

Article

Effectiveness of an Educational Intervention to Teach Spiritual Care to Spanish Nursing Students

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Abstract: Spirituality and spiritual care in professional nursing are conceptualised and recognised as fundamental components of holistic healthcare. Despite the acceptance of and interest in spiritual care, a lack of education and clinical training on the subject limits nurses' ability to meet patients' spiritual needs. Consequently, the aim of this study was to analyse the effectiveness of a training programme designed to teach the specific knowledge, attitudes and competencies necessary to provide spiritual care in nursing practice. This study consisted of a one-group pre-post intervention design with two measurement times (baseline/pre-intervention and post-intervention). A teaching activity about spiritual care in nursing practice was designed and implemented (focal groups, open discussion, discussion groups and clinical case studies). The educational intervention was developed by the authors based on a literature review, research and feedback from the undergraduate students. A convenience sample of 369 nursing students at the University of Alicante (Spain) who were enrolled in the teaching subject of Psychology participated in this study. The effectiveness of the teaching activity was assessed through a self-administered 15-item questionnaire. The post-intervention results indicated that the programme was effective in improving knowledge, competencies and attitudes related to spiritual care. The implications of this study for teaching practice and future research are discussed

Keywords: assessment; education; nursing; spirituality; spiritual care; teaching methods on spirituality

1. Introduction

An expert report issued by the World Health Organisation has stated that “The spiritual aspect of human life may be viewed as an integrating component, holding together the physical, psychological and social components. It is often perceived as being concerned with meaning and purpose and, for those nearing the end of life, this is commonly associated with a need for forgiveness, reconciliation and affirmation of worth” (WHO 1990). In accordance with this premise, European Union Member States consider spiritual care an essential component—rather than an optional element—of healthcare based on a holistic quality model (EC 2010). Consequently, this European document recommends that specific training in spirituality be included in the healthcare curriculum. However, it is difficult even today to provide a clear conceptualisation of the meaning attributed to spirituality and spiritual care in healthcare (Deng and Liu 2020; Whelan 2019).

In an attempt to clarify the concept, a number of common elements have been established which underlie all proposals: (1) spirituality is unique to each person; (2) spirituality is a broader construct than religious beliefs or affiliations; (3) there is a transcendent dimension to the human condition; (4) spirituality implies a connection to oneself, to others, to nature and/or to a higher power; and (5) spirituality is associated with the need to find meaning in life (Best et al. 2020; Puchalski et al. 2014). Nevertheless, despite attempts by experts to provide a coherent, consensus-based approach to

understanding concepts such as spirituality and spiritual care, the outcome of such deliberations and activities may not be transferable or universally acceptable. For example, limitations may arise due to culture, context or language (McSherry et al. 2020).

In the field of palliative care in Spain, these common attributes have been integrated into an inclusive and multiconfessional model of intra-, inter- and trans-personal relationships. This relationship model defines spiritual resources and needs as the search for meaning in life, connection and belonging (Oliver et al. 2016). However, despite this progress, the need for healthcare professionals to receive training in spirituality is yet to be addressed in the Spanish health system.

The lack of consensus on educational models for spirituality in clinical practice has given rise to a multitude of instructional approaches worldwide. In a review conducted by Lewinson et al. (2015), 28 international studies were identified that confirmed earlier perceptions of a lack of preparation on the part of healthcare staff and the need for better training. Some of these studies were based on the ASSET model proposed by Narayanasamy in 1999 (Baldacchino 2015; Taylor et al. 2014), and others on models developed by the authors themselves (Burkhart and Schmidt 2012; Van Leeuwen et al. 2008). Diverse methods were employed, but the most frequent formats were small focus groups, talks and individual reflection prompted by open-ended questions.

In an attempt to meet this training need, a Europe-wide project has been launched entitled “Enhancing nurses’ and midwives’ competence in providing spiritual care through innovative education and compassionate care” (EPPIC; www.epicc-project.eu). Three studies were carried out between 2010 and 2016 (Attard et al. 2019; Ross et al. 2016; Ross et al. 2014), two of which focused on identifying student nurses’/midwives’ perceptions of spirituality and factors contributing to the development of spiritual care competency (SCC). The third study developed a spiritual care competency framework.

In Spain, however, there have been few educational initiatives aimed at exploring nursing students’ spirituality or exerting an effective impact on their subsequent professional practice as regards to identifying and meeting patients’ spiritual needs and demands. Consequently, the present study had a twofold objective: first, to design and apply a standard training package that covered basic and specific knowledge related to spirituality, and second, to assess the effectiveness of the educational intervention using the Nursing Students’ Spirituality Training Questionnaire (NSSTQ).

Taking the EPPIC Gold Standard as our framework of reference, we designed a training programme adapted to our educational context and intended for first-year nursing students. This programme explores and analyses students’ knowledge of their own spirituality and the personal attitudes and competencies necessary to provide spiritual care to patients.

We wished to explore at least four major categories of analysis, study and consideration:

- (1) The relationship between the concepts of spirituality and religiousness (Intra-personal Spirituality).
- (2) Attention to, reflection on and cultivation of one’s own spirituality (Inter-personal Spirituality).
- (3) Spiritual care as a fundamental professional competence in nursing (Spiritual Care: Intervention and Evaluation).
- (4) Personal spiritual competency in relation to patients (Spiritual Care: Assessment and Planning).

2. Materials and Methods

2.1. Design

This was a single-group, pre-post intervention study. The study sample was selected by means of non-probability random sampling.

2.2. Participants

The study population consisted of 369 first-year students taking a Degree in Nursing at the University of Alicante and enrolled in the teaching subject of Psychology, in the academic year 2019–2020. The age of participants ranged between 18 and 45 years ($M = 19.93$; $SD = 4.36$). By sex,

17.1% were men and 82.9% were women. The distribution according to participant nationality was as follows: 98.37% Spanish and 1.63% other nationalities. When it came to religion, 9.49% were practising Catholics, 40.38% were Catholics but did not practice, 0.54% practised other religions, 18.43% considered themselves agnostic, and 31.16% said they were atheists.

2.3. Materials

The following materials were provided for the educational intervention:

- A *teaching guide* developed by the authors, describing the training objectives, the competencies to acquire, the course content, the method and the activities to carry out in Sessions 1 and 2.
- A series of *six texts* related to the study subject that included a discussion guide for the focus groups. The readings included current research and theory articles related to spirituality, spiritual care, spiritual care competencies and spiritual assessment (Austin et al. 2018; Timmins and Caldeira 2019; Cone and Giske 2018; Jaber et al. 2019; Reig-Ferrer et al. 2019).
- Three *case studies* that included an analysis and discussion guide for the focus groups. The method used to structure the clinical case study was based on the conceptual model of personal relationships (intra-, inter- and trans-personal) and the proposal by Tirado Pedregosa et al. (2011) using the NANDA International taxonomy (Herdman and Kamitsuru 2015), Nursing Interventions Classification (NIC) (Butcher et al. 2018) and Nursing Outcomes Classification (NOC) (Moorhead et al. 2018).
- A PowerPoint presentation to support assessment of and comment on responses to the questions posed by the proposed content.

2.4. Instruments

We administered three measurement instruments:

An ad hoc *Socio-Demographic Variables Questionnaire* (age, sex, marital status and nationality).

The *Nursing Students' Spirituality Training Questionnaire* (NSSTQ).

This contains 15 questions covering the four main categories of analysis and training content (Spiritual Care as a Specific Nursing Competence; Spirituality and Religiousness; Personal Spiritual Competency in Relation to Patients; Attention to One's Own Spirituality). Responses to each question are given by indicating degree of agreement or disagreement using a seven-point scale from 1 (strongly disagree) to 7 (strongly agree).

A *Teaching Activity Satisfaction Questionnaire* (TASQ). This instrument consists of nine items and responses are given using a five-point scale from strongly disagree to strongly agree.

In a previous pilot study (Reig-Ferrer et al. 2016), both questionnaires (NSSTQ and TASQ) presented satisfactory psychometric properties.

2.5. Procedure

The educational intervention entitled "Spirituality and Nursing Care" was implemented in two practical training sessions, each lasting two and a half hours. The sessions were guided by two members of the research team.

At the beginning of Session 1, students individually completed and submitted the ad hoc *Socio-Demographic Variables Questionnaire* and the *Nursing Students' Spirituality Training Questionnaire* (NSSTQ) online.

Once this had been done, the session commenced with a focus group activity, for which students were divided into groups of no more than five members. Based on the objectives defined for the present study, a focus group discussion guide was drawn up (see Table 1) with questions covering a range of thematic categories, from the conceptualisation of spirituality, religiousness and spiritual care, to the identification of specific attitudes and competencies required for the provision of spiritual care to patients.

Table 1. Focus group discussion guide.

1.	How would you define spirituality?
2.	Do you think religiousness and spirituality are synonymous?
3.	In what ways do you think they are similar or different?
4.	What do you understand by spiritual needs?
5.	What would we need to observe, what would we need to be told or what would a person have to do for us to say that he or she has spiritual needs?
6.	What do you understand by spiritual needs?
7.	What do you understand by spiritual well-being?
8.	What do you understand by spiritual suffering?
9.	Who do you think is primarily responsible for providing patients with spiritual care?
10.	What difficulties do you think healthcare staff face in the provision of spiritual care?
11.	How do you think we can identify patients' spiritual needs?
12.	How would you assess a patient's spiritual suffering?
13.	What attitudes and aptitudes do you think are necessary to provide spiritual care?
14.	Do you think it is important to be aware of the patient's spiritual or religious beliefs?

At the end of the focus group activity, one member from each group presented a summary of the most important or relevant issues they had discussed. This was followed by a general discussion and assessment guided by the teacher, in which all students were encouraged to make suggestions, ask questions or present what they considered to be the most important points.

Based on the objectives defined for Session 2, we drew up a case study discussion guide for the focus groups (see Table 2). The cases studies were designed according to the holistic care model. We attempted to describe the case studies as accurately and vividly as possible to engage the students and to achieve that they could experience the process of holistic nursing care (McEvoy and Duffy 2008). Fifteen days later, at the end of Session 2, we administered the *NSSTQ* for the second time and the *Teaching Activity Satisfaction Questionnaire*.

Table 2. Case study activity.

Introduction	Incorporation of basic and specific knowledge related to spirituality (focus group) Presentation of case and activity objectives
Formation of focus groups	Creation of focus groups and assignment of roles
Case analysis	Individual reading of case; reflection and decision-making in focus group Analysis and identification of spiritual needs according to the following conceptual model: (a) need for meaning and coherence; (b) need for connection; (c) need for transcendence Correlation between the needs analysed and the defining characteristics established in the NANDA taxonomy ¹ Development of a NIC Care Plan ² Operationalisation of the expected outcome indicators using the NOC taxonomy ³
Synthesis and guided assessment	Presentation by one member from each focus group of the most important or relevant aspects discussed Assessment guided by the teaching team

Note. ¹ North American Nursing Diagnosis Association; ² Nursing Interventions Classifications; ³ Nursing Outcomes Classification.

2.6. Data Analysis

The data obtained in the study were analysed using SPSS statistical software package version 25. We applied descriptive and differential statistics for statistical analyses of the assessment questionnaires administered.

3. Results

An initial descriptive and differential analysis of the questionnaire developed for this training programme revealed the absence of significant differences in item content between women and men, in both the pre- and post-intervention administration of the instrument. Neither did we observe significant sex-related differences in the total score obtained with this instrument.

Subsequently, we analysed the effectiveness of the educational intervention. Table 3 below presents a descriptive analysis (mean and standard deviation) for each of the 15 items in the NSSTQ, pre- and post-intervention, as well as the results of the test of differences between both measurement times. The items are presented in relation to their corresponding scale and the total score obtained with this measurement instrument is given at the end.

Table 3. Descriptive and differential pre-post analysis of the *Nursing Students' Spirituality Training Questionnaire* (NSSTQ).

	Pre M (SD)	Post M (SD)	<i>t</i>
<i>Spiritual Care as a Specific Nursing Competence</i>	31.28 (4.87)	35.53 (4.35)	−17.55 ***
1. Spiritual care of the patient is a fundamental aspect of nursing care.	5.28 (1.3)	6.08 (0.98)	−11.9 ***
4. Good patient care demands a commitment on the part of the nursing professional to attend also to the patient's spirituality.	5.52 (1.1)	6.06 (0.93)	−8.74 ***
6. It is important for healthcare professionals to receive an education in spirituality as part of their competencies.	4.83 (1.35)	5.96 (0.99)	−16.46 ***
8. Nursing staff are primarily responsible for providing patients' spiritual care.	4.57 (1.43)	5.32 (1.42)	−8.01 ***
9. The competencies necessary for providing spiritual care are acquired through experience.	5.04 (1.02)	5.70 (0.98)	−10.31 ***
15. Active attention and listening are necessary to identify patients' spiritual needs.	6.05 (0.91)	6.42 (0.81)	−7.37 ***
<i>Spirituality and Religiousness</i>	9.60 (3.74)	6.87 (3.10)	12.81 ***
2. I believe that religiousness and spirituality are the same thing.	2.98 (1.55)	1.63 (1.02)	15.13 ***
5. Spirituality is related to belief and faith in God or a superior being.	3.51 (1.69)	2.31 (1.64)	11.40 ***
14. Spiritual care of the patient is the responsibility of a priest or other religious figure.	3.20 (1.49)	2.93 (1.63)	2.71 **
<i>Personal Spiritual Competence in Relation to Patients</i>	16.36 (2.05)	16.53 (2.32)	−1.52
10. I believe that I am capable of identifying patient needs.	5.16 (0.93)	5.11 (1.06)	0.95
11. I am capable of maintaining effective patient communication.	5.44 (0.83)	5.56 (0.87)	−2.61 **
12. On the whole, I think I am a sensible, thoughtful, tactful, communicative and empathetic person.	5.77 (0.81)	5.85 (0.84)	−2.15 *

Table 3. Cont.

	Pre M (SD)	Post M (SD)	<i>t</i>
<i>Attention to One's Own spirituality</i>	16.03 (2.97)	18.04 (2.34)	−14.62 ***
3. Spirituality is important to feel at peace with oneself.	4.80 (1.35)	6.04 (0.84)	−16.99 ***
7. I strongly believe that if I do not look after myself (physically, psychologically, socially and spiritually), it will be difficult for me to look after others.	6.05 (1.06)	6.13 (0.98)	−1.64
13. I think that it is necessary to explore one's own spirituality in order to be able to provide spiritual care.	5.18 (1.29)	5.87 (1.06)	−10.25 ***
<i>Total NSSTQ Score</i>	73.28 (7.27)	76.95 (7.57)	−10.22 ***

Note. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

This analysis revealed statistically significant differences according to time of measurement in 87% of the questionnaire items.

As Table 3 shows, the most significant changes occurred in relation to spiritual care as a specific nursing competence (items 1, 4, 6, 8, 9 and 15), attention to one's own spirituality (items 3 and 13) and knowledge of the concepts of spirituality and religiousness (items 2 and 5). However, despite variation in mean pre-post scores, differences in the Personal Spiritual Competence in relation to Patients' scale did not reach significance for identifying needs, but did do so for communicative competency and empathy.

Even though they assess a different dimension, the two items (7 and 10) in which no statistically significant differences emerged may be linked, an aspect that we will address a little later.

In general, these results suggest that the educational intervention was effective in achieving a change in attitudes and knowledge. The data for the total of all the items in the scale again confirmed a significant pre-post change.

To assess students' overall satisfaction with the case study method used in the educational intervention, we administered a Teaching Activity Satisfaction Questionnaire. As mentioned earlier, the questionnaire contains nine items that measure satisfaction with the method used in the educational intervention.

Table 4 gives the results for the sum of the categories in agreement (in percentages) for each of the items in the scales. The responses were computed by grouping them according to the alternatives termed high value (strongly agree, agree and somewhat agree) and low value (strongly disagree, disagree and somewhat disagree).

It is interesting to note the percentage of students who agreed (high values) with the content of each of the nine statements in the questionnaire.

Table 4. Results for items in the *Satisfaction Questionnaire* concerning the educational innovation activity.

<i>Satisfaction</i>	High Values	Low Values
1. Discussing clinical cases has helped improve my learning and knowledge of the subject in question.	87.1	12.9
2. I found it easy to resolve the clinical cases.	87	13
3. I resolved the clinical cases with my peers.	92.2	7.8
4. The information provided in class was sufficient to resolve the clinical cases.	84.5	15.5
5. I think that the mark awarded for the clinical cases (10% of the overall subject mark) is appropriate.	81.9	18.1
6. Resolving clinical cases has helped me understand the subject better.	83.2	16.8
7. I think that sufficient time was given to resolving the practical case.	85.8	14.2
8. The teacher was always ready to help in the resolution of the practical case.	98.7	1.3
9. In general, I am satisfied with the activity.	88.4	11.6

Note: High value: response options “strongly agree, agree and somewhat agree”; Low value: response options “strongly disagree, disagree and somewhat disagree”.

4. Discussion

Below, we detail and discuss the main results obtained in the study according to the four categories analysed.

4.1. Religiousness and Spirituality (Intra-Personal Spirituality)

The first finding that merits particular attention is that the educational programme was effective in teaching students to distinguish between spirituality and religiousness. Traditionally, the concepts of spirituality and religiousness have been used interchangeably and it is not uncommon to find spirituality and religiousness being used as synonyms in nursing research and clinical practice alike (Timmins and Caldeira 2017). Although some patients may experience spirituality solely through the dimension of religiousness, others may consider themselves spiritual without being religious (Paul Victor and Treschuk 2020). Thus, this change in students’ understanding is important from the point of view of clinical practice because the scientific literature indicates that reluctance on the part of healthcare staff to deal explicitly with spirituality may be due to the persistent misconception that spirituality is synonymous with religion (Ross et al. 2018).

4.2. Spiritual Care as a Professional Competence Specific to Nursing (Spiritual Care: Assessment and Planning)

A relevant question here is whether aspects concerning spirituality or religiousness are the responsibility of healthcare staff or other professionals (e.g., priests, chaplains or spiritual advisers). Similarly, it is worth asking whether patients wish to discuss spiritual matters with health professionals or whether they consider spirituality to be a strictly private matter. In any event, who would be the most suitable or appropriate professional to address spiritual issues? The doctor? A nursing professional? Another professional? A good friend or adviser? In line with previous studies (Reig-Ferrer et al. 2019; Kuven and Giske 2019), our results suggest that nursing students believe spiritual care is the professional responsibility of nurses.

The results of our literature review suggest that healthcare staff tend not to ask about patients’ spirituality or religiousness, except to a limited extent in end-of-life situations (Best et al. 2020). Some of the most frequent barriers giving rise to this lack of communication have been identified as: insufficient time, personal unease, lack of knowledge or preparation, little or no training, lack of clarity about

whether this is part of the health professional's role and concern that the patient may be upset or take it badly (Oxhandler et al. 2019; Zumstein-Shaha et al. 2020). Thus, despite awareness that spiritual needs arise in the health context, they are currently not being met, recognised or addressed by doctors or nurses (Batstone et al. 2020).

4.3. Personal Spiritual Competence in Relation to Patients (Spiritual Care: Intervention and Evaluation)

Although this requires verification, it is highly likely that the teaching subject of *Health counselling* taught as part of the nursing curriculum at our University has the knowledge, skills and attitudes necessary to endow nursing students with initial therapeutic resources for cultivating and maintaining good patient communication. Although our training programme does not change or modify nursing students' degree of personal spiritual competency with respect to identification of patients' spiritual needs, it does foster communication and empathic understanding. In line with previous research (Ross et al. 2014, 2018), the area in which our students felt least competent was the more specialised area of spiritual care linked to the identification of spiritual needs. It would be foolish of us to suggest this learning experience alone is the way that the students could have achieved the level of skills and competencies that would help them to develop a true sense of salience around spiritual care as Benner et al. (2009) suggest.

Rogers (1997) has defined health counselling as "one in which one of the participants intends that there should come about, in one or both parties, more appreciation of, more expression of, more functional use of the latent inner resources of the individual". In the field of health, this type of relationship is based on the acquisition and application of three core attitudes (Barbero Gutiérrez et al. 2016): empathy, congruence-genuineness and unconditional acceptance. Empathic understanding is the ability to put oneself in the patient's shoes and perceive reality as the patient does, apprehending the patient's internal frame of reference, perspective or particular way of experiencing reality, events, opinions, feelings and beliefs. Congruence—expressing oneself with genuineness—is achieved through integration and interdependence of what is thought, felt and expressed. As regards to unconditional acceptance, this involves maintaining a deep respect for and positive consideration of the patient as a person, demonstrating a non-judgemental, cordial manner and showing interest in the patient's interests and what the patient considers important, regardless of whether or not this coincides with our personal assessment. This acceptance of the patient is not the same as acceptance of his/her behaviour; acceptance of a behaviour implies that it is seen as natural, normal or expected given the patient's circumstances and perceptions, but does not imply approval of said behaviour.

These three communicative attitudes described by Carl Rogers for person-centred therapy form the basis of the three other elements necessary for spiritual support: compassion, hospitality/receptivity and presence. Compassion is empathy in action, a human feeling of "suffering together" and a desire to alleviate the patient's suffering. Compassion involves intentionality and commitment. As Cecily Saunders (2011, p. 23) observed, "we have to learn how to 'feel with' patients, without 'feeling like' them, if we are to give the kind of listening and steady support that they need to find their own way through". Presence is related to congruence and consists of the capacity and knowledge necessary to be there with the patient. Hospitality is the ability to welcome and entertain guests or strangers with warmth and is linked to unconditional acceptance. In short: "Support requires us to be empathetic and go beyond, with compassion. It obliges us to be genuine and to 'be there' when nothing more is asked of us. Supporting gives us the satisfaction of a good host when the guests have left, because they have been accepted as they are and together with their host, they have constructed a space for recognition and greater dignity" (Barbero and Esperón 2014, p. 127).

4.4. Attention to One's Own Spirituality (Intra-Personal Spirituality)

It is quite possible that healthcare professionals delve little into their own spirituality. Previous studies suggest a link between attention to one's own spirituality and the disposition and perceived capacity to provide spiritual care. If healthcare providers do not take care of or neglect themselves

spiritually, they are likely to neglect the spiritual needs and demands of patients (Cone and Giske 2017). Conversely, nurses who are specifically trained in religious and spiritual issues have been reported to be more likely to include spiritual care in their clinical practice (Zumstein-Shaha et al. 2020).

In this respect, our results are encouraging, indicating that our spirituality training programme for nursing students exerted a very positive effect on their awareness of the need for spiritual care. These positive results agree with those obtained by other authors whose programmes differed from ours in terms of length and content (Ross et al. 2018).

As regards to the limitations of our study, we would like to mention some aspects to address in future research. First, the sample analysed was not probabilistic and therefore caution should be observed when extrapolating our results to nursing students in general. Second, the subject associated with the project, Psychology, corresponded to the second semester of the first year of the Degree in Nursing, when students had not yet undertaken clinical placements. Consequently, we were unable to assess medium- to long-term maintenance of the positive results of the intervention or their application in clinical settings. Thus, future longitudinal research could provide a clearer understanding and a better assessment of the results achieved.

Finally, another possible limitation of the study is the disparity in numbers of male and female participants. However, this is a frequent occurrence in studies with nurses. The literature suggests (Jager et al. 2017) that the key disadvantage of homogeneous convenience samples, relative to conventional convenience samples, is their narrower generalisability. Although homogeneous convenience samples have clearer generalisability, their findings also generalise to a more circumscribed population. It would be interesting for future research to explore the role that culture, context or language can play on the intervention effects.

5. Conclusions

Based on an analysis of the results obtained, we can draw several conclusions concerning the study variables.

First, the educational intervention aimed at improving knowledge of one's own spirituality and spiritual care in clinical nursing practice through the use of case studies has been effective. Our main results suggest that it is possible to develop the communication skills and specific competencies necessary to provide spiritual care. Significant changes in the expected direction were observed as regards to consideration of spiritual care as a specific professional competence in the discipline of nursing, awareness of spirituality and religiousness, the importance of caring for one's own spirituality and the feeling of greater personal competence in maintaining appropriate, effective patient communication. Future research should investigate whether competence in the identification of spiritual needs improves as the curriculum advances to include clinical placements.

This change has been achieved with a short training programme consisting of only two sessions which blended theoretical content with clinical practice by developing critical thinking, improving problem-solving skills and addressing case studies individually.

Another aspect of interest was our analysis of the degree of overall student satisfaction with the case study method. Our results indicated that their degree of satisfaction was high. In general terms, the intervention can be considered positive since the results indicated a high degree of student satisfaction with the different elements involved in the training activity.

Besides our main conclusions, and unlike other interventions, our study also provides a standard, secular and non-denominational training initiative for spirituality.

Author Contributions: A.R.-F. and M.D.F.-P. designed and guided the research. A.R.-F. and M.D.F.-P. wrote the article and produced the final version. All the authors contributed equally to data collection and analysis, contributed to discussion of the results and revised the draft. All authors have read and agreed to the published version of the manuscript.

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