Designing the Spiritual Care Training Courses for Healthcare Staff

Mohammad Hassan Lotfi [1,4], Maesomeh Dashtabadi [2,4], Esmail Emami [3], Hasan Zare Khormizi [4]*

1. Department of Biostatistics & Epidemiology, Health Faculty, ShahidSadoughi University of Medical Sciences, Yazd, Iran, Islamic Republic Of Iran
2. Department of Counseling, Yazd Branch, Islamic Azad University, Yazd, Iran
3. Department of Islamic Revolution, University of Islamic Sciences, Qom, Iran
4. Spiritual Health Research Center, Department of Health Research, Shahid Sadoughi University of Medical Sciences, Yazd, Iran

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Corresponding Author:
Hasan Zare Khormizi
mh.zare48@gmai.com

ABSTRACT

Background: Admission to a hospital increases individuals' vulnerability and consequent requirements for religion and/or spirituality. Religion and spirituality are two relevant but inequivalent concepts. Religion consists of a set of beliefs, rituals, and affairs that usually characterize a community's faith in a sacred power. The purpose of this research is to design the title and objectives of the spiritual care course for service providers**.**

Methods: This research was a mixed exploratory study (qualitative and quantitative) with text analysis and descriptive-analytical methods. First, the review of similar texts and sources published between 2012 and 2023, and after classifying and analyzing them, the final components and titles of spiritual care courses, including 32 components, are available to experts and experts for valid review and evaluation. The statistical community at this stage includes all medics, nurses, clergy, managers, and carers in the field of spiritual health in the country, and 13 people were selected by purposive sampling to reach the Theoretical saturation stage. By examining and revising the components by experts and specialists, the final components and titles of spiritual care courses were designed as 8 goals and 4 titles. To validate the components extracted from Lavshe's method (to convert qualitative to quantitative judgment) two quantitative validity indices (CVI) and validity ratio (CVR) were used.

Results: The minimum and maximum acceptable values were 0.80 in the CVR index and 0.77 in the CVI index. The research findings showed that out of 8 objectives, 7 goals, and 4 titles, all the proposed titles are approved and valid.

Conclusion: Based on the findings, it can be concluded that the designed titles and goals of spiritual care can be used as a guide for developing spiritual care training courses in medical centers and hospitals.

Keywords: Spiritual care, Healthcare staff, Courses

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Introduction

Admission to hospital increases individuals' vulnerability and their consequent requirements for religion and/or spirituality (1). Religion and spirituality are two relevant but inequivalent concepts. Religion consists of a set of faith, rituals, and affairs that usually are characteristics of a community's faith in a sacred power. However, spirituality is defined as "the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose, and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant, and/or the sacred." (2, 3). Over the last few decades, spirituality has received a great deal of attention in health settings, and the demand for the integration of spirituality into health-based systems has increased. In this regard, a frequently utilized caring approach under the title "biopsychosocial-spiritual model" has largely been highlighted (4). The model highlights a comprehensive patient-centered notion in which patients are regarded as the whole person. In other words, all aspects of patients' essence, more specifically their spirituality, should be taken into consideration during their hospital stay (5). Several positive outcomes have been attributed to the integration of spirituality into medical and health domains, namely reduced mental and physical problems, improved satisfaction and life quality, altered coping responses to distress, et cetera (1, 4, 6). Some studies have shown that the majority of patients rated their desire for spiritual care highly (7- 9). A study showed that more than %90 cancer patients requested at least one need that was related to spirituality (10). Although a large body of evidence has been devoted to the concept of spirituality, the discrepancy between the theoretical and practical aspects of this approach creates a gap (2, 6). According to the literature, healthcare staff generally acknowledges the provision of spiritual care in health domains (5, 14). When it comes to practice, however, some barriers hindered the implementation of this paradigm shift. Of the previously mentioned barriers, the caregivers' unpreparedness was regarded as one of the primary attributions (2, 5). As a result, many health practitioners consider this spiritual caring approach as a challenging task and thereby either overlook it or delegate it to clergy (men and/or women) and chaplains (3, 9). Insufficient training of healthcare providers has been considered the most crucial barrier to their preparation for the implementation of the spiritual approach. A study demonstrated that %77 of the respondents received no training in spiritual care provision, of whom the majority desired to receive such pieces of training (14). Studies have shown that the training of the health professional team enhances their knowledge, competence, and preparation for the implementation of spiritual care in the therapeutic domains (6, 10). Despite the beneficial outcomes of spiritual care in healthcare settings alongside the dominant religious atmosphere governing Iran, the spiritual caring approach has been neglected in our training courses and practice. A crucial prerequisite to the implementation of this paradigm shift is to develop a training framework that sufficiently addresses our national requirements (15). Therefore, we attempted to conduct the current study to develop and standardize a spiritual training course for healthcare staff.

Methods

This research was a mixed exploratory study (qualitative and quantitative) with text analysis and descriptive-analytical methods. A mixed design for understanding the phenomenon begins with qualitative data and then continues with a secondary or quantitative phase. Researchers who use mixed methods use the qualitative phase as the basis for developing an instrument, identifying variables, or describing the necessary items to test a new theory or framework.

In this research, the research questions were answered first with a qualitative approach and then with a quantitative approach. First, high-quality documents, books, articles, and other sources were examined. Review of similar texts and sources published between 2012 and 2022 using the

keywords “spiritual care”, “spiritual health”, “healthcare providers”, “healthcare recipients”, “training course”, “Islamic spiritual health”, and “educational curriculum” in "PubMed", "Scopus" and Google Scholar databases, websites of international institutions and databases related to the content of the spiritual care package were reviewed and the necessary points were extracted.

The full text of the sources was studied separately and after their classification and analysis, the final components including 32 components were extracted. Then it was given to experts for review and validation. The statistical community at this stage includes all medics, nurses, clergy, managers, and carers in the field of spiritual health in the country, and 13 people were selected by purposive sampling to reach the Theoretical saturation stage**.** By examining and revising the components by experts and specialists, the initial draft of the goals and titles of the courses was extracted. In the quantitative stage, to validate the components extracted from the Lawshe method, and to convert the qualitative judgment into a quantitative one, two Content Validity Indexes and Content Validity Ratio were used. The components were designed in the form of a validation questionnaire with a 4-option Likert spectrum (completely relevant, relevant, somewhat relevant, unrelated) and 3-option (necessary, not necessary but useful, not necessary) to experts and specialists for diagnosis The degree of relevance and the degree of necessity were presented. To review, meet with the sample group and hold an expert panel, get the consent of the experts to participate in this research, and explain the importance of the issue. After collecting the information from the expert panel analyzing the opinions and calculating the CVI and CVR scores, the titles and objectives of the spiritual care training courses were compiled.

Results

The findings in the qualitative section showed that there are 5 theses, 12 articles, and 4 books among the internal sources and 8 books and 6 articles related to the research topic among the external sources. After reviewing, classifying, and analyzing the texts and sources, the number of 32 extracted components was provided to the experts for review.

Demographic characteristics of experts and specialists can be seen in Table 1.

Table 1. Demographic characteristics of the expert panel

Variable		N
gender	Male	10
	Female	3
Ages	30 to40	2
	40 to50	3
	50 to 60	5
	60 to 70	5
Expertise	medic	4
	spiritual care	3
	managers	3
	nurses	3
	clergy	2

The First research question :What are the suggested objectives of spiritual care training courses? The results of the analysis and review of experts and experts showed that there are 8 categories of objectives of the spiritual care training course (Table 2).

Table 2. The results of analysis and revision of experts and specialists in the proposed objectives of training courses

Row	objectives
1.	Explain the definitions, concepts, and terms of spiritual health
2.	Explain the types of spiritual health models in the world's health systems.
3.	Compare the components of spiritual health in monotheistic and non-monotheistic systems.
4.	To be able to describe the history of the patient applying for spiritual health services by using appropriate tools (observation, interview, and questionnaire).
5.	Evaluation of screening and stratification of patients based on the components of the patient's spiritual health (physical, emotional, psychological, spiritual, faith)
6.	Provide or refer spiritual health services appropriately...
7.	Able to recognize the appropriate service for the patient based on the patient's symptoms and spiritual health leveling patterns.
8.	Identify the necessary indications for referring the applicant patient to receive spiritual health services.

The Second research question :What is the suggested Title of spiritual care training courses? The results of the analysis and review of experts and experts showed that there are 4 categories in the Title of the spiritual care training course (Table 3).

Table 3. The results of the analysis and revision of experts and specialists in the proposed Title of training courses

Row	Title	content
1	The basics of spiritual health	o History o Definitions of terms o The place of spiritual care in the health system o Importance and necessity o Definition of spiritual care o Spiritual care in different countries (monotheistic and non-monotheistic spirituality and its pathology
2	Familiarity with the Islamic spiritual care model (Ana Allah and Anna Eliya Rajjoon system, Salim heart, Hayat Tayyaba)	o The difference between secular sciences and Islamic sciences o Anthropology and the place of man in the material world o Human movement and ascending and descending o The place of the heart in health o Dimensions of the human relationship with himself, God, and others
3	Description of history and screening	o Description of history tools o Common spiritual health tests o Spiritual screening) o Identifying the symptoms of spiritual conflicts in the physical, emotional, questioning, and religious aspects
4	Indications and clinical referral	o Types of essential indications for referral to spiritual care o Cancer, bereavement, end of life, Shariah rulings, addiction, suicide, abortion, difficult surgery and organ transplant, mothers with children with special needs, ICU patients, corona, AIDS o Clinical referral method o Target community for referral: patient, patient's family, medical staff

Based on the results of Table 4, the minimum and maximum values of CVR were reported as 0.08 to 1 and for CVI as 0.77 to 1. Also, the findings of the study showed that among the 8 goals, the second goal was removed with a content validity ratio of 0.08 and a content validity index of 0.77, and the rest of the goals were approved in terms of content

Table 4. The results of the ratio and content validity index of the Objectives Spiritual Care Training course

Row	objectives	CVR. Present	CVI. Present	Accept /reject
1	Explain the definitions, concepts, and terms of spiritual health	0/69	0/92	Accept
2	Explain the types of spiritual health models in the world's health systems	0/08	0/77	Reject
3	Compare the components of spiritual health in monotheistic and non-monotheistic systems	0/54	0/92	Accept
4	To be able to describe the history of the patient applying for spiritual health services by using appropriate tools (observation, interview, and questionnaire).	1	1	Accept
5	Evaluation of screening and stratification of patients based on the components of the patient's spiritual health (physical, emotional, psychological, spiritual, faith)	0/54	0/85	Accept
6	Provide or refer spiritual health services appropriately.	0/69	0/92	Accept
7	Able to recognize the appropriate service for the patient based on the patient's symptoms and spiritual health leveling patterns.	0/69	1	Accept
8	Identify the necessary indications for referring the applicant patient to receive spiritual health services	0/80	1	Accept

Based on the results of Table 5, the minimum and maximum value of CVR was reported as 0.70 to 1 and for CVI 0.80 to 1. Also, the findings of the study show that all 4 chapters of the spiritual care training course were approved in terms of content.

Table 5. The results of the ratio and content validity index of the title of the spiritual care training course

Row	Selective codes	Axial codes	CVR. Percent	CVI. Percent	Accept /reject
1	The basics of spiritual health	• History • Definitions of terms • The place of spiritual care in the health system • Importance and necessity • Definition of spiritual care • Spiritual care in different countries (monotheistic and non-monotheistic spirituality and its pathology)	0.81	0.92	Accept
2	Familiarity with the Islamic spiritual care model (Ana Allah and Anna Eliya Rajjoon system, Salim heart, Hayat Tayyaba(	• The difference between secular sciences and Islamic sciences • Anthropology and the place of man in the material world • Human movement and ascending and descending • The place of the heart in health • Dimensions of the human relationship with himself, God, and others	1	0.80	Accept
3	Description of history and screening	• Description of history tools • Common spiritual health tests • Spiritual screening) • Identifying the symptoms of spiritual conflicts in the physical, emotional, questioning, and religious aspects	0.76	1	Accept
4	Indications and clinical referral	• Types of essential indications for referral to spiritual care • Cancer, bereavement, end of life, Sharia	0.70	1	Accept

rulings, addiction, suicide, abortion, difficult surgery and organ transplant, mothers with children with special needs, ICU patients, corona, AIDS
- Clinical referral method
- Target community for referral: patient, patient's family, medical staff

Discussion

The purpose of this research was to design the Spiritual Care Training Courses for Healthcare Staff. In the process of content analysis using interviews and extracted documents, 8 categories of qualitative data were obtained as the objectives of the spiritual care training course, and 4 categories were obtained as the title of the spiritual care training course. The study's findings showed that comparing the components of spiritual health in monotheistic and non-monotheistic systems was the objective of the spiritual care training course. In the current era, humans have felt weak in their existence, although they have more growth and control over natural disasters and disasters and have more opportunities. Humans need to take refuge in a supernatural power in the difficulties and problems of life. Monotheistic religions, especially Islam, have responded to this human need and proposed a suitable solution. Humans can cover all aspects of their health with the basics of Islam. The religion of Islam has a personal beginning and as a school, it covers different dimensions of life and provides specific definitions and tasks for its followers. Review researchers consider mental health as a function of emotional, behavioral, and cognitive dimensions and they evaluate the relationship of health with Islam and spirituality as good. In another review article about spiritual and Islamic interventions in Iran's health system, it was found that spirituality has a positive relationship with health, hope, quality of life, job satisfaction, coping, happiness, and mental health, and a negative relationship with anger, depression, anxiety, stress, and obsession (16) .Trusting in God and having a monotheistic vision are associated with a decrease in the level of depressive symptoms, and distrust in God and negative religious coping are associated with a greater increase in depressive symptoms (17).

Therefore, it is possible to find the best form of spiritual care in the monotheistic religion of Islam (18). God-centeredness is especially relevant in human health, which is best present in Islam (19). Also, the results showed that “Evaluation of screening and stratification of patients based on the components of the patient's spiritual health", and" Provide or refer spiritual health services appropriately as the objectives of the spiritual care training course. In recent years, there has been an increasing growth in paying attention to the spiritual dimension in humans for health care . Obtaining the spiritual history of patients is one of the ways to deal with this issue .Evaluation and screening in spiritual care will identify part of patients' spiritual beliefs and experiences. And it can affect their care and treatment process. The interdisciplinary model and the referral system in spiritual care have been investigated by many studies and their effectiveness has been expressed. Polchawski's model (2016) is one of these models, which was introduced for end-of-life patients. This model states that nurses, doctors, clergy, and social workers should take a proper spiritual history from the patient before hospitalization (20). Also, the results showed that Familiarity with the Islamic spiritual care model was the title of the spiritual care training course. According to Islam, spiritual health is like an umbrella over physical, mental, emotional, and social health. Humans always need spirituality, especially in difficult mental situations and problems. Monotheistic religions, especially Islam, have responded to this human need and proposed a suitable solution. Humans can cover all aspects of their health with the basics of Islam .

Therefore, in this study, the Islamic nature of spiritual health education was confirmed by experts. This study also had limitations, including access to not all experts were possible.

Conclusion

The knowledge gained through this Qualitative Study with the integrated review helps to understand some key issues. In the end, the findings were evaluated and confirmed by the panel of experts. Spiritual care training in our country, based on the research and experience of the professors, is conducted in various ways in the educational and treatment centers of the universities of medical sciences in the country, and a specific field is needed for specialized work in this field. Therefore, it is suggested that experts use consistent courses that are compatible with the culture and religion of our country to standardize and specialize educational courses also experts, experts, and policymakers to develop spiritual care activities in health care centers should prepare their specialized packages .It is suggested that the educational topics according to the present comparative study be standardized in the specialized spiritual care course for Healthcare Staff and the specialized education of spiritual health in hospitals is far from taste.

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Conflicts of interest

The authors declare no competing interest.

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Ethical considerations

The study was carried out by the institutional ethical standards and the Helsinki Declaration. Informed consent was taken and the data was de-identified

Code of ethics

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Authors' contributions

M. H. L, acquired funding conceived the experiment(s) and performed the clinical studies along with reviewing the manuscript; H. Z. K, supervised the work and developed the design of the experiment and the analyses; E. E, wrote the first draft of the manuscript with support from; M. D, did the literature research and the data acquisition. All authors have read and agreed to the published version of the manuscript.

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