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Teaching spirituality and spiritual care in health sciences education: A systematic review

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Abstract

Teaching spirituality and spiritual care in health sciences education has been identified as a need to enhance holistic care. However, educators seemed to be unprepared and have insufficient knowledge about how to include spirituality in teaching. This review aimed to systematically review previous literature from 2000 to 2013 regarding the content knowledge and teaching strategies used to teach spirituality and spiritual care in health sciences education. Fifty-three studies met the inclusion criteria for the review and provided suggestions for teaching spirituality and spiritual care in health sciences education. The review was conducted using electronic databases: CINAHL, Educational Resources Information Centre (ERICA), and Science Direct in the Ebscohost search engine. The results suggest that the content knowledge may include concept analysis, self-awareness, cultural beliefs, diversity and social justice, ethics, spiritual competence, person-centred attributes and barriers, evidence-based practice, and possible areas where spirituality and spiritual care may be covered. Furthermore, learning objectives should involve knowledge-based, skills-based learning and attitudes-based learning. Teaching strategies should include educators' teaching strategies in the classroom, collaborative learning and practice learning. This systematic review provides a framework for designing and developing guidelines for integrating spirituality and spiritual care in health sciences education.

Introduction

The topic of teaching spirituality and spiritual care in health sciences education is one of the most active areas in research and the healthcare fraternity, as many healthcare professionals indicate that they have insufficient knowledge (Lucchetti *et al.*, 2012; Marriotti *et al.*, 2011; Koenig, 2004; Prozesky, 2009; Puchalski, 2012). Therefore, based on this need, the institutions of higher learning are expected to develop healthcare professionals who have the knowledge and skills regarding spirituality and spiritual care (Paal, Roser & Frick, 2014; Prentis *et al.*, 2014; Tisdell, 2007). It is important for the health care professionals to learn about spirituality and spiritual care to improve patients' quality of life, health, well-being, coping mechanisms and decision-making (Puchalski, 2012; Tiew, 2011; Monareng, 2013). Despite the acceptance of, and interest in, spirituality and spiritual care in health sciences education and clinical practice, there remain pervasive inconsistencies and uncertainties such as terminology, content knowledge, teaching

methods, expected competencies and outcomes measures (Prentis *et al.*, 2014; Barry & Gibbens, 2011; D'Souza, 2007; Hood, Olson & Allen, 2007; Baldacchino, 2006). These inconsistencies were identified as hampering the infusion of spirituality and spiritual care in health sciences education and practice. For example, McSherry (2000) and Monareng (2013) concur that educational issues surrounding the teaching of spirituality and spiritual care are complex and adverse. These educational issues include lack of consensus about how to define spirituality, lack of training, lack of knowledge, lack of time and inconsistency in teaching spiritual care. This study may contribute to providing educators and students with content knowledge and teaching strategies to integrate spirituality and spiritual care. Thus this systematic review aimed to (i) systematically examine the content knowledge for teaching spirituality and spiritual care in health sciences education; (ii) identify the teaching strategies for teaching of spirituality and spiritual care in health sciences education. Table 1 presents the terms and definitions used in this systematic review.

Table 1: Terms and definitions

Terms	Definitions
Spirituality	The aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred (Puchalski *et al.*, 2009).
Spiritual care	The care that is embodied in the health professionals' respect for patients' dignity, display of unconditional acceptance and love, honest health professional-patient relationship, and the fostering of hope and peace (Sawatzky & Pesut, 2005, p 23).

Methodology

The following electronic databases (CINAHL, Educational Resources Information Centre [ERICA], and Science direct) were searched for articles from January 2000 to December 2013 using the Ebscohost search engine. The databases were searched using the following search terms: 'spirituality, spiritual care, health sciences education, teaching strategies and curriculum on spirituality'. Titles and abstracts were searched against the inclusion criteria and the full text was retrieved for articles that met the criteria: (i) studies published in English (ii) studies conducted with samples from health professions such as nursing, medicine, occupational therapy, social work, physiotherapy and psychology (iii) studies focussed on health sciences students, educators and/or clinicians (iv) Two categories of studies were used included: (1) studies that used only quantitative methods (2) studies that used only qualitative methods and (V) studies focussed on content knowledge and teaching strategies of spirituality and spiritual care.

Data extraction

The first author (TGM) independently extracted and summarised data in the tables and templates that were adapted from Haq, Steele, March, Seibert and Brody (2004);

Masterson, Gill, Turner, Shrichand and Giuliani (2013), Roman and Frantz (2013). Data extracted was checked by LW and NVR for discrepancies. Figure 1 presents the process followed in order to retrieve the studies included in the review.

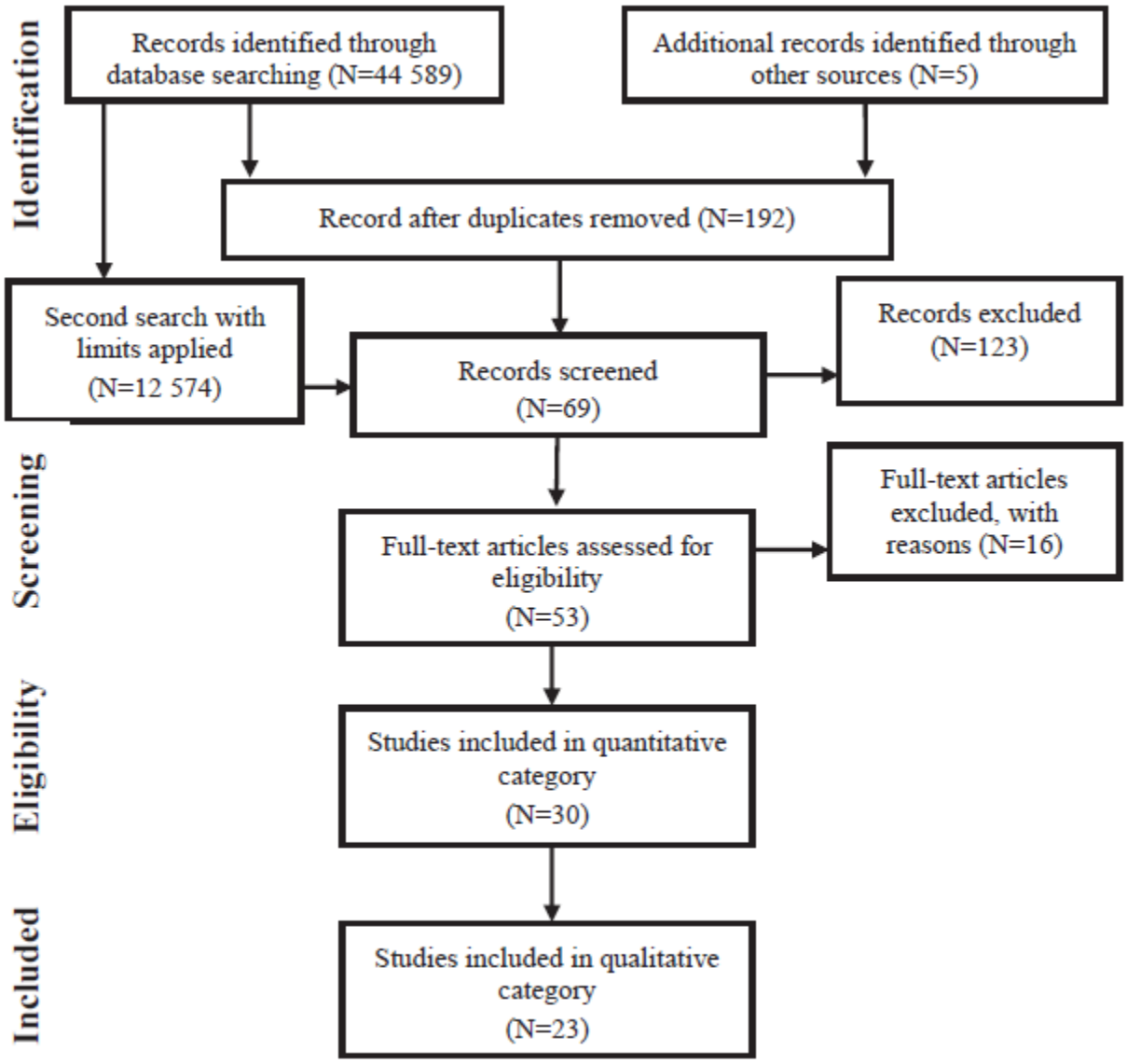

Figure 3: Flow diagram of the studies included in the review

Assessment of methodological quality

Regarding the methodological scores, 53 studies met the inclusion criteria for the systematic review, studies only using quantitative methods (N=30) and studies only using qualitative methods (N=23).

Studies only used quantitative methods

Studies only using quantitative methods were judged for methodological quality by means of an assessment tool adapted from Roman and Frantz (2013). Then Table 2 shows results of the thirty quantitative studies (n=30) that met the inclusion criteria and were assessed for methodological quality. **Good quality**: 23 studies were of good quality and met the desired criteria of 67–100% (Anandarajah, 2004; Cavendish *et al.*, 2003; Chan *et al.*, 2006; Chandramohan, 2013; Costello, 2012; Dobmeier & Reiner, 2012; King, 2005; Kirsh *et al.*, 2001; Lemmer, 2002; Lind, 2011; Lucchetti, 2012; McClain *et al.*, 2008; Neely, 2008; Olson *et al.*, 2003; Pitts, 2005; Sandor *et al.*, 2006; Shores, 2010; Stranahan, 2001; Taylor *et al.*, 2008; van Leeuwen, 2008; Vlasblom *et al.*, 2011; Wallace *et al.*, 2008; Wu *et al.*, 2012).

These studies were consistent in their methodological quality and met the inclusion criteria. **Satisfactory quality**: six studies (n=6) were classified as satisfactory quality, as they met the criteria (33–67%) (Ai *et al.*, 2008; Anandarajah *et al.*, 2007; Curtis, 2002; Karvinen & Vaskilampi, 2012; Ku & Shen, 2011; Wehmer *et al.*, 2010). These studies had strong methodological characteristics which were consistent with the good quality studies. **Poor quality**: However, one study was classified as poor quality 0–33% as it did not meet the criteria related to sampling, response rate and type of study (Berg *et al.*, 2013).

Studies used qualitative methods

Studies only using qualitative methods were assessed for methodological quality by means of a critical review form for qualitative studies (Version 2.0) (Letts, Wilkins, Law, Stewart, Bosch & Westmorland, 2007). In this review, twenty-three (n=23) studies using qualitative methods met the inclusion criteria and were assessed for methodological quality using the quality criteria as presented in Table 3.

Good quality: there were twenty-one studies (n=21) with good quality which met the desired criteria (67–100%) (Baldacchino, 2008; Baldacchino, 2010; Baldacchino, 2011; Barber, 2008; Coholic, 2006; Cone & Giske, 2012; Cone & Giske, 2013; Csontó, 2009; Dhamani, 2011; Furtado, 2005; Giske & Cone, 2012; Hood *et al.*, 2007; Hood, 2004; Janse van Rensburg, 2010; McClain, 2008; Mooney, 2007; Shih *et al.* 2001; Tanyi *et al.*, 2008; Thompson & MacNeil, 2006; van Leeuwen, 2008). These studies provided a clear description of methodology, specific type of study and principles of trustworthiness. In addition, there were two studies that were classified as **satisfactory for quality** purposes as they met the criteria of 33–67% (Barry & Gibbens, 2011; Janse van Rensburg *et al.*, 2012).

Table 2: Studies using quantitative methods after methodological critical appraisal (N=30)

Author/s	1	2	3	4	5	6	7	8	9	Score
Ai *et al.*, 2008	0	0	1	0	1	0	1	1	1	55.5
Anandarajah *et a*l., 2007	0	0	0	0	1	0	1	1	1	44.4
Anandarajah, 2004	0	0	1	0	1	1	1	1	1	66.6
Berg *et al.*,2013	0	1	0	0	1	0	0	0	1	33.3
Cavendish *et a*l., 2003	1	0	0	1	1	1	1	1	1	77.7
Chan *et al.*,2006	1	0	1	1	1	1	1	1	1	88.8
Chandramohan, 2013	1	0	1	1	1	1	1	1	1	88.8
Costello, 2012	0	0	0	1	1	1	1	1	1	66.6
Curtis 2002	0	0	0	0	1	0	1	1	1	44.4
Dobmeier & Reiner, 2012	0	1	0	0	1	1	1	1	1	66.6
Karvinen & Vaskilampi, 2012	0	0	1	0	1	1	1	1	0	55.5
King, 2005	1	1	1	0	1	0	1	1	1	77.7
Kirsh *et al.*, 2001	0	0	1	1	1	1	1	1	1	77.7
Ku & Shen, 2011	0	0	1	0	1	0	1	1	1	55.5
Lemmer, 2002	1	1	0	1	1	1	1	1	1	88.8
Lind, 2011	0	1	1	0	1	0	1	1	1	66.6
Lucchetti *et al.*, 2012	0	1	0	0	1	1	1	1	1	66.6
McClain *et al.*, 2008	0	1	1	0	1	1	1	1	1	77.8
Neely, 2008	0	1	0	0	1	1	1	1	1	66.6
Olson, 2003	1	1	1	0	1	1	1	1	1	88.8
Pitts, 2005	1	1	0	1	1	1	1	1	1	88.8
Sandor *et al.*, 2006	0	0	0	1	1	1	1	1	1	66.6
Shores, 2010	0	1	1	1	1	1	1	1	1	88.8
Stranahan, 2001	0	1	0	0	1	1	1	1	1	66.6
Taylor *et al.*, 2008	0	1	1	1	1	1	1	1	1	88.8
van Leeuwen, 2008	0	0	1	1	1	1	1	1	1	77.7
Vlasblom, 2011	0	0	1	0	1	1	1	1	1	66.6
Wallace, 2008	0	0	0	1	1	1	1	1	1	66.6
Wehmer *et al.*, 2010	0	0	0	1	1	1	1	0	0	44.4
Wu *et al.*, 2012	0	0	1	1	1	1	1	1	0	66.6

Table 3: Studies using qualitative methods after methodological critical appraisal (N=23)

Author/s	1	2	3	4	5	6	7	8	9	10	11	12	13	Score
Baldacchino, 2008	1	1	1	1	0	1	0	1	1	0	1	1	1	76.7
Baldacchino, 2010	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Baldacchino, 2011	1	1	1	1	0	1	1	1	1	1	1	1	1	92.3
Barber, 2008	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Barry & Gibbens, 2011	1	1	1	1	0	1	0	0	1	0	1	0	1	61.5
Coholic, 2006	1	1	1	1	1	1	1	1	1	1	1	0	1	92.3
Cone & Giske, 2012	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Cone & Giske, 2013	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Csontó, 2009	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Dhamani, 2011	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Furtado, 2005	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Giske & Cone, 2012	1	1	0	1	1	1	1	1	1	1	1	1	1	92.3
Hood *et al*., 2007	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Hood, 2004	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Janse van Rensburg, 2010	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Janse van Rensburg *et al*., 2012	1	1	1	1	1	1	0	0	0	0	0	0	1	53.8
McClain, 2008	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Mooney, 2007	1	1	1	1	0	1	1	1	1	1	1	1	1	92.3
Shih *et al.* 2001	1	1	1	1	0	1	1	1	1	0	0	0	1	69.2
Tanyi *et al.*, 2008	1	1	1	1	1	1	1	1	1	1	1	1	1	100
Thompson & MacNeil, 2006	1	1	1	1	1	1	0	0	1	1	1	1	1	84.6
Van Leeuwen, 2008	1	1	1	1	0	1	1	1	1	1	1	1	1	92.3

Data analysis

A narrative synthesis was conducted in analysing the studies that were selected for the systematic review. The studies were subsequently described according to the strategies that was used for spirituality and spiritual care in health sciences education. Additionally, the studies for this review were described based on the countries where they were conducted, content knowledge, learning objectives, teaching and learning strategies as well as educators' teaching strategies in classroom for spirituality and spiritual care.

Results

Many countries have identified the importance of spirituality and spiritual care in health sciences education. This review identified studies that were conducted in various countries including the United States of America (n=17), Malta (n=3), Canada (n=5), Norway (n=3), South Africa (n=3), Netherlands (n=2), Greece (n=1), Ireland (n=1), Taiwan (n=2), China (n=1), Kenya (n=1) and Brazil (n=1). However, some of the studies' geographical locations were not clearly defined.

Content knowledge for teaching spirituality and spiritual care

Concept analysis

The review identified 11 studies which highlighted the concepts that might be incorporated into the content knowledge for teaching spirituality and spiritual care in health sciences education (Baldacchino, 2011; Baldacchino, 2008; Belcher, 2005; Coholic, 2006; Cone & Giske, 2013, Furtado, 2005; Giske & Cone, 2012; Hood, 2004; Janse van Rensburg, 2012; van Leeuwen *et al*., 2009; Anandarajah, 2004; Anandarajah *et al*., 2007; Chan *et al*., 2006; Curtis, 2002; Dobmeier & Reiner, 2012; Karvinen & Vaskilampi, 2012; King, 2005; Lemmer, 2002; Lind, 2011; Sandor *et al*., 2006; Vlasbom *et al*., 2011; Ku & Shen, 2011). The concepts that were identified from the studies included spirituality, spiritual coping, spiritual well-being, spiritual care, religion, spiritual distress, spiritual dimension, spiritual needs and spiritual diversity.

Cultural beliefs

There were five studies which suggested that cultural beliefs should be considered as an important component of teaching spirituality in health sciences education (Anandarajah, 2004; Lemmer, 2002; Lucchetti *et al*., 2012; Neely *et al*., 2008; Vlasbom *et al*., 2011). These studies further reported that people seem to be diversified based on their cultural beliefs and values which influence birth and death/dying rituals, as well as dietary requirements.

Diversity and social justice

The review identified three studies which suggested that spirituality should be included in topics such as diversity and social justice (Ai *et al*., 2008; Lucchetti *et al*., 2012; Neely *et al*., 2008). These studies indicated that health sciences students tend to learn and gain more knowledge from clients with different religious beliefs as a multidisciplinary team. As a result, the students' confidence and motivation seemed to be enhanced through providing care to everyone, irrespective of beliefs and social background.

Ethics

In this review, four studies highlighted that ethics should be considered for inclusion in spirituality and spiritual care in health sciences' teaching and learning (Anandarajah *et al*., 2007; Lucchetti *et al*., 2012; Lemmer, 2002; Neely *et al*., 2008). These studies indicated that health sciences students may need to be assisted in learning to identify ethical considerations and boundaries related to the privacy of clients and families, particularly

spiritual and religious needs. Therefore, these studies indicated that ethics should be considered as part of integrating spirituality without infringing on clients' rights while promoting a person-centred approach and quality of life.

Spiritual competence

Within this review, there were spiritual competencies and skills that were identified in seven studies (Costello *et al.*, 2012; King, 2005; Lemmer, 2002; Lucchetti *et al.*, 2012; Neely *et al.,* 2008; Vlasbom *et al.*, 2011; Ku & Shen, 2011). These studies listed skills such as spiritual assessment skills, assessment of spiritual needs, self-knowledge when addressing spiritual needs, appropriate times and methods of making referrals to pastoral care or clients' ministers. Furthermore, these studies highlighted that active listening tends to be a crucial skill for spiritual care while using the integrative bio-psycho-socio-spiritual integrative model during patients' management. Overall these studies highlighted that the health sciences students could be assisted to enhance their knowledge on how to plan, execute, guard and evaluate the spiritual care of the patient in association with other disciplines.

Person-centred

Six studies in the current review suggested that the person-centred approach should incorporate all the essential elements of human beings, including mind, body and spirit (Baldacchino, 2011; Baldacchino, 2008; Lucchetti *et al.*, 2012; Olson *et al.*, 2003; Pitts, 2005; Anandarajah *et al.*, 2007). Furthermore, these studies indicated that assessing patients' body and mind needs, without addressing and considering the spiritual needs of the patients, influenced person- centred care. Consequently, Olson *et al.*'s (2003) study indicated that undergraduates should be educated on how to provide holistic care based on the knowledge of physiological, psychosocial, cultural, spiritual and environmental dimensions. These studies suggest that students should be educated about the significance of viewing human beings as a whole rather than as a sum of the parts. Lucchetti *et al.*'s (2012) study reported that compassion and love were important personal attributes that may be needed to enable health sciences students, educators and clinicians to integrate spirituality and spiritual care into health sciences education and practice. Pitts' (2005) study emphasised that students should be taught how spirituality and spiritual care may influence the health, disease and disability of the patients, families, and communities.

Evidence-based practice

One study identified evidence-based practice as a significant aspect of teaching and learning about spirituality and spiritual care in healthcare (Sandor *et al.*, 2006). This study pointed out that empirical evidence and ongoing research pertaining to spirituality in health and patients using their spirituality and religion may be incorporated into teaching and learning to enhance students' knowledge (Sandor *et al.*, 2006). This study indicated that evidence-based practice may help students, educators, clinicians, patients and their families to make an informed decision about effective intervention driven by empirical studies.

Areas to cover spirituality and spiritual care

This systematic review identified six studies which provided the areas where spirituality and spiritual care may be included in health sciences education (Shih, *et al.*, 2001; Wallace *et al.*, 2008; McClain, 2008; Sandor *et al.*, 2006; Lemmer, 2002; Ku & Shen, 2011). These studies identified areas such as birth and death/dying rituals, dietary requests/requirements, health assessments, geriatric nursing, wellness into illness, grief, nursing women and the childbearing family and mental health nursing. Additionally, these studies supported the incorporation of spirituality and spiritual care into professional nursing, the community, leadership and management, and nursing of children and family.

Learning objectives for spirituality and spiritual care

Knowledge-based learning objectives: Definitions of terms

Studies with regard to knowledge-based learning objectives for spirituality and spiritual care indicated that health sciences students may need a foundation to understand the following terms: spirituality, spiritual well-being and spiritual care and religion (Baldacchino, 2011; Baldacchino, 2008; Janse van Rensburg *et al.*, 2012; Ai *et al.*, 2008; Kirsh *et al.*, 2001; Ku & Shen, 2011; Olson *et al.*, 2003). Baldacchino's (2011) study indicated that nursing students with a good foundation and understanding of the terms seemed to be confident and value the importance of spiritual health in patients' care.

Theories

One of the most significant elements of integration of spirituality into health sciences education includes theories. Four studies revealed that students should be introduced to theories related to spirituality and religion in their courses (Baldacchino, 2011; Baldacchino, 2008; Cone & Giske, 2012; Ai *et al.*, 2008). In a study by Ai *et al.* (2008) it was indicated that students should demonstrate an integrated approach which comprised moral and faith development-related issues, bio-psycho-social-spiritual journeys and critical views of individuals in order to address spirituality and spiritual care. In addition, two studies by Baldacchino (2011) and Baldacchino (2008) highlighted that theories of stress and coping may be used to introduce students to spiritual care. Hence Cone and Giske's (2012) grounded theory study that highlighted a theory of journeying with students through maturation which seemed to be relevant in enhancing students' awareness about the essence of spirituality.

Attitudes-based learning objectives: Increased awareness

Thirteen of the identified studies indicated that self-awareness exercises seemed to be important in the facilitation of one's personal spirituality, spiritual care, essence of spirituality, self-reflection, self-understanding and taking care of self (Baldacchino, 2011; Baldacchino, 2008; Cone & Giske, 2013; Giske & Cone, 2012; Ai *et al.*, 2008; Curtis, 2002; Kirsh *et al.*, 2001; Ku & Shen, 2011; Sandor *et al.*, 2006; Shih, *et al.*, 2001; Anandarajah, 2004; Anandarajah *et al.*, 2007; Chan *et al.*, 2006). These studies reflected that raising awareness in health sciences students about spirituality and spiritual care could enhance their personal spiritual development. For instance, Ku and Shen's (2011)

study also reported that increasing awareness enabled students to improve their self-reflection skills and self-knowledge more deeply. Additionally, these studies revealed that awareness facilitated development of one's own values and relationship to spirituality (Baldacchino, 2011; Giske & Cone, 2012; Ai *et al.*, 2008; Curtis, 2002; Kirsh *et al.*, 2001). Ku and Shen (2011) add that students analyse their own and others' spiritual status in three dimensions of relationship - with themselves, with others, and, with respect to faith, to enhance their spiritual assessment skills. Baldacchino's (2011) study indicated that awareness and self- discovery enable nursing students to sharpen their critical thinking skills about their own spirituality, education and practice. Thus these studies suggest the use of case analysis and applying literature, music, nature and art as spiritual nursing interventions to the nursing process of the patient to solve his/her spiritual problems (Ku & Shen, 2011).

Change agents

The review identified eight studies that reported on the value of students as change agents of spirituality and spiritual care in health sciences education (Baldacchino, 2011; Baldacchino, 2008; Cone & Giske, 2013; Giske & Cone, 2012; Kirsh *et al.*, 2001 ; Ku *&* Shen, 2011; Olson *et al.*, 2003; Wallace *et al.*, 2008). Two of the studies advocated that the holistic approach should be strengthened in health sciences education by acknowledging spirituality as an essential part of care (Baldacchino, 2011; Baldacchino, 2008). These two studies indicated that nursing students were considered as change agents among their colleagues for spirituality and spiritual care to promote holistic care. Additionally, these studies reported that students appeared to gain skills, such as networking, communication and collaboration, when they considered spirituality as part of holistic care.

Kirsh *et al.*'s (2001) study indicated that occupational therapy students who are exposed to spirituality in their education have a propensity for being change agents when they provide services to, and work with, people with disabilities. However, Wallace *et al.*'s (2008) study highlighted that learning objectives related to physical, psychological and spiritual care, as well as being sensitive to clients' values, goals and culture, were found to be significant to nursing students. Only two of the eight studies suggested that spiritual health should be incorporated into learning objectives related to female clients in the childbearing cycle as these clients are vulnerable at that stage of their lives (Olson *et al.*, 2003; Wallace *et al.*, 2008), and the studies found that students may have more understanding of the needs of the female clients due to their vulnerability at this stage.

Diversity and social justice

In the studies reviewed, it was identified that both diversity and social justice seemed to be facilitators for integrating spirituality and spiritual care in health sciences education. Three studies by Ai *et al.* (2008), Vlasbom *et al.* (2011) and Wallace *et al.* (2008) identified that social and cultural identities were important aspects of diversity which may be incorporated into learning about spirituality and spiritual care. In addition, these studies proposed that societal power relations and forces need to be integrated as part of the

learning objectives of spirituality and spiritual care in health sciences education. For instance, Ai *et al.*'s (2008) study provided a variety of learning objectives for spirituality in social work education. These learning objectives included helping first-year MSW students to understand the interplay between social and cultural identities, societal power relations, and other societal forces. Ai *et al.*'s (2008) study indicated that these learning objectives might help students to learn how to work with clients across different barriers. Overall, these studies suggested that students should be given an opportunity to participate in dialogue about personal and environmental factors such as social, spiritual and cultural factors in their education (Ai *et al.*, 2008; Vlasbom *et al.*, 2011; Wallace *et al.*, 2008). Consequently, the students would also learn to formulate care for populations with diverse social, cultural and spiritual aspects (Wallace *et al.*, 2008).

Spirituality in Ethics

Regarding ethics, there were five studies which indicated that spirituality and spiritual care may be incorporated into ethics (Cone & Giske, 2013; Janse van Rensburg *et al.*, 2012; Ku & Shen, 2011; Wallace *et al.*, 2008; Olson *et al.*, 2003). These studies suggested that students should be taught the importance of respect, openness and tolerance as part of ethics and spirituality. Similarly, these studies emphasised the inclusion of the principles of ethics, including autonomy, justice, beneficence and non-maleficence while learning about spirituality. Hence Olson *et al.*'s (2003) and Wallace *et al.*'s (2008) studies reported that nursing students should learn to respect people's rights to participation and decision-making in health care. Wallace *et al.* (2008) indicated that nursing students should examine their role in identifying and resolving spiritual and legal issues related to the distribution of healthcare resources.

Create supportive environments for teaching and learning

With regards to creating a supportive environment for teaching and learning about spirituality in health sciences education, two studies indicated that students exposed to small groups in the classroom, with support from and a trustful relationship with their educators, tend to feel free to express their views and misconceptions about spirituality (Baldacchino, 2011; Cone & Giske, 2012). Moreover, these two studies highlighted that an environment that promotes sharing and connections among students and role models seems to be appropriate for integration of spirituality and in practice to enhance their knowledge and practical skills. Accordingly, Cone and Giske's (2012) study demonstrated that an environment which promotes reflections in group discussions and journal writing seemed to foster students' learning about spirituality.

Skills-based learning objectives: Professional competency

There were eight studies which pointed out that students should have professional competency for spirituality and spiritual care (Cone & Giske, 2012; Curtis, 2002; Ku & Shen, 2011; Olson *et al.*, 2003; Vlasbom *et al.*, 2011; Janse van Renseburg, 2012; Wallace *et al.*, 2008; Barry & Gibbens, 2011). Six of these studies indicated that students need to be taught how to record a comprehensive history and make a physical examination (Cone & Giske,

2012; Janse van Rensburg, 2012; Wallace *et al.*, 2008; Ku & Shen, 2011) and spiritual assessment (Olson *et al.*, 2003; Ku & Shen, 2011). Amongst the studies, two of them reported that communication and collaboration between students and clients provided opportunities for learning about spirituality in practice. Some of these studies indicated that nursing and psychiatry students were taught about the role of multidisciplinary teams and spiritual professionals (Janse van Rensburg, 2012; Vlasbom *et al.*, 2011). However, Barry and Gibbens' (2011) and Curtis' (2002) studies showed that students' confidence in acknowledging spiritual issues might increase by observing how other health professionals consider spirituality in practice. These studies revealed that students may learn how the referral systems work in various settings to collaborate with other members of the team.

Teaching and learning strategies used for spirituality and spiritual care

Educators' teaching strategies in classroom

A variety of teaching strategies used by educators in the classroom to teach spirituality and spiritual care were identified in fourteen studies, as presented in Table 4. These studies indicated that the teaching strategies that were used within classrooms were effective in enhancing students' understanding of spirituality and spiritual care.

Table 4: Educators' teaching strategies for spirituality and spiritual care

Teaching strategy	Authors
Power point and hand-out during the class lesson	Baldacchino, 2011; Baldacchino, 2008; Anandarajah *et al.*, 2007
Brainstorming	Baldacchino, 2011; Baldacchino, 2008
Students' presentations	Belcher, 2005; Coholic, 2006; Ai *et al.*, 2008; Curtis, 2002; Dobmeier, 2012; Pitts, 2005
Role-play	Coholic, 2006; Cone & Giske, 2012; Costello *et al.*, 2012; Anandarajah *et al.*, 2007; Costello *et al.*, 2012; Dobmeier & Reiner, 2012; Pitts, 2005; Sandor *et al.*, 2006; Wallace *et al.*, 2008
Role model	Cone & Giske, 2013; Hood, 2007; Furtado, 2005; Giske & Cone, 2012; Hood, 2004; Lemmer, 2002; Olson *et al.*, 2003
Dialogue about spirituality and spiritual care	Ai *et al.*, 2008; Lucchetti *et al.*, 2012
Guest speakers	Anandarajah *et al.*, 2007; Kirsh *et al.*, 2001; Lemmer, 2002; Olson *et al.*, 2003

Collaborative learning strategies for spirituality and spiritual care

Central to learning about spirituality and spiritual care is the concept of collaborative learning as a social construct that promotes interaction among students and their educators, as presented in Table 5. This review indicated that there were studies which described teaching strategies used in practice to acknowledge spirituality and spiritual care. Three studies reported that field trips to observe religious rituals helped students to learn about spirituality (Mooney, 2007; Shih, *et al.*, 2001; Lemmer, 2002). Additionally, five studies

revealed that shadowing experience provided students with an opportunity to observe how other members of the health team promote spirituality in practice (Anandarajah *et al*., 2007; Lemmer, 2002; McClain, 2008; Neely *et al*., 2008; Thompson & MacNeil, 2006). Similarly, seven studies indicated that the interdisciplinary panels seemed to play an important role in sharing knowledge and imparting skills about spirituality and spiritual care (Cone & Giske, 2013; Hood, 2007; Kirsh *et al*., 2001; Lucchetti *et al*., 2012; McClain, 2008; Pitts, 2005; Sandor *et al*., 2006). This is consistent with the four studies which promoted workshop and continuous education programmes (Hood, 2004; Belcher, 2005; Anandarajah, 2004; Chandramohan, 2013; Neely *et al*., 2008).

Discussion

The present review aimed to examine systematically the content knowledge and to identify the teaching strategies for teaching spirituality and spiritual care in health sciences. The results of this review show that the content for spirituality and spiritual care may include various viewpoints such as cultural diversity, spirituality, social justice, religion, human behaviour, social environment, whole person, palliative, ethics and professionalism. These findings support previous research which reported that the content of spirituality and spiritual care needs to be integrated into health sciences education (Bennett & Thompson, 2015; Prentis *et al*., 2014; Schonfeld, Schmid & Boucher-Payne, 2014).

Table 5: Collaborative learning as a teaching strategy in classroom

Frequencies	Collaborative learning	Authors
15	Group discussions	Baldacchino, 2011; Baldacchino, 2008; Cone &Giske, 2013; Costello *et al*., 2012; Giske & Cone, 2012; Hood, 2004; van Leeuwen, *et al*., 2009; Anandarajah *et al*., 2007; Chan *et al*., 2006; Dobmeier, 2012; Kirsh *et al*., 2001; Lucchetti *et al*., 2012; McClain, 2008; Olson *et al*., 2003; Sandor *et al*., 2006
13	Case studies	Baldacchino, 2011; Baldacchino, 2008; Coholic, 2006; Costello *et al*., 2012; Hood, 2007; Anandarajah *et al*., 2007; Chan *et al*., 2006; Kirsh *et al*., 2001; Lemmer, 2002; Lind, 2011; Olson *et al*., 2003; Pitts, 2005; Wallace *et al*., 2008
7	Seminars for case presentations	Baldacchino, 2011; Baldacchino, 2008; Belcher, 2005; Shih, *et al*., 2001; Chandramohan, 2013; King, 2005; Lucchetti *et al*., 2012
8	Self-reflective exercise	Baldacchino, 2011; Baldacchino, 2008; Belcher, 2005; Barry & Gibbens, 2011; Coholic, 2006; Cone & Giske, 2013; Olson *et al*., 2003; Wallace *et al*., 2008
10	Reflective sharing discussion	Belcher, 2005; Cone & Giske, 2013; Cone & Giske, 2012; Furtado, 2005; van Leeuwen, *et al*., 2009; Costello *et al*., 2012; Kirsh *et al*., 2001; Ku & Shen, 2011; Lucchetti *et al*., 2012; Olson *et al*., 2003
9	Experiential and reflective journaling	Coholic, 2006; Cone & Giske, 2013; Cone & Giske, 2012; Hood, 2007; van Leeuwen *et al*., 2009; Curtis, 2002; Dobmeier & Reiner, 2012; Lemmer, 2002; Olson *et al*., 2003
9	Journal reading about spirituality	Belcher, 2005; Cone & Giske, 2013; Giske & Cone, 2012; Dobmeier & Reiner, 2012
5	Literature search about spirituality	Cone & Giske, 2012; Giske & Cone, 2012; Kirsh *et al*., 2001; Lucchetti *et al*., 2012; Sandor *et al*., 2006
2	Online tutorials about spirituality	Lucchetti *et al*., 2012; Pitts, 2005
4	Videos	Anandarajah *et al*., 2007; Lind, 2011; Lucchetti *et al*., 2012; Olson *et al*., 2003

Similarly, the results of this review indicated that understanding of the following concepts: spirituality, spiritual care, spiritual distress, spiritual coping and spiritual well-being, might help students. Conversely, some of the results indicated that students should learn to differentiate between spirituality and religion. Therefore, the findings of Prentis *et al.* (2014) in the current review are in agreement with the findings which show that spirituality and spiritual care may be integrated in specific areas such as oncology and palliative care and more general topics, for example morality and ethics. These findings may help the educators with ideas on how to incorporate spirituality and spiritual care into health sciences education in order to enhance students' and clinicians' knowledge. Self-awareness was found to be the key facilitator for incorporating spirituality in health sciences education (Malinski, 2000; Scheurich, 2003; van Leeuwen *et al*., 2006; van Leeuwen *et al*., 2009, Bennett & Thompson, 2015). Both spirituality and self-awareness were identified as being connected to each other and facilitated students' personal development (Bennett & Thompson, 2015; Prentis *et al*., 2014; Schonfeld *et al*., 2014; Baldacchino, 2008). Additionally, self-awareness provides students with an opportunity to identify their spiritual needs and learn to reflect on their own experiences. The findings of this study further suggest that students need to be introduced to spiritual assessments in

order to sharpen their skills and provide holistic care. For example, a study by Kelso-Wright (2012) examined students' perceptions of spiritual history assessments and/or the experience of administering the Faith, Importance, Community and Address (FICA©) with an adult client in an on- campus clinic. Kelso-Wright's (2012) findings indicated that exposure to FICA increased students' confidence in conducting a spiritual history assessment. The findings further show that students learn more about their clients; clients' motivation; rapport; holistic care; scope of practice and increased confidence to deal with the subject of spirituality. To this end FICA may be used as an effective tool for spiritual assessment.

The current review found that there were various teaching strategies for spirituality and spiritual care. In addition, the teaching strategies were linked to the learning engagement model concepts which assisted in discussing the teaching strategies (Guthrie & Wigfield, 2000). The learning engagement model concepts included teacher involvement, autonomy support, collaboration, real world interaction, strategy instruction and interesting texts. It can be seen from the findings that the teaching strategies discussed met the concepts of the learning engagement model. Therefore, the findings of the review suggest that the teaching strategies provided by the studies may be used in teaching health sciences students about spirituality and spiritual care. However, there were two concepts which were under-addressed, based on the learning engagement model (Guthrie & Wigfield, 2000). These under-addressed concepts included the strategy instruction and reward, as well as praise. In relation to the learning engagement, there were no instructions found to guide how spirituality and spiritual care should be integrated into health sciences education. This is in agreement with Rushton's (2014) review which identified a lack of guidelines for healthcare professionals in providing spiritual care, lack of time and lack of training being the main barriers. In addition, from the studies reviewed, there was a gap in the reward and praise concepts to motivate students to learn about spirituality and spiritual care. Conventional teaching strategies, including self- reflection exercises, case studies and small group discussions to augment learning, were identified as effective methods used for teaching spirituality and spiritual care in the current review, and were consistent with Bennett and Thompson (2015) and Prentis *et al.* (2014) and also Lemmer (2010). This supports the assertion that the learning engagement model seemed to facilitate collaboration between students and their educators to promote participation and learning. Accordingly, the findings in the present systematic review suggest that these teaching strategies may be used to include spirituality and spiritual care in health sciences education. The present findings support other research that indicated that learning about spirituality and spiritual care has positive implications for students' and educators' personal, academic and professionalism (Mthembu *et al.*, 2014; Baldacchino, 2008; Schonfeld *et al.*, 2014). Furthermore, previous students reported that students seemed to benefit from learning about spirituality, as they are able to count their blessings regarding their own quality of life and health (Bennett & Thompson, 2015; Mthembu *et al.*, 2014; Baldacchino, 2008). These findings therefore suggest that health sciences students should be introduced to spirituality and spiritual care.

Implications for Health Sciences Education

The study contributes to the expansion of knowledge of health sciences educators and students regarding spirituality and spiritual care in health sciences education. This is supported by the work of Prentis *et al*. (2014) who reported that willingness to debate the issues of spirituality among healthcare lecturers may lead to reduced confusion about definitions and greater understanding of how to integrate this into teaching and therefore into practice. Integration of spirituality may help students to cope with stress caused by their training and face the demands of a challenging career in health care (Schonfeld *et al*., 2014). This review used studies that were only quantitative in nature and studies that only employed qualitative methods. Therefore, this might be a limitation of the present review as studies using both quantitative and qualitative methods were not included as part of the inclusion criteria.

Conclusion

In this review, the aim was to systematically examine the content knowledge and identify the teaching strategies for teaching spirituality and spiritual care in health sciences education. Overall, it was shown that the content of spirituality and spiritual care may be incorporated using the concepts of analysis, self- awareness, cultural beliefs, person-centred approach, diversity and social justice as well as ethics. These findings suggest that students could be assisted to gain spiritual competencies such as spiritual assessment and methods of making referrals to pastoral care or clients' ministers. Additionally, the findings that emerged from this review indicated that a variety of teaching strategies could be used in the classroom, such as power point, hand-outs, role play, brainstorming, guest lecturers, case studies and presentations. Some studies indicated that field trips, role models, workshops and continuous education programmes seemed to enhance students' understanding of spirituality in practice. The evidence from this review may contribute to the development of guidelines to integrate spirituality and spiritual care into health sciences education.

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