# Developing Spiritual Care Capacity for Hospice Palliative Care: A Canadian Curricular Resource Kit

This resource is the first Canadian effort at a coherent and intentional integration of educational materials in a single source and aligned with the CHPCA Model to Guide Hospice Palliative Care Based on National Principles and Norms of Practice and a comprehensive occupational analysis developed by a diverse pan-Canadian cross-section of professional hospice palliative care spiritual care professionals.

Developing Spiritual Care Capacity is intended to support Canadian Association of Pastoral Practice and Education (CAPPE) accredited Clinical Pastoral Education (CPE) [Note: CAPPE accreditation for teaching supervisors and sites is undertaken through a site-based application process administered directly by CAPPE].

Developing Spiritual Care Capacity can also be used as a source document to support the development of a range of local staff/professional development interventions that support improved local spiritual care.

**NOTE:** See the pages following this description for a detailed presentation of the resource Table of Contents, a discussion of its intended use and a sample of a module outline, module alignment with CHPCA Model and sample lesson framework which is used throughout the resource.

## Resource Format
- 3 ring-binder based curricular resource kit
- Companion CDR with supplemental materials listed in the appendices
- Facilitating Healing DVD – a 30 minute “grand rounds” style presentation comparing and contrasting spiritual and religious care and outlining the importance of effective spiritual care in palliative case management.

## Alternate/Other Formats
N/A

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Discussed in resource introductory section below

## Peer-review Status
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Chapter 1
Spiritual Care Development Initiative

Overview

These curriculum resource materials are presented to the Hospice Palliative Care (HPC) Community in the hope that they may provide a suitable starting point for focused reflection on the clinical theory, methods of practice and professional qualities deemed requisite for HPC Spiritual Care Providers. They have been prepared in the form of a modularized core curriculum (discussion papers accompanied by suggested lesson plans), a set of recommended resources and clinical case studies. They are not intended as exhaustive studies of the topics covered nor do they seek to offer definitive or prescriptive approaches to the understanding or provision of spiritual care. Spiritual care is not as susceptible to structured analysis as other disciplines may be. Much must be left to the individual practitioner’s creative reflection on theory and supervised practice as the main methods of learning what to do and how to do it well.

It is assumed that educators will use this material in addition to the materials they routinely present on other, typical components of clinical education.

Possible uses of these materials:

• as core components of Clinical Pastoral Education programs, particularly those focused in HPC, for the professional formation of persons intending to engage in institutionally-based or community-based ministries to the suffering and dying;
• as continuing professional development resources for institutional Spiritual Care Providers desiring to enhance their understanding of the needs of the suffering and dying in their care;
• as discussion starters for community religious leadership wishing to reflect on the spiritual and religious care needs of members of their congregations who are suffering and dying and how better to journey with them; and
• as materials that will assist other disciplines to gain an insight into the provision of spiritual care from the perspective of HPC Spiritual Care Providers.
A major strength of these materials is that they are solidly linked to several important sources of peer-validated, competency-based approaches and standards of practice-based approaches to spiritual care:

- *The Professional Hospice Palliative Care Spiritual Care Provider* occupational analysis profile of fourteen Major Areas of Responsibility and eighty-one related Major Tasks, developed through a formal DACUM Workshop in Calgary, Alberta in January 2005.¹ This provides for a peer-validated, occupational analysis-based approach to the development of this resource package.

- *A Model to Guide Hospice Palliative Care: Based on national principles and norms of practice* published by the Canadian Hospice Palliative Care Association (CHPCA), March 2002.² This document establishes the vision of the Canadian HPC community for holistic care which includes the provision of skilled spiritual and religious care as part of the *Square of Care* and *Square of Organization*.

- Documents from leading spiritual and religious care, chaplaincy and pastoral counselling organizations in Canada and the United States.

A thorough discussion of these source documents and their application to competency-based education for HPC Spiritual Care Providers is found in **Part II**.

Reasonable methodological limitations in the use of these materials include:

- The near impossibility of speaking accurately or inclusively in regard to the vast diversity of thought and practice found in the Canadian religious and multi-cultural milieu. The principal authors acknowledge, as unavoidable, a North American and English-language bias in our thinking and in our access to the world literature of HPC. This is somewhat ameliorated by the inclusion of francophone members in the Collegial Development and Peer Review Group, who participated in the Calgary DACUM Workshop and formally reviewed these materials. The DACUM Chart has been translated into French.

- The related issue of the very considerable differences in theory and practice of HPC Spiritual Care Providers. Prior to this Pallium Project (Phase II) initiative, there had not been a formal attempt in Canada to move towards a consensus within this area of practice. Spiritual care is still attempting to make a good case for itself as a ‘disciplined practice.’ While our diversity is a sign of the vitality of the spiritual and religious care community in Canada, increasing demand for demonstrable quality of service provision and greater accountability to consumers and health care systems is calling us to reach a greater degree of theoretical consensus and commonality of practice. These materials are intended to further the conversation towards this end, but they will not constitute the last word.

1 © The Pallium Project 2005.

1.1 Scope and Content of the Material

The limitations inherent to a work of this size regrettably require that we focus only on a selection of the central issues, theories and approaches in HPC spiritual care. Many important topics, such as pediatric palliative care, palliative care in the ICU, palliative care in long-term care facilities, and others are beyond the scope of this early integration effort. Much that is creatively unique in individual practice and in local contexts of care will not be adequately represented. Religious and cultural diversity, while deeply respected throughout this work, cannot be fully reflected. Inevitably, much will be left to the subsequent development of others.

We have attempted to provide resources that will be applicable in as wide as possible a context. It will be evident, therefore, that these materials have something of a ‘generic’ flavour, suited to what is often described as ecumenical and multi-faith spiritual and religious care, rather than care that is specific to one religious, theological or philosophical perspective. We hope that this emphasis serves as a strong general foundation upon which to further extend for those whose practice is set in the context of a specific religious tradition.

The package contents consist of 14 segments, including 10 Modules. Part I contains the Preface. Part II, Chapter 2 offers an introduction to the Project and SCD Initiative, an exploration of the recent North American discussion concerning the training, certification, professional role and practice of the HPC Spiritual Care Provider, and a description of the process followed in curriculum design and development. Chapter 3 discusses educational theory and methods of instruction. Chapter 4 presents case studies used frequently throughout the Modules.

Part III is the modular portion of the Resource Package. Chapters 5 and 6 contain Modules 1 and 2, which focus on the key foundational task of understanding the similarities and differences between spirituality/philosophy of life and religion and the various modalities of care suitable to both. We have intentionally taken an inclusive rather than particularistic approach to this material. Chapter 7 contains Module 3, addressing the important topic of providing care in the contemporary multi-faith and multi-cultural context. Chapter 8 contains Module 4 and addresses the client-centred and therapeutic models of care common to HPC. Chapter 9 containing Module 5 addresses the ongoing conversation in the HPC literature around understanding the nature of suffering and the implications of these notions for the way in which care is offered. The importance of offering appropriate spiritual and religious care at the end-of-life is indicated in this material. Chapter 10 contains Module 6 focusing on the theory and methods of discernment (assessment) and care planning. How does a Spiritual Care Provider understand this process in ways that are similar to or distinct from other health professionals?

In Chapters 11 and 12, Modules 7 and 8 explore the frequently observed issues and concerns of HPC clients and various approaches to addressing these concerns in practice. The reader is encouraged to note that Module 7 is more oriented towards theory than practice and Module 8 more towards practice than theory. The two Modules are, however, closely linked and
follow the one from the other. There is an approximate identity of the numbering in these two Modules. Issues raised in Section 11.1 of Module 7, for instance, will be addressed in Section 12.1 of Module 8.

Chapter 13, containing Module 9, offers an overview of major ethical issues in end-of-life care and explores the role of the Spiritual Care Provider as a member of the interdisciplinary team in ethical decision-making. Chapter 14, containing Module 10, addresses aspects of grief and bereavement, and interventions suitable to the Spiritual Care Provider.

Part IV, Chapter 15 contains a selection of recommended peer-reviewed and learner-contributed textual, journal and audiovisual resources for Spiritual Care Providers. Supporting documents and a suggested learner evaluation form are included.

1.2 Words of Appreciation

The principal authors of this material would like to express their thanks to those who have contributed to its production and review.

The Government of Canada, Health Canada, Primary Health Care Transition Fund (National Envelope) for the investment in the Pallium Integrated Care Capacity Building Initiative [i.e., Pallium Project (Phase II)].

The Pallium Project (Phase II), and in particular to Dr. Jose Periera, MBChB, DA, CCFP, Project Leader, and Michael Aherne, M.Ed., CMC, Director of Initiative Development and Project Oversight, for their identification of the HPC Spiritual Care Development Initiative as an important initiative within Phase II, their generous support in achieving its objectives and their personal encouragement at every point.

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Members of the Collegial Development and Peer Review Group for their collaboration in this enterprise, in the analysis of source materials, the Calgary DACUM Workshop, ongoing editorial review of the developing modules and formal review of the final draft. Members of this group include:
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A thorough description of the DACUM process, as part of systematic curriculum design may be found in the *DACUM Handbook* (Norton, 1997)\(^{38}\)

**How the DACUM Process was Used for Spiritual Care Competency Profiling – Calgary 2005**

In January, 2005 eleven HPC Spiritual Care Providers and spiritual care educators accredited in HPC practice settings met in Calgary, Alberta (Canada) to complete a professionally facilitated DACUM Workshop. This group of skilled HPC practitioners, all with years of experience in HPC environments, and a variety of academic qualifications and professional certifications, shared one evening and two days of intense reflection (and some soul searching) on the practice of their ministries. Utilizing a structured DACUM group interviewing technique a normative Scope of Practice, Major Areas of Responsibility and Major Tasks for *The Professional Hospice Palliative Care Spiritual Care Provider* were identified.\(^{39}\)

The DACUM Chart is a Canadian first for the HPC spiritual care community. It is not to be taken as prescriptive but normative. It highlights what HPC Spiritual Care Providers need to demonstrate in practice. It provides a solid basis in educational theory and practice for future efforts to inform curriculum development that will assist learners to acquire the stated competencies.

The DACUM Chart has been widely shared in the Canadian HPC community and with Initiative stakeholder organizations (CHPCA, CAPPE/ACPEP Education Standards Commission, and the Health Canada Secretariat for Palliative End-of-Life Care). It has been presented, with considerable interest expressed, at several Canadian regional and national HPC and Oncology conferences. It has been translated into French.

An extension of the DACUM process that has not been completed in the Pallium project (Phase II) is detailed task analysis of each Major Task in the DACUM bands. In this stage, skilled practitioners look at the steps involved in accomplishing specific tasks and the specific knowledge, skills and attributes required in each task. Given the strong orientation of “being” rather than “doing” tasks of spiritual care practice, further thought and innovation may be required to get to this point.

**2.4.1 A Model Competency Profile (2005)**

A full version of the profile for *The Professional Hospice Palliative Care Spiritual Care Provider* is provided with this resource package. Briefly, here are the key elements:

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\(^{39}\) The Pallium Project (2005), 5.
A Scope of Practice Statement was first developed. It states:

The Professional HPC Spiritual Care Provider practices the art of skilled spiritual companionship, entering into the lives of the suffering and dying.

As noted, this process was not without debate! A key concern was whether or not to state the intent of the offer of spiritual companionship. Some thought it ought to include a concluding phrase, such as, “with therapeutic intent,” however, the consensus at the end was to define the role and not to limit the intent of the action. This seemingly small point was important in terms of the recognition that, for Spiritual Care Providers, persons are encountered as persons (in and of their own right and for purposes of their own) and not for any ostensible purpose of the caregiver.

The process then identified 14 Major Areas of Responsibility (Bands), and 81 component Tasks within those bands which were arranged in order of relative importance. These areas are:

1. Discern, identify and understand spiritual and religious history, resources and care needs. (6 related tasks),
2. Provide appropriate, culturally sensitive spiritual care (14 related tasks),
3. Provide for appropriate religious care (6 related tasks),
4. Provide spiritual counselling (6 related tasks),
5. Collaborate as a member of the interdisciplinary team (8 related tasks),
6. Provide leadership in ethical decision making (6 related tasks),
7. Advocate on behalf of patient and family (3 related tasks),
8. Provide grief and bereavement care (3 related tasks),
9. Facilitate functional relationships (4 related tasks),
10. Provide support to staff (5 related tasks),
11. Nurture the organizational soul (5 related tasks),
12. Provide education and engage in research (5 related tasks),
13. Perform administrative duties (6 related tasks), and

Of these, the most challenging in terms of agreement was the first (“discern, identify and understand …”). In health care, the term assessment is widely used to describe the process whereby a professional takes a history and forms an opinion about the resources and needs of client, as the basis for communicating to the team and devising a plan of care. After considerable ‘soul searching,’ the group agreed that the CHPCA description of the process of assessment\(^{40}\) served us better than the term assessment itself. It was agreed that the Spiritual Care Provider’s approach needed to be one of discerning, in the sense of developing intimacy and being spiritually sensitive to the other, rather than assessing, in the more formal and possibly distant

sense connoted by that term. It may seem like a small point, but it was important. It is a matter of professional attitude and approach to the client.

Each participant in the DACUM Workshop was provided with an opportunity to review the results and write in differing opinion or afterthoughts, which are duly recorded in the final document. Participants generally indicated strong support for the process and substantial endorsement of the conclusions.

2.4.2 Developing Curriculum and Testing Learner Acquisition of Competencies

One of the interesting questions in this process has been how best to test the competency levels of learners? This was examined within in two learning laboratories, units of Clinical Pastoral Education, focusing in Hospice Palliative Care and Oncology, held in 2004 and 2005, in Regina, Saskatchewan, using evaluative tools available at the time.


The intent of this unit was to experiment with elements of curriculum that might prove to be suitable for training in HPC. Five adult learners participated in the Unit, three at the Advanced level of CPE and two at the Basic Level. Three of the participants were health care and community non-governmental organization Chaplains, one a community pastor and one completing a graduate degree in Pastoral Counselling. As is mandated by CAPPE/ACPEP Standards for educational programs, the students spent approximately one-half of their time in team-based clinical work and one-half of their time in individual and group supervision, lectures and other individual and peer learning activities.

The curriculum for this unit was developed prior to the DACUM Chart and was based on the clinical experience of the Initiative Consultant, a CPE Teaching Supervisor with extensive clinical expertise in HPC. Since the program was in a formative stage, it was not formally reviewed by the Accreditation Committee of the Education Standards Commission of CAPPE/ACPEP, although the Committee Chair was advised and kept informed of developments, as required by CAPPE/ACPEP Standards. The Supervisor functioned, with permission, under the accrediting authority of a previous CAPPE/ACPEP Program Approval.

Prior to the January 2005 DACUM Workshop, the closest thing to a relevant Canadian occupational profile was an in progress tool created by the National Strategy for Palliative/End-of-Life Care (Working Group on Education for Formal Caregivers). It was in the process of being validated by web-based surveys when it came to the attention of the HPC-SCD Initiative

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Consultant. This profile identifies six competency areas for HPC spiritual care professionals, each with a sub-set of knowledge, skills and attitudes (KSAs):

1. Address pain and symptoms (4 items),
2. Address end-of-life decision-making and planning (7 items),
3. Communicate effectively (5 items),
4. Collaborate as a member of an interdisciplinary team (6 items),
5. Address psychosocial and spiritual needs (6 items), and
6. Attend to suffering (6 items).

This profile was used, with permission of the authors, as an initial attempt to evaluate learner competency development in a 12-week, 400 hour CPE unit. The instrument was re-designed for competency testing by the Supervisor utilizing a 1 – 5 point Likert Scale, with the following descriptors:

1 = “no or very little observed demonstration of the identified competency” (i.e. learner at an entry level and requires complete training and direct supervision)
2 = “some observed demonstration of the identified competency” (i.e. a good Basic CPE level, but continuing to require significant further training and direct supervision)\(^{42}\)
3 = “satisfactory/adequate observed demonstration of the identified competency” (i.e. learner ready to enter Advanced training and capable of functioning in the discipline with some supervision)\(^{43}\)
4 = “well developed/strong observed demonstration of the identified competency” (i.e. learner functioning mostly at an Advanced level and can function in the discipline with minimal or no direct supervision)\(^{44}\)
5 = “full/very advanced observed demonstration of the identified competency (i.e. learner functioning fully at an Advanced level and can function in the discipline without direct supervision – ready for a process leading towards certification as a Specialist)\(^{45}\)

For instances where the competency had not been observed (or perceived by the learner), the score of not observed could be entered. The scores for each item were averaged to provide a score for the competency area. These scores could then be compared between learners or seen as averaged scores for all learners for that period. The instrument was administered to learners in


\(^{44}\) “Admission to Advanced Training” at [www.cappe.org](http://www.cappe.org).

Week 1 to provide a baseline score. It was re-administered in Weeks 6 and 12. For the purpose of comparison only, in week 6 the Supervisor also scored each learner and in Week 12 the Supervisor and one or more clinical staff members chosen by the learner also scored the learner.

It is important to note that these results were not shared with the learners or others completing the instrument at any time. Neither were they considered in the Supervisor’s required CAPPE/ACPEP evaluations of the student. The results were filed during the unit and entered into Excel and graphed only following the program. The results of this process were entirely for the purposes of evaluating how competency changes over time in a CPE program with content focused on HPC and Oncology. Students were informed of this competency testing procedure in advance and signed consents on the first day of the program permitting the use of their de-identified scores for the evaluative and development purposes, including conference presentation.

The Working Group instrument proved easy to comprehend and use for this evaluative purpose. The results overall demonstrated that learners perceived strong competency development over the weeks of the CPE program. Subsequent evaluation by the CDPRG of the competency areas identified in the document, however, demonstrated the need for a more rigorous design process for an occupational profile, utilizing the aforementioned DACUM Workshop approach.

CPE 2005 Educational Laboratory (May 2 – July 21, 2005)

Following the DACUM Workshop, the Initiative Consultant, in collaboration with a Research Associate, commenced a thorough revision of components of the curriculum resource package. The revision focused on the Scope of Practice statement, the 14 Major Areas of Responsibility and 81 Major Tasks identified in the DACUM Chart, dispersed throughout a series of Modules. The content of the DACUM chart is further detailed in Section 2.4.1, above.

A second Learning Laboratory was convened in 2005, with three adult learners, one at the Advanced level and two at the Basic level of training. Two learners were health care Chaplains and one a graduate student in Theology. The intent of this program was to further test and validate the content of the curriculum resource package modules from the learners’ perspectives and to explore the use of the DACUM Chart for learner assessment. Participants were fully informed of the intent of the competency testing and signed the required consents on the first day of the program.

A competency evaluation tool was developed using the 14 Major Areas of Responsibility organized into a chart and the aforementioned 5-point Likert scale. Participants (and clinical staff in Week 12) received the full DACUM Chart to guide their understanding of the content of the Major Areas. As before, the instrument was administered in weeks 1, 6 and 12 of the program. Following the CPE unit, the learner scores were graphed and compared as before. Again learner scores demonstrated significant self-assessed improvement in competency over the period of the
Developing Spiritual Care Capacity for Hospice Palliative Care

...program with the focused curriculum. Learners’ written evaluations of the curriculum components were completed after each educational session and participants’ comments were positive about the content and instructional methods. An important insight was an observation that discussion of this material cannot be rushed and that considerable time is needed for reflection on the content and integrating its personal application to ministry.

For both the 2004 and 2005 competency evaluation processes, only learner self-assessment is formally documented in support of the impact on competency acquisition of the curriculum and other components of the training program. It is acknowledged that this is a limited approach to evaluation, and that further study of the use of this curriculum resource package in supervised pastoral education, and of the use of the occupational profile for *The Professional HPC Spiritual Care Provider* as a competency evaluation tool would be beneficial.

**Peer Review and Completion of the Curriculum**

Members of the CDPRG have informally evaluated the modular components of the curriculum throughout the writing process. Their suggestions have been integrated as feasible into the final draft product. In October 2005, this body of material was then delivered to the Pallium Project Development Office for a formal, modified blind peer review. This process involved sending the material to CDPRG members for full review and criticism. Their comments were reported directly to the office on de-identified forms. These forms were then collated and provided to the principal authors (Initiative Consultant and Research Associate) as the basis for a final integration of review feedback. Members of the CDPRG were invited to sign off on the curriculum resource package.
Chapter 6
Module 2 – Definitions of Spiritual Care and Religious Care

Source Document Alignment for Module 2

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<thead>
<tr>
<th>CHPCA Model</th>
<th>HPC-SCP Occupational Profile</th>
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<tbody>
<tr>
<td>Definition of HPC</td>
<td>Scope of Practice Statement</td>
</tr>
<tr>
<td>Values 1 – 7</td>
<td>Areas A, B, C, D, E, F, G, H, I</td>
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<tr>
<td>Guiding Principle 1, 2, 3, 4, 5, 7</td>
<td>Appendix A</td>
</tr>
<tr>
<td>Foundational Concept 2.2</td>
<td></td>
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<tr>
<td>Square of Care and Organization</td>
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</tbody>
</table>

Overview

This module provides an introduction to the concepts of Spiritual Care and Religious Care. The reader is referred to Module 1 as preparation for this module. Due to the interconnectedness of the notions of religion and spirituality, it is not always possible to make a clear-cut distinction between Spiritual and Religious Care. Neither do we suggest that there are two clearly distinct types of individuals. It is often helpful in clinical practice, however, to attempt such distinctions where doing so may assist in making care decisions that are relevant to the client’s self-understanding and experience.

If we were fortunate when we were growing up, we were well cared for by a number of adults – parents, guardians, teachers, instructors, doctors, nurses, religious leaders – and even by siblings and friends. Care came in various forms, nurturing our physical, psychological and spiritual selves so that we might grow into reasonably healthy adults who in turn care for others. Care can be the wheel that turns community.
In our modern culture, care is often offered in hospitals or other health care institutions, rather than in the home, and our caregivers are often health care providers. Some areas or departments within these facilities have developed an interdisciplinary\textsuperscript{145} team approach to client or patient centred-care. This ideally means that there is a more holistic approach involving many different disciplines, such as medicine, nursing, pharmacy, therapies (Occupational Therapy, Physical Therapy, Music Therapy, Recreational Therapy, Respiratory Therapy, etc.), Social Work, Psychology and Spiritual Care, work together to assess and care for the client. The provision of holistic\textsuperscript{146} care that is both compassionate and competent is essential to people who are dying. Spiritual and Religious Care are optimally provided when the HPC Spiritual Care Provider is a full and integrated member of the interdisciplinary team.\textsuperscript{147}

HPC is committed to seeing that people get the quality of end-of-life care they need and desire. The role of the HPC Spiritual Care Provider is to provide or facilitate appropriate spiritual and/or religious care. How do we discern the difference between these modalities of care?

\textsuperscript{145} See definition of “interdisciplinary” below.

\textsuperscript{146} See definition of “holism” in Module 1.

\textsuperscript{147} The Pallium Project. (2005). The Professional HPC Spiritual Care Provider. See HPC-SCP Competency Profile, Area “E,” pages 5 - 9.
Lesson Plan #2

Module 2: Definitions of Spiritual Care and Religious Care

Instructional Notes

The following is a suggested process only. Modules are designed around conceptually similar materials and are best reviewed sequentially. Experience has shown that they contain more material than can be comfortably absorbed in one session. The following outline is, therefore, based on a sequence of one or more one-hour sessions according to learner and educator needs and preferences. Some educators may prefer to present one or more case studies or use a narrative approach before exploring definitions.

Participants may benefit from prior instruction in a method or methods of theological/philosophical reflection, such as the processes suggested by Killen and deBeer (1994). Such methods need to be appropriate to the individual participant’s religious and cultural tradition.

Preparation

• Re-read Module 1
• Read Module 2

Goals and Objectives

At the end of this session, the participant will be able to:

• Articulate his or her own perspectives and self-understanding as a Spiritual and Religious Care Provider.
• Discuss the theoretical distinctions and differences in clinical application between “Religious Care” and “Spiritual Care.”
• Discern which ‘kind’ of care is appropriate for the client in order to:
  – provide religious care and/or make a referral to the client’s faith community
  – attend to the spiritual needs of the client.
• State the ways in which role and identity as a caregiver may be influenced by our understanding of spiritual and religious care.
• Identify the role and importance of religious tradition in the client’s decision-making.
• Identify areas in which the learner may be able to become more sensitive to the client’s needs and wishes for care, and more respectful and inclusive of diversity.

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Outline
(for one or more small group-based seminars)

Questions for participants
- Invite participants to reflect on moments in which they have offered or received spiritual and religious care. What did this look like? In what ways was this important?
- What is religious care? What is spiritual care? How do we discern the appropriate plan of care?
- How is the role of the HPC Spiritual Care Provider similar to or different from that of community religious leadership?
- What knowledge, skills and attitudes are required to provide competent spiritual and/or religious care?

Present Several Definitions
(or highlight from assigned reading material from different sources on Spiritual/Religious Care)

Present Case Studies
(choose from cited or attached resources, for example, Case Study #3 Existential Needs and the Spirituality of Golfing, or role play a scene where the client does not want/need religious care but is demonstrating a spiritual need. (If a role play, the instructor or a participant may act as the Spiritual Care Provider, and a participant or someone from outside of the group, as a client)
- See Case Studies (Chapter 4)

Further Discussion and Recapping.

Theological/Philosophical Reflection
Invite participants to reflect on the ways in which spirituality and religion appear fundamental to human nature.

Ask participants how an understanding of Spiritual and Religious Care will impact:
- their “operative theology”? (how what one “really” believes is reflected in one’s life and work, as this compares with one’s “supposed” or publicly professed beliefs)
- their “Spiritual Care Provider identity”? (sometimes called “pastoral identity” i.e. how the care provider understands his or her identity and role in the caregiving situation)

Evaluation
- Hand out Evaluation forms for completion during session.