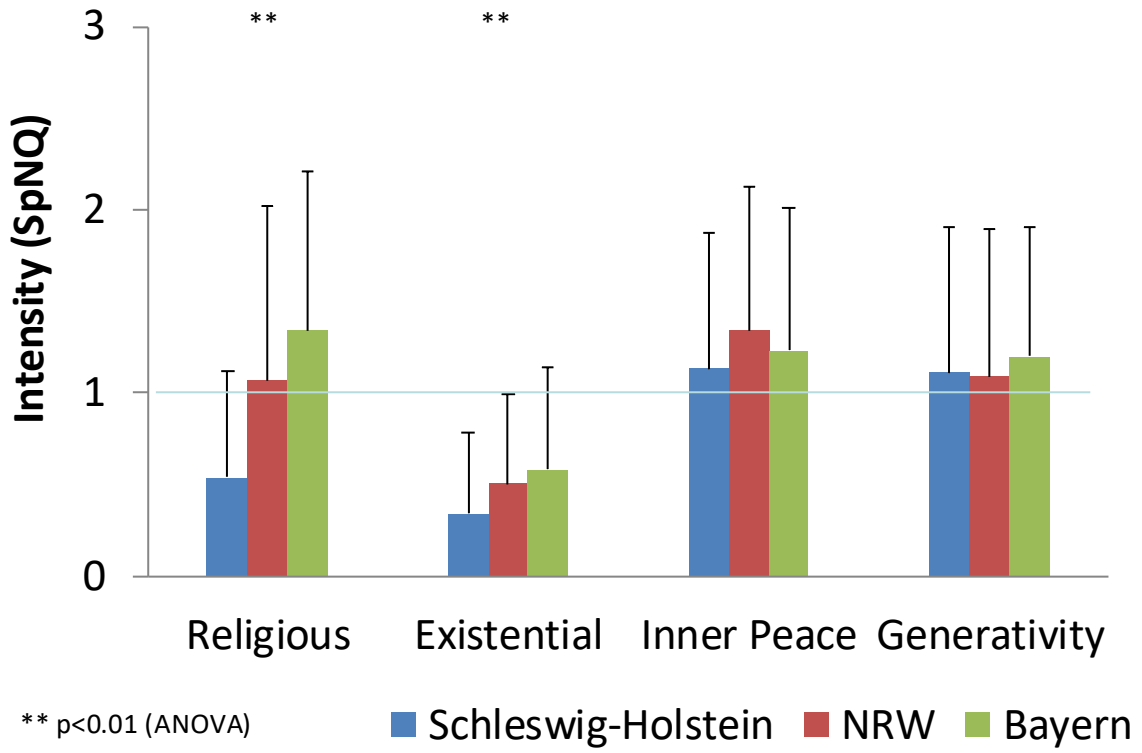
Büssing et al., J *Relig. Health* (2014)

Predictors of these spiritual needs:

Anxiety and Depression, illness interpretation as a Threat, but also spiritual *Search* and *Religious Trust*

Spiritual Needs of the elderly living in retirement/nursing homes

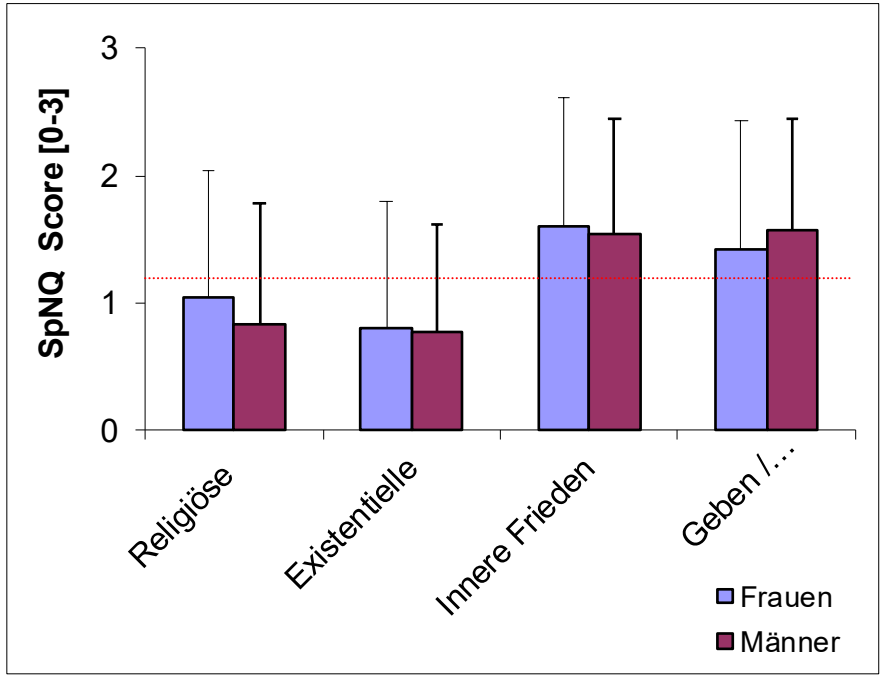
N=345: age 84 ± 7 years; 77% women, 23% men;
87% Christians, 2% other, 11% without religious affiliation



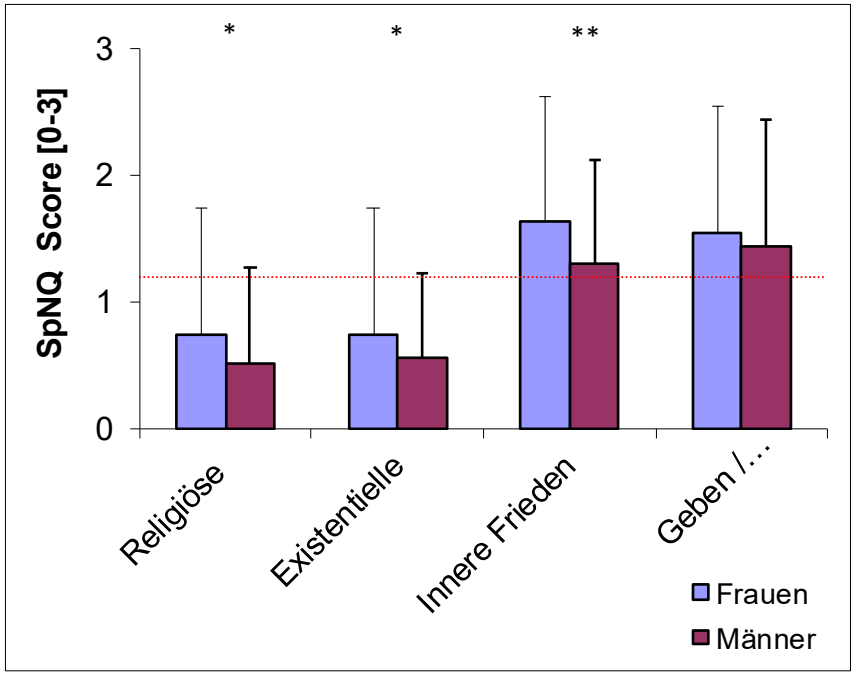
Significant differences in *Religious Needs* between people from the northern and southern parts of Germany!

- Regional differences might be due to confession (Protestants and Catholics), cultural characteristics, family support, and ‘temperament’.

Do the needs of cancer patients receiving palliative care differ from those in the early stages of their disease?



Terminal cancer patients (palliative care unit)
N= 125; 56% women 42% men; age 64 ± 11 years
74% Christian, 2% other, 24% none
Büssing et al. *Dtsch Z Onkol* (2020)



Early stage cancer patients
N= 285; 49% women, 51% men; age 61 ± 13 years
73% Christian, 25% none
Höcker et al., *Eur J Cancer Care* (2014)

→ Not essentially

Support patients´ spirituality only in the palliative situation?

- While the support of spiritual needs is well accepted in palliative care,
- it is not yet recognized as a topic of relevance in the early phases of diseases when patients are informed about the medical implications of their disease.

➢ In these phases, patients are mostly left alone with their existential and spiritual needs.

➢ Addressing their spiritual needs may help to support them in their struggle with their life situation

Gap of Support
in the socio-spatial environment

Who cares for person´s unmet needs
when they are at home?

Which structures of help are available

Spiritual Care, Participation & Inclusion
I have questions – I want to participate

People with disabilities also have unmet spiritual needs

- Spiritual needs are closely linked to participation and inclusion
- Dialogue may help identify needs, barriers, and resources
- Spiritual Care supports belonging and social participation

Easy Read Booklet → available online, too

➢ The *Spiritual Needs Questionnaire was* adapted into an Easy Read format addressing 7 dimensions of social participation.

In cooperation with the Inclusion Officers of the Diocese of Limburg, the Archdiocese of Paderborn, and the Protestant Church of Hessen/Nassau.

What is needed for Implementation of Spiritual Care?

Requirements for Implementing Spiritual Care:

- Trainable Spiritual Care competencies
- Structured assessment of spiritual needs
- Competent and supported healthcare professionals
- Sufficient time and organizational structures

Spiritual Care Competencies Questionnaire (SCCQ): *Conducting conversations, Perception, Documentation, Team spirit, Empowerment, Self-awareness*
www.spiritual-competence.net

Spiritual Needs Questionnaire (SpNQ): *Religious, Existential, Inner Peace, Generativity, (Family)*
www.spiritualneeds.net

Structural / organizational changes

Testing the SpECi curriculum across 7 education centers

- Developed by an interprofessional group of experts → www.speci-deutschland.de
- Only certified curriculum in Germany → *German Society of Palliative Medicine* (*Deutsche Gesellschaft für Palliativmedizin*)
- Curriculum published Pallia Med Verlag (2024)

Aims of the curriculum:

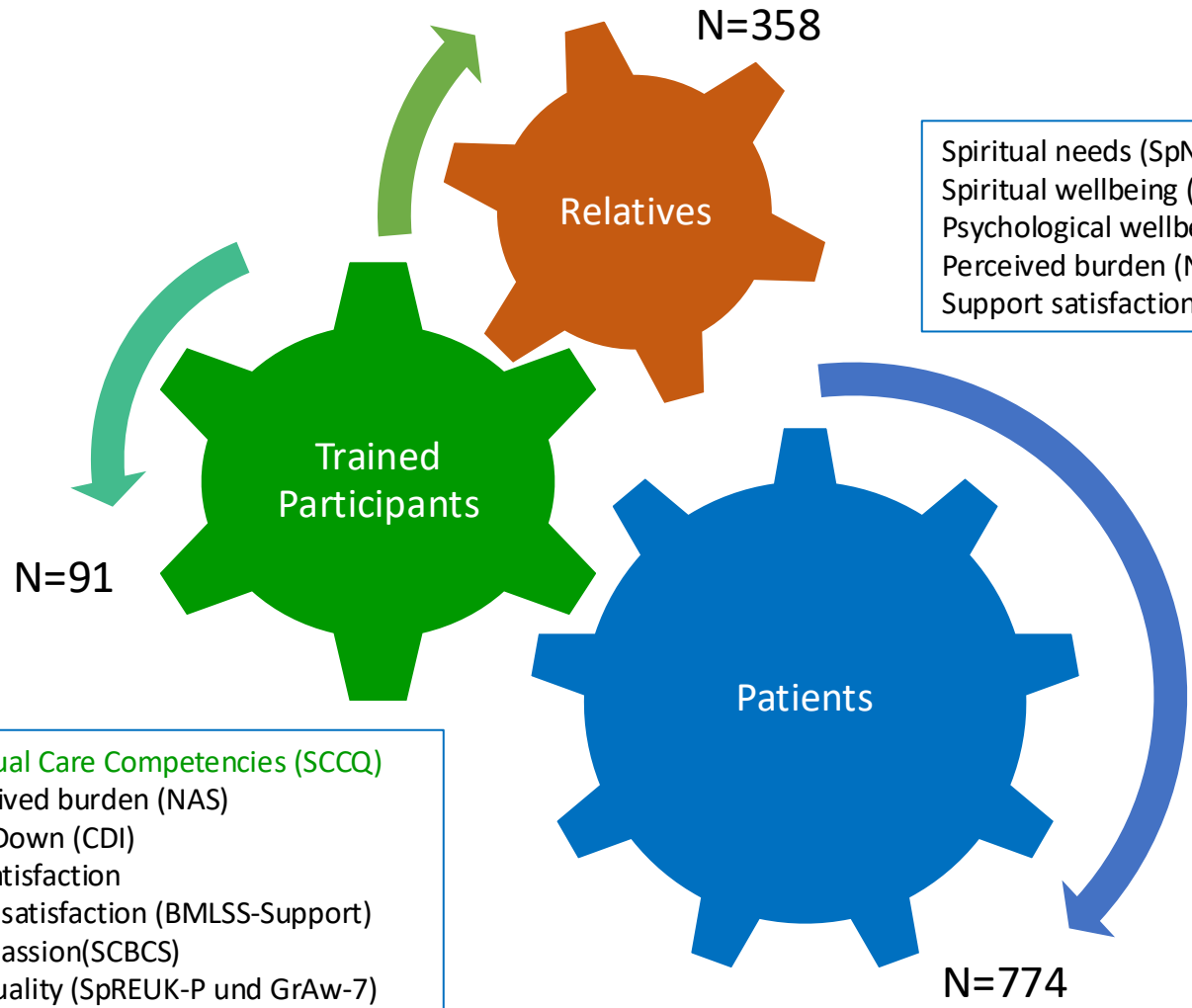
- Improving the spiritual care competencies of employees from inpatient geriatric care, hospices, and palliative care units (and other areas)
- Improved perception and support of patients´ existential/spiritual needs and well-being

Module	Topics of the Curriculum
1	Spirituality: approaches and clarifications / Spirituality in health and illness
2	Spiritual needs and Spiritual Care competencies
3	Perceiving existential concerns
4	Spiritual and existential communication in professional practice
5	Legal issues - intersections and contexts
6	Communication on unsolvable questions
7	Facing loss and grief
8	Spiritual resources: What comforts and what gives inner peace?
9	Spiritual resources: What gives hope?
10	Helpful rituals

Expectation: What is conveyed to the course participants has an impact on their patients and relatives

Motivations
→ Quality of care and relationships
→ Spiritual Care Ideals

Work load
→ Working time compression
→ Job dissatisfaction
→ Emotional distancing from patients



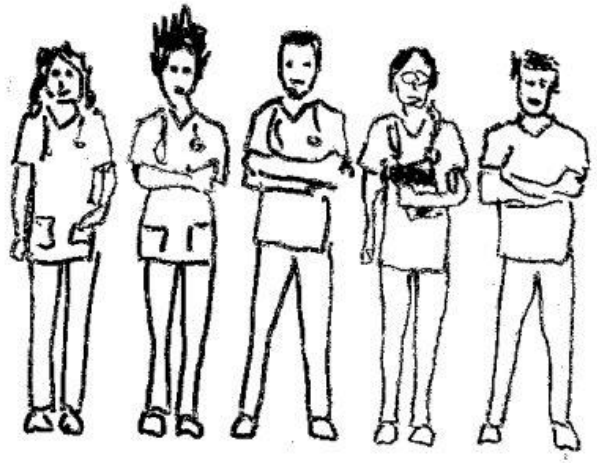
Spiritual needs (SpNQ-20)
Spiritual wellbeing (FACIT-Sp)
Psychological wellbeing (WHO-5)
Perceived burden (NAS)
Support satisfaction (BMLSS-Support)

Spiritual Care Competencies (SCCQ)
Perceived burden (NAS)
Cool Down (CDI)
Job satisfaction
Team satisfaction (BMLSS-Support)
Compassion(SCBCS)
Spirituality (SpREUK-P und GrAw-7)

Beyond basic spiritual competence and specific professional competence:

Spiritual Care competencies to be further developed

- Perception: perception of existential/spiritual needs and concerns
- Documentation: knowledge of instruments and documentation
- Team spirit: exchange and openness to the topic
- Self-awareness: deepening your own spirituality
- Knowledge: about other religions
- Conversation: open conversations about the topic
- Empowerment: support and enablement



Assessed with the SCCQ questionnaire developed by Frick & Büssing (2018)

Frick et al., *Spiritual Care* (2019); Mandelkow et al., *Journal of Spirituality in Mental Health* (2021); Pastrana et al., *Journal of Religion and Health* (2021); Muhammad Sohail et al., *Religions* (2022); Shimizu et al., *International Journal of Nursing and Health Care Research* (2023)

Workload affects well-being and behavior

Particularly during the COVID-19 pandemic …

Already before the training:
26% high workload, 58% moderate (“normal”), 16% low workload
3% not satisfied with their job, 22% partially satisfied, 75% satisfied with their job

	Workload	Job satisfaction
Workload	1.000	
Job satisfaction	-.498**	1.000
Team support	-.333**	.546**
Cool down	.434**	-.287**
Psychological wellbeing	-.349**	.375**
Compassion	.065	.165

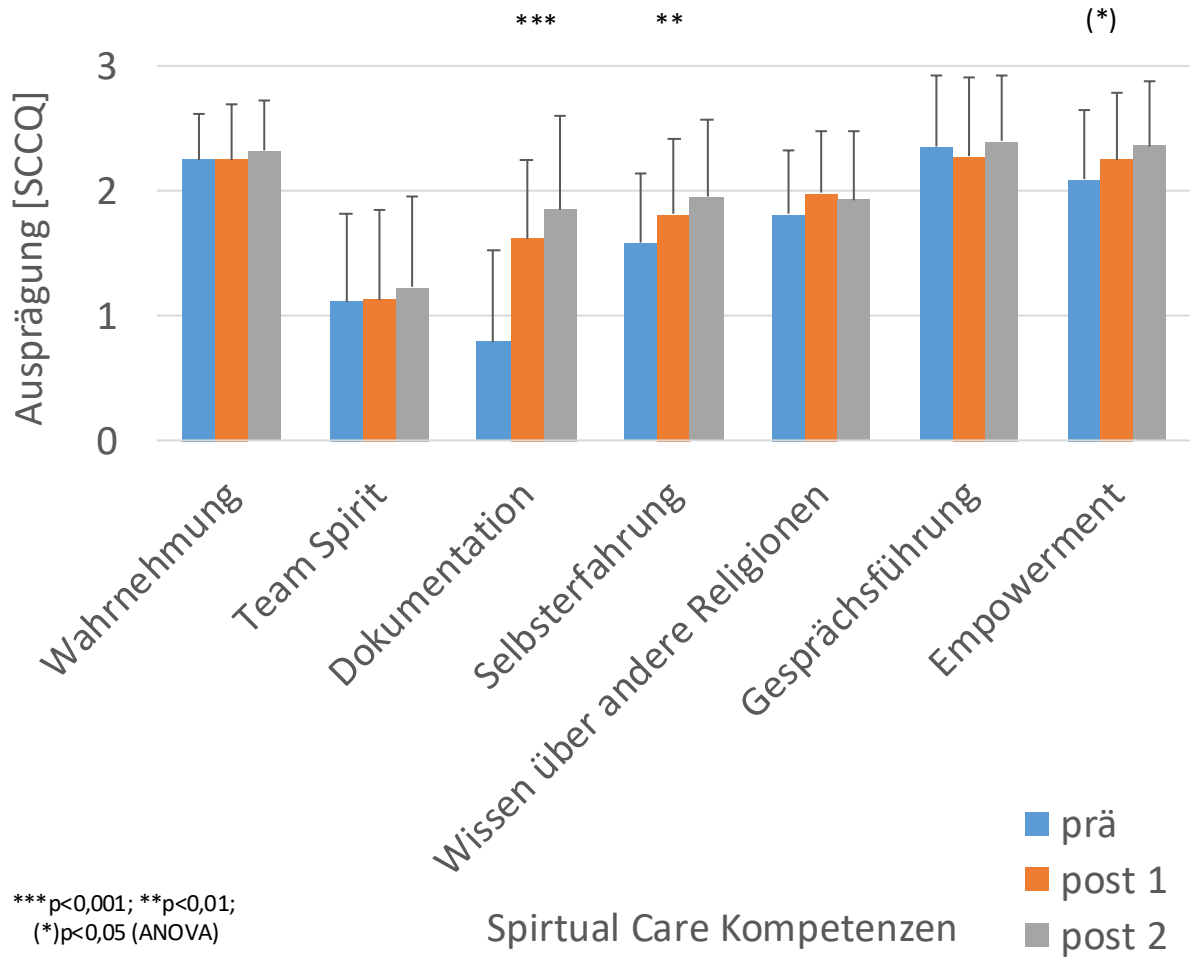
- Burdened by work → low job and team satisfaction, lower psychological well-being, more emotional exhaustion, and distancing from those being cared for (“cool down”)
- Satisfied at work → much greater team satisfaction, higher psychological well-being, and less cool down
- Compassion is independent of this

**p<0,001 (Spearman rho)

Büssing et al. *Journal of Religion and Health* (2025)

Trained Participants

Certain Spiritual Care Competencies could be further developed



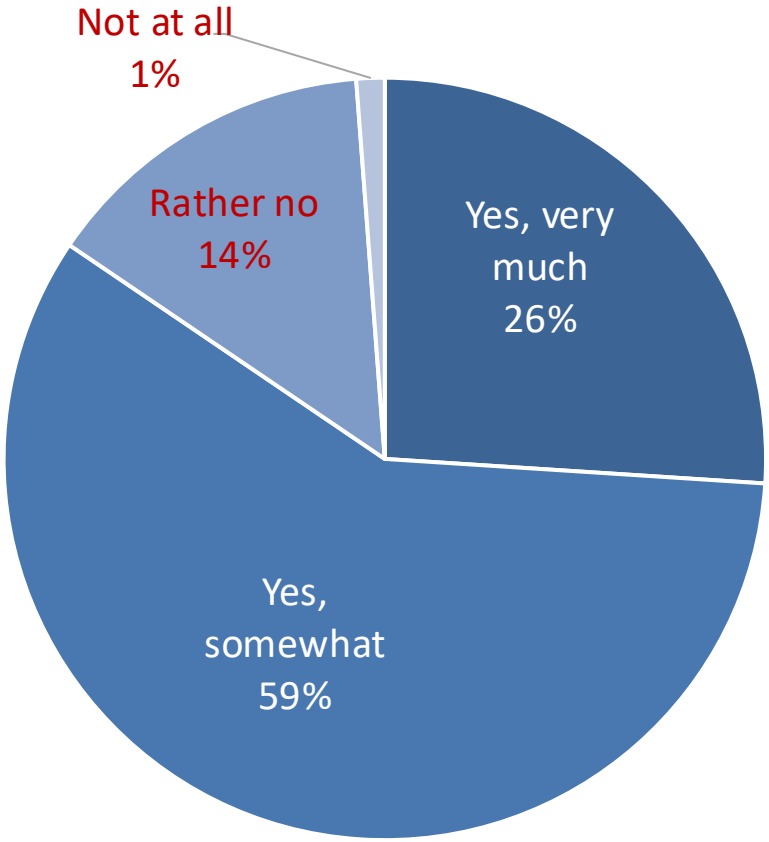
***p<0,001; **p<0,01; (*)p<0,05 (ANOVA)

- Some competencies were high already right from the start: Perception, Conversation skills, and Knowledge of other religions.
- Others have further developed: Documentation, Self-awareness, and Proactive empowerment.
- The low Team spirit remains the challenge!

Trained Participants

The SpECi course made participants more confident in dealing with patients´ spiritual needs

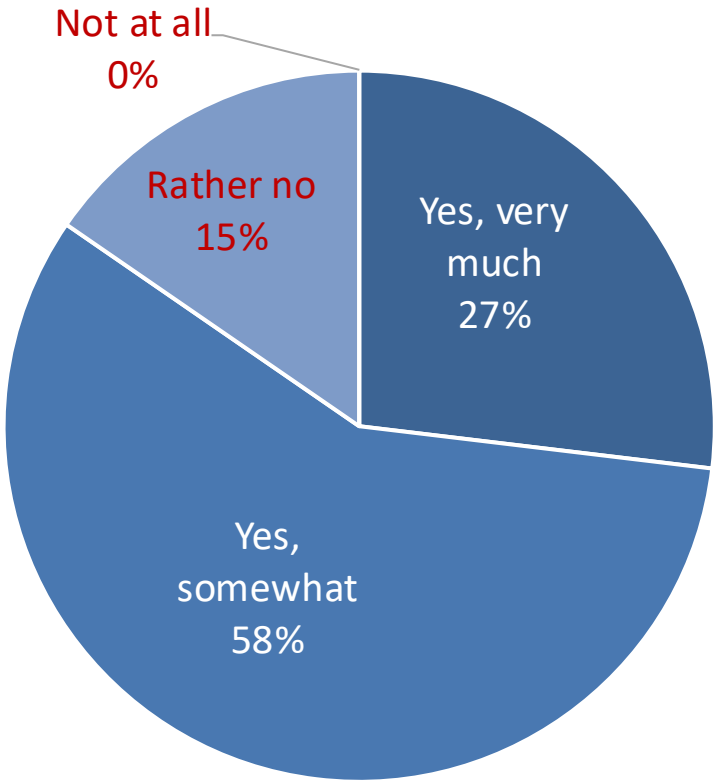
I respond to my patients´ spiritual needs much more often than before (85%)



They also pay more attention to the appropriate setting for such talks (p=0.009; Eta^2=0.052)

87% would like more time to talk about spiritual needs - even after the course!

Since the training, I feel significantly more confident in dealing with my patients´ spiritual needs (85%)



Büssing et al. *Journal of Religion and Health* (2025)

Competencies improve the likelihood to address spiritual needs

Dependent variable: I respond to my patients´ spiritual needs much more often than before

Stepwise Regressions (R^2=0,51)

- Self-awareness competencies: Beta = .53
- Team Spirit: Beta = .33
- Job satisfaction: Beta = .25

Dependent variable: Since the training, I feel significantly more confident in dealing with my patients´ spiritual needs

Stepwise Regressions (R^2=0,21)

- Perception competencies: Beta = .29
- Team Spirit: Beta = .26

➢ Team spirit is essential: is moderately related to job satisfaction (r=.31) and team satisfaction (r=.32), and weakly well-being (r=.25) and compassion (r=.26); the other competencies are not related

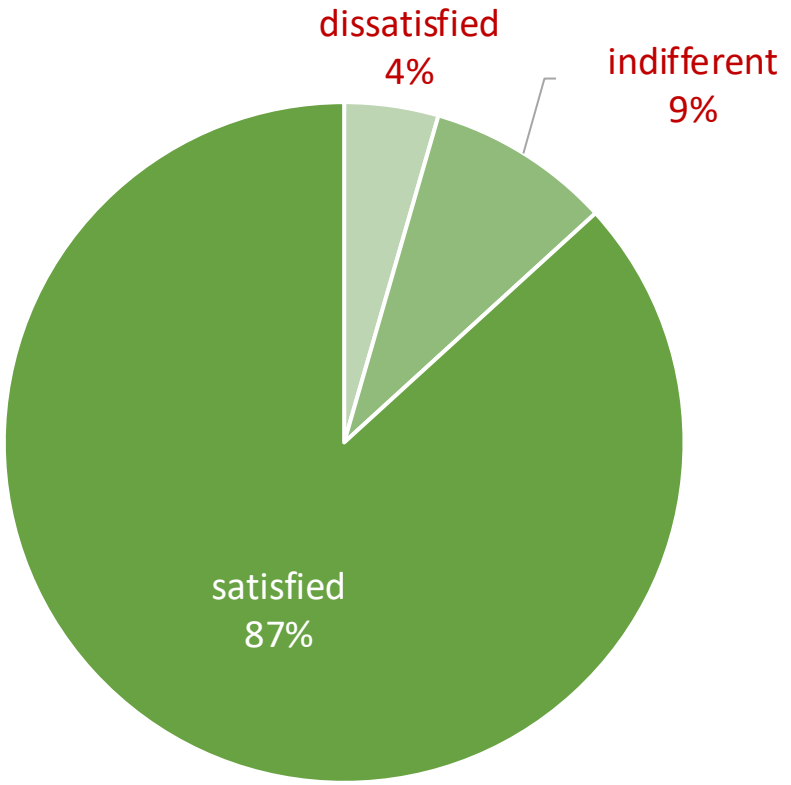
Büssing et al. *Journal of Religion and Health* (2025)

Patients

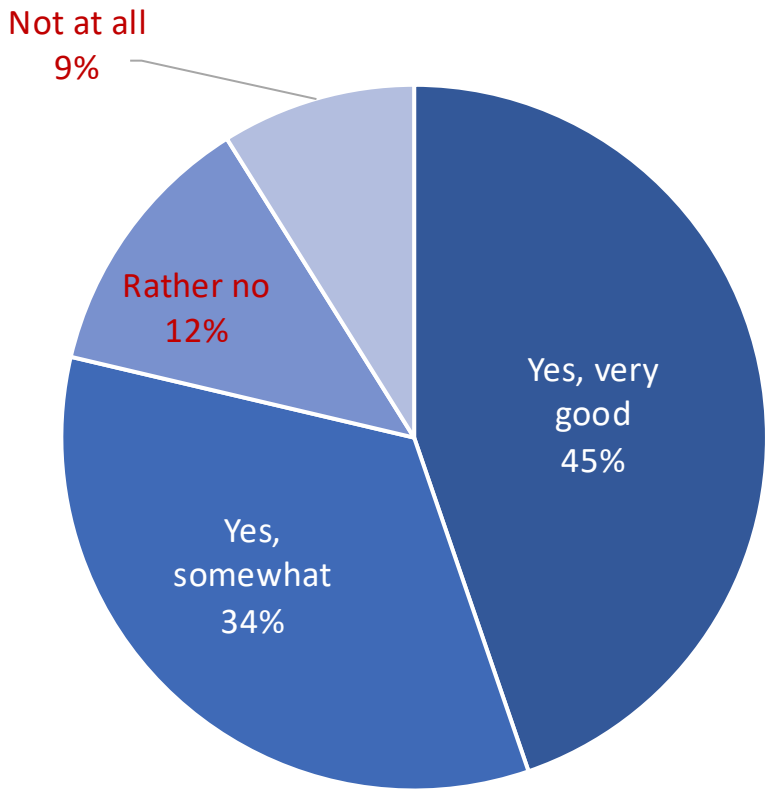
Did SpECi bring anything to the patients?

Yes: Overall, the satisfaction with the support from the stressed team was very high

Satisfied with the support of the team (87%)



Felt supported by the team in my spiritual needs (79%)



Most were satisfied with the general support from the team (87%).

But 21% do not feel well supported in their spiritual needs.

→ Support satisfaction remained high.

Büssing et al.. *Journal of Religion and Health* (2025)

Predictors of patients´ satisfaction with the support of their Spiritual needs (Regression analyses)

Dependent variable: Support of spiritual needs Model 6: F=25.9, p<.001; R^2=.197	Beta	T	p-Wert
(constant)		16.432	<.001
Support from the Therapeutic Staff	**.286**	7.348	<.001
Treatment side: Palliative care unit / Hospice	**.118**	**3.015**	**.003**
Support by Pastoral Care providers	**.101**	**2.608**	**.009**
Generativity needs	.075	2.067	.039
Spiritual wellbeing: Faith	.090	2.363	.018
Age	-.088	-2.316	.021

Not significant in the regression model: Existential Needs, Inner Peace Needs, psychological wellbeing, and gender

- Those cared for in the palliative care unit or hospice are in poorer health, but they feel well supported there.
- Particularly by the therapeutic staff – and also by Pastoral Care providers.

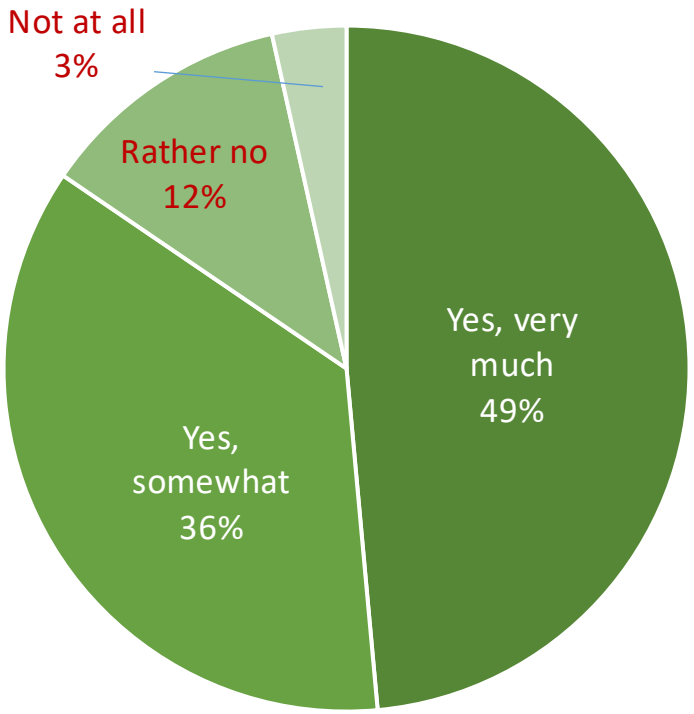
Büssing et al.. *Journal of Religion and Health* (2025)

Relatives

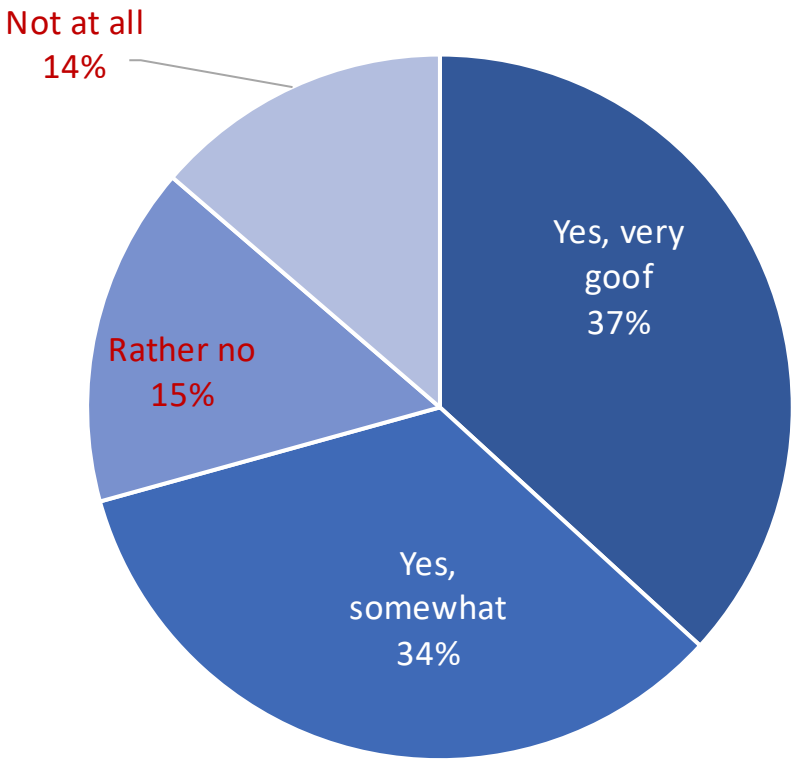
SpECi has also brought something to the family/relatives

Overall, satisfaction with the support from the stressed team was high

The team took good care of my family member's spiritual needs (85%)



Felt supported by the team in my own spiritual needs (71%)



Most found that the team took good care of their relatives (85%).

But 29% did not feel well supported with their own spiritual needs → they are the "visitors" for whom there is no mandate to provide care.

→ Support satisfaction remained high

Büssing et al. *Journal of Religion and Health* (2025)

Caring for relatives is theoretically considered as essential – yet, often enough, merely optional

Spiritual Distress (as measured with the Spiritual Distress Screener) among 150 Relatives of Hospice Residents

	Due to my current life situation …	How strong is the Distress?			
		Not at all	Some-what	Strong	Very strong
1	I feel sad, angry, and disappointed.	8	29	33	30
2	many things in my life have become unimportant and irrelevant to me.	28	35	25	13
3	I can no longer find any support in my life.	58	32	8	2
4	I have lost my support in my faith (or in what has always been important to me).	67	22	5	5
5*	I feel abandoned by family and friends.	68	23	5	4
6	I feel completely forsaken by God (or what is sacred to me).	72	18	4	6
7	I have lost my hope.	59	26	9	6
8	I wonder what the meaning of my life is.	52	28	17	3
9	I feel that my prayers go unanswered.	61	28	4	7
10	I need someone to give me the courage to keep going on.	37	38	16	9

Spiritual distress correlated strongly with low psychological well-being ($r = -.56$), moderately with perceived burden stemming from the relative's situation ($r = .42$), and with low resilience – specifically, the ability to tolerate and endure emotions ($r = -.48$).

Büssing & Rüther, *Spiritual Care* (2025)

An intervention study involving nurses, physicians, and chaplains who were trained together

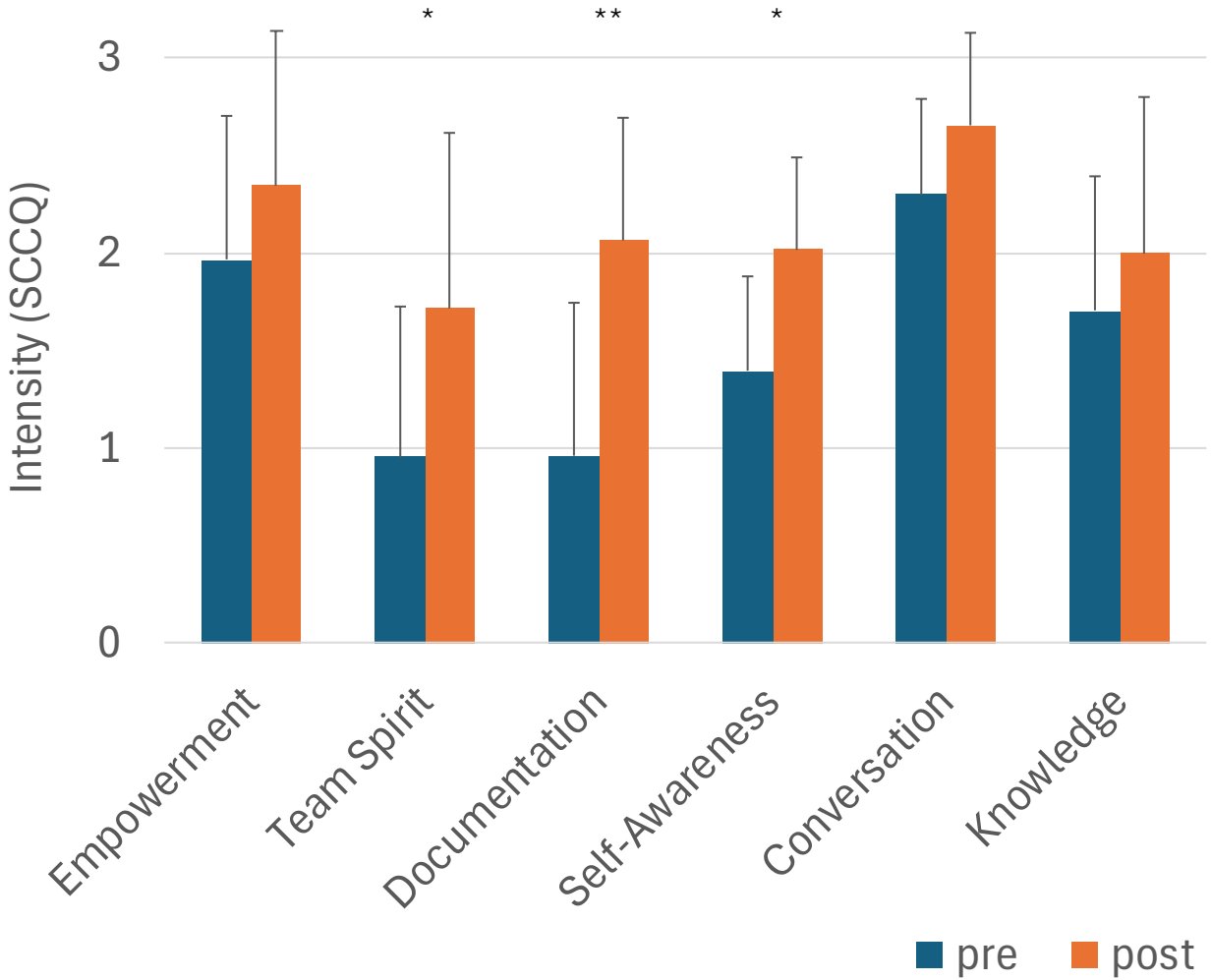
Nineteen trained staff members from three therapeutic facilities:

- elderly care
- Oncology
- disability support.

Alexianer

– Predominantly women (only 3 men)
– mean age 47 ± 9 [31–64] years
– All had a nominal Christian religious affiliation – but 1/3 regarded themselves as not religious

Spiritual Care Competences improved



- Conversation competences, Empowerment competences and also Knowledge of other religions were high already from the start
- Team-Spirit, Documentation und Self-awareness were moderate at the start and improved significantly and strongly.
  - Documentation (Eta^2=0,390)
  - Team Spirit (Eta^2=0,182)
  - Self-awareness (Eta^2=0,129).

➢ Compared to the initial intervention with individuals, in this group intervention higher scores were observed in all cases. However, due to the small sample size, these differences barely reached statistical significance.

SpECi Implementation: *Take-Care-Together!*

- Providing Impulses for Organizational and Cultural Development based on Interprofessional Training in Spiritual and Existential Care (SpECi)
- Healthcare professionals in six diaconal healthcare facilities from East Germany

➢Aim is the development of a spiritual culture of care in healthcare facilities

✓Resulting in strengthened resilience, job satisfaction, and professional identification among healthcare professionals

✓Improving employability and scope of employment for healthcare facilities and providers

Key Focus Areas of *Take Care Together!*

Cultural Development and Change

Attitudes and Values
Communication and Cohesion
Spirituality and Care Ethics

Employees

Empowerment, Professional Development, Spiritual Care, Self-Care/Resilience

Organization

Structures, Processes, Workflows, Roles, Responsibilities

The Innovation

Joint development of a site-specific culture of care

Growing Dissemination of the SpECi Curriculum

Pilot phase (2020-2024) with 7 SpECi training courses at the application partners in Essen, Cologne, Olpe, Bielefeld, Hamburg, Berlin, and virtually

Transition Phase (2024):
At least 8 SpECi training sessions, and 1 Course Instructor Training with 50 participants

2025

SpECi
Spiritual Existential Care inter-professionell

Training courses

2026

Spiritual Needs reflect a longing for life – which cannot easily be “fulfilled”

Spiritual needs could be considered “vital signs”!

Some can be addressed and therefore may become “less”,
while others remain “unquenchable” (inner peace; attention)

Recommendations

- Nourish your own spirituality (as a nurse, physician, therapist, …)
- Generate a surrounding in which spirituality is (not only theoretically) appreciated
- Encourage patients / elderly to talk about their psychosocial, existential and spiritual needs
- Ask how you can support them
  (there is no mandate to solve all problems…)

"Spiritual or compassionate care involves serving the whole person – the physical, emotional, social, and spiritual. Such service is inherently a spiritual activity."

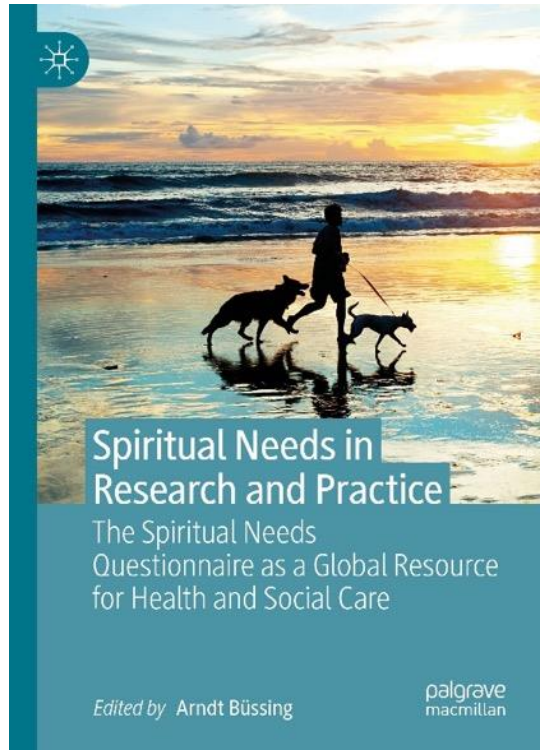
Christina Puchalski, Proc (Bayl Univ Med Cent) (2001)

Conclusions

Addressing patients´ spiritual needs is not optional.

- It indicates that HCP values and respect the person with their specific life situation, biographical background, current sense of purpose and meaning in life, hope, moral values, religious and non-religious convictions, and spiritual rituals important to them, depending on the resources available to them.
- Spiritual Care is an essential dimension of person-centered healthcare.

Büssing & Koenig *(*2021)



www.spiritualneeds.net

Take home messages

1. Existential and spiritual needs are integral dimensions of healthcare → Awareness
2. Acknowledging these needs affirms the dignity and individuality of patients → Recognition
3. Spiritual Care flourishes when interprofessional teams learn and work together → Team-Spirit
4. Compassionate care requires time, staffing, and supportive structures — otherwise even highly committed professionals risk emotional exhaustion → Prevention