religions

MDPI

Article

Understanding Spiritual Care—Perspectives from Healthcare Professionals in a Norwegian Nursing Home

Marianne Morland [1,*], Wilfred McSherry [1,2,3] and Linda Rykkje [1]

[1] Faculty of Health, VID Specialized University, 5009 Bergen, Norway; w.mcsherry@staffs.ac.uk (W.M.); linda.rykkje@vid.no (L.R.)
[2] Department of Nursing, School of Health and Social Care, Staffordshire University, Stoke-on-Trent ST4 6QG, UK
[3] The University Hospitals of North Midlands NHS Trust, Newcastle ST4 6QG, UK
* Correspondence: marianne.morland@vid.no

Abstract: Nursing home professionals have reported that spiritual care is an unclear concept, and research suggests that healthcare professionals have a limited understanding of this dimension of care. The provision of spiritual care is well-investigated internationally, but research is sparse within Norway's secularized society. This study investigated healthcare professionals' understanding of spiritual care in one nursing home. Methods: Data were collected from individual interviews (N = 8) and one focus group (N = 5) of nursing home personnel; the study used qualitative content analysis and a hermeneutic methodology. Results: One central question emerged during the data analysis: what is spiritual care versus good care? This starting point resulted in four themes (1) caring for the whole person, (2) having a personal touch, (3) seeing the person behind the diagnosis, and (4) more than religiousness. Some healthcare professionals had not heard of spiritual care, and many were not aware of this in their daily work with older patients. Nevertheless, they facilitated and cared for the patient's spiritual needs, but they did not address it as spiritual care. Other participants were familiar with the concept and understood spiritual care as an essential part of daily care. Conclusion: healthcare professionals' understanding of spiritual care is broad and varied, including practical and non-verbal aspects. The results indicated a need for an open dialogue about spiritual needs and resources in clinical practice and the teaching of personnel about how to facilitate older people's spirituality. Moreover, there is a need for more research into spiritual care and how it differs from the concept of good fundamental care.

Keywords: spiritual care; nursing homes; healthcare professionals; good care; hermeneutics; qualitative content analysis; older persons

Citation: Morland, Marianne, Wilfred McSherry, and Linda Rykkje. 2022. Understanding Spiritual Care—Perspectives from Healthcare Professionals in a Norwegian Nursing Home. *Religions* 13: 239. https://doi.org/10.3390/rel13030239

Academic Editor: Antonio Muñoz-García

Received: 11 February 2022
Accepted: 2 March 2022
Published: 10 March 2022

1. Background

Research exploring the impact of spiritual care on health reveals that it is essential and therefore it must be supported (Steinhauser et al. 2017). The International Council of Nurses stated in their *Code of Ethics*, that nurses are responsible for promoting an environment for the patient where human rights, values, customs, and spiritual beliefs are respected and acknowledged (ICN 2021). In nursing homes for older people, family members, nurses, and allied healthcare professionals are central in facilitating and caring for the spiritual needs and resources of the patients (Batstone et al. 2020). According to the population projection for Norway (2015–2050), as in other western countries, there will be a demographic shift to more older persons above 70 years than children and teenagers (Statistics Norway (SSB) (2021)). As a result, nursing homes will become a key workplace for healthcare personnel. In institutions, caring for older people's spiritual and existential needs is a critical aspect of holistic nursing and whole-person care (McSherry et al. 2021). Providing spiritual care is just as crucial as caring for patients' social, physical, and mental needs (de Moura Scortegagna et al. 2018). Spiritual care is recognized as an essential part of whole-person

care, and when caring for older persons, one cannot omit this dimension (Rykkje et al. 2013; ICN 2021). One way of describing spirituality is found in the definition developed by the European Association for Palliative Care:

> Spirituality is 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.
>
> The spiritual field is multidimensional, containing:
>
> Existential challenges (e.g., questions concerning identity, meaning, suffering and death, guilt and shame, reconciliation and forgiveness, freedom and responsibility, hope and despair, love and joy).
>
> Value based considerations and attitudes (what is most important for each person, such as relationships with oneself, family, friends, work, nature, art and culture, ethics and morals, and life itself).
>
> Religious considerations and foundations (faith, beliefs and practices, the relationship with God or the ultimate) (EAPC 2021, p. 1).

Spirituality can be understood as a fundamental dimension of life and is expressed when interacting with others (Rykkje 2016). Spirituality can be expressed in various ways, some within a religious tradition and many within a secular context (Holmberg et al. 2017). However, understanding the concept of *spirituality* can be a challenge because spirituality is understood to be private, and the connection spirituality has to religion may, for some, fit poorly in a secularized country like Norway (Kleiven et al. 2021). According to La Cour et al. (2012), a common understanding of spirituality does not exist in a secularized country because spirituality means "*different things depending on whom one asks*" (La Cour et al. 2012, p. 77). According to Bruce (2011), Norway is considered one of the world's most secularized countries; despite this, as many as 70% were members of the Norwegian Lutheran church in 2021 (Den Norske Kirke (the Norwegian Church) (2021)), although church attendance was only 2% (Urstad 2017). Norwegian white papers and governmental guidelines (Ministry of Health and Care Services 2009; Meld. St. nr. 15 (2017–2018); The Dignity Guarantee 2011) state that older people's spiritual and existential needs should be supported by caregivers in the health and welfare sector. Nevertheless, according to research done in Norway, healthcare professionals find it hard to address spiritual care in practice (Ødbehr et al. 2014). Therefore, it is necessary to investigate nursing home staff's perspectives on spiritual care (Mlinar Reljić et al. 2021) and explore how spirituality and spiritual care are understood in healthcare settings (Rykkje et al. 2021).

During the past decade, a broad range of research has been undertaken to address issues of spiritual care, specifically focusing on how healthcare professionals can facilitate and meet patients' spiritual needs (Lucchetti et al. 2019). Several studies have described that healthcare professionals are familiar with the spiritual dimensions of health care and their role in caring for the whole person (McSherry et al. 2021; Lewinson et al. 2015; Santos et al. 2021; Lewinson et al. 2018). However, they frequently do not feel competent enough to carry out conversations of a spiritual and existential nature (Gautam et al. 2019). According to several studies (Ødbehr et al. 2014; Veloza-Gómez et al. 2017; Kleiven et al. 2021), spiritual care and caring for patient's spiritual needs are concepts associated with various definitions (Giske and Cone 2019). This means that, healthcare professionals often have inadequate skills and knowledge about addressing spiritual aspects of care (Batstone et al. 2020; Ødbehr et al. 2014). In addition, patients often report that spiritual care is missing in clinical practice due to a lack of time and de-prioritization (Selman et al. 2018). Moreover, patients describe spiritual care as necessary for finding meaning in life and coping with existential issues, and they value healthcare professionals supporting them to meet their spiritual needs (Gautam et al. 2019). Furthermore, healthcare professionals who provide spiritual care to patients operate from a holistic worldview arising from their own spirituality, life experiences, maturity, education, and the professional practice of working with dying patients

(Batstone et al. 2020; Giske and Cone 2015). Much research has addressed healthcare professional practice within hospice care (O'Brien et al. 2019; Batstone et al. 2020), but research conducted within nursing homes addressing spiritual care and caring for the patient's spiritual needs is however, sparse, especially in Norway (Ødbehr et al. 2014). Findings from the few studies out of Norway that have investigated spiritual care with healthcare professionals illustrate that spiritual care is considered as a multi-layered dimension and that the spiritual dimension contained within it helps to improve health, find meaning, and decrease patient suffering (Torskenæs et al. 2015; Ødbehr et al. 2014). However, one of these previous studies indicated that spiritual care in a nursing home context must be investigated further, involving healthcare staff in different professions with a wider range of life views (Ødbehr et al. 2014).

1.1. Theoretical Foundation

The theoretical perspective underpinning this study is the caritative caring theory developed by the Finnish nurse and caring science professor, Katie Eriksson (1943–2019). Her theory has its roots in humanities, and its basic epistemology is hermeneutical (Eriksson et al. 2003). Eriksson stated that the ethical motive and core of caring is to foster health and alleviate suffering to ensure a patient's sense of dignity and worth (Nystrøm et al. 2021). Within the caritative caring theory, the human being is understood as an indivisible entity of body, soul, and spirit (Bergbom et al. 2021; Eriksson 2002), and spirituality is related to changes in the individual experiences of health and suffering (Eriksson 1997). Spirituality has a potential for calming and healing, at least for those who acknowledge this dimension in life, and it can, for many people, be a source of inner strength. As such, caregivers should facilitate and help patients utilize the potential health resources inherent in the spiritual dimension (Rykkje et al. 2011).

The caring science study by Rykkje and Råholm (2014) found that spirituality is vital for older people, because being able to connect with one's inner space may provide peace, calm, wholeness, and health. This was in line with Eriksson et al.'s (2006) notion of becoming in health, which is related to the patient experiencing wholeness as a human being, and thus allowing them to experience confirmation of their dignity. Spiritual care in old age is providing *caring care*, being present and listening, providing touch, and facilitating participation in social settings and maintaining significant relationships, in addition to providing meaningful activities adapted to the individual's wishes and needs (Rykkje 2016). This means that spirituality is more than religiousness, moreover it comprises what is meaningful in the life of the older person. If the patients' spiritual dimensions are ignored, their dignity is violated, because they are not treated as whole persons (Råholm and Eriksson 2001). The healthcare personnel's role as spiritual caregivers might become vital when patients encounter spiritual suffering (Rykkje et al. 2011). Furthermore, it is emphasized that in whole-person care, the caregiver must accept and understand the patient. Therefore, professional nurses and other health care professionals must meet and recognize the patient's spiritual needs, irrespective of their own religious and spiritual attitudes (Eriksson 1997). In caritative caring, *care* can be described as *caring care* and the opposite of this is *uncaring care*, which can mean the neglect of a patient's needs (Eriksson et al. 2006). Caring is at the core of nursing; caring is more than a behaviour, it is an ontology. As a healthcare professional, one should do more than *be there* for the patient. Creating a communion with the patient opens new possibilities and a caring relationship develops. Caring communion is *"the art of making something very special out of something less special"* (Eriksson 1997, p. 73).

According to Eriksson, care is a natural phenomenon for the human being (Bergbom et al. 2021), which means some parts of caring cannot be taught. However, compassion, love, and mercy are fundamental concepts of knowledge incorporated in caritative caring (Lindstrøm and Zetterlund 2018). These must be emphasized in teaching and should be evident when practicing whole-person care.

1.2. Aim and Research Question

This is a sub-study and part of a larger project concerning spiritual care in nursing and healthcare education and practice (spiritualcare.no). In this sub-study, the practice setting is spiritual care for older people and it is carried out with an awareness that spiritual care competency may be low in nursing home practices. To this end, the aim of this study was to investigate healthcare professionals' understanding of spiritual care in one nursing home. The research question was:

"What are healthcare professionals' understandings of spiritual care?"

2. Materials and Methods

This study was qualitative and the data collection involved conducting interviews. The methodology was based on Gadamer's philosophical hermeneutics (Gadamer 2003; Gadamer 2010), which has been used to search for new knowledge and new understanding. Hermeneutics (Gadamer 2010) was adopted for this research because it has many nuances that provide opportunities to understand what is not immediately visible and perceptible. The hermeneutic understanding in this study guided the interviews, as presented in Table 1, by providing examples of questions to help develop the conversations. The participants' understanding of spiritual care also guided how the conversations evolved. As seen in Table 1, question 1, their pre-understanding of spiritual care was investigated. If they answered that they were unfamiliar with the concept of spiritual care, the interviewer read the Norwegian definition of spiritual care from EAPC (2021). However, this definition was sometimes hard to grasp for the participants. Therefore, the interviewer found it useful to ask question 2 in Table 1.

Table 1. Example questions for focus group and individual interview.

1.	Have you heard of spiritual care?
2.	How do you provide care for your patients?
3.	Do you have any experience with spiritual care?
4.	Do you think spiritual care is important for the patients in a nursing home? Why/why not?
5.	Based on your pre-understanding of spiritual care, what is the most important thing healthcare professionals can do to provide patient's spiritual needs?

2.1. Participants

Participants were recruited from the staff in a large nursing home in Western Norway using purposive sampling. The nursing home had 90 patients all receiving long-term care. The recruitment was managed by a gatekeeper in the nursing home, and the strategy was to include personnel working with patients, persons with different life views, ages, and job roles, see Table 2.

The selection strategy for the focus group was to recruit staff who performed key-functions in the nursing home. The focus group comprised of a mix of professionals. In total 13 persons agreed to participate: individual interviews ($N = 8$) and focus group ($N = 5$). The participants were aged between 21–63 years. There were two men and 11 women with experience of working in nursing homes ranging from 6 months to 25 years.

Table 2. Participants.

Name	Profession	Setting
Maya	*Assistant nurse*	Individual interview
Leila	*Assistant nurse*	
Meshid	*Assistant nurse*	
Winita	*Assistant nurse*	
Kari	*Occupational therapist*	
Sayid	*Healthcaresupport worker*	
Ingrid	*Registered nurse*	
Helena	*Registered nurse*	
Nora	*Assistant nurse*	Focus group interview
Sara	*Registered nurse*	
Tone	*Registered nurse*	
Kristin	*Registered nurse*	
Harald	*Chaplain*	

2.2. Data Collection

The individual interviews were conducted between January–February 2021, and they lasted between 20 and 90 min. The focus group was held in November 2020 with an interviewer and a moderator (Krueger and Casey 2014); this lasted 60 min. Interviews were audio recorded. After every interview, the first author wrote a few reflections, to support the interpretation of the material. The focus group and individual interviews were conducted at the nursing home. Strict Covid-19 guidelines were followed, such as wearing a facemask and keeping a distance of 3 m between participants. A semi-structured interview guide was used for the individual interviews and the focus group, see examples of questions in Table 1. The interview guide was not tested prior to use.

2.3. Analysis

All interviews were audio-digitally recorded and transcribed verbatim. First, in order to gain an overview of the data in line with the hermeneutic methodology (Gadamer 2010), the transcribed text and the researchers own notes were read several times. This was both the individual parts and the whole material as one text to find commonalities and variations. This was a part of an "open-coding process" following Bengtsson (2016) as a guide. During this process, codes and ideas related to the research question were written in notes alongside the text using NVivo 12. Then, data analysis was performed according to the qualitative content analysis framework, using the approach outlined by Graneheim and Lundman (2004). Meaning units in each transcription were identified and coded into preliminary themes using Nvivo 12. Afterwards, the meaning units were condensed into a latent structure with interpretation of these units to describe their underlying meaning, see Table 3.

Next, the latent condensed meaning units were transferred into themes and sub-themes. The interpretation and preliminary sub-themes and themes were discussed with all the authors throughout the analytical process. Themes that did not fit with the aim of the study were discarded. In the final phases of interpretation, the selected themes were combined as a whole text. Again, as in the hermeneutical (Gadamer 2010) research process, the whole data material, including themes that were discarded, were revisited. This was to ensure that no significant meaning units were omitted and to support the overall interpretation of the findings. The dialogical movement back and forth between the whole and the parts was an important feature of the hermeneutic methodology (Gadamer 2010;

Gadamer 2003) and it was essential in the process of interpretation of the latent content of the meaning units. Finally, only one central theme and four sub-themes remained. However, the authors chose to present these as four themes, but with one central headline *how healthcare professionals understand spiritual care* and with the question *what is spiritual care versus good care?*

Table 3. Example of a meaning unit, condensed meaning units and theme.

Meaning unit	Condensed meaning unit (description close to the text)	Condensed meaning unit (Interpretation of the underlying meaning)	Theme
But if it becomes very religious then I do not know if we have the same understanding or views about it	If it becomes very religious, personnel might not have the same understanding or view of spiritual care	Healthcare professionals own personal spirituality and religious beliefs colour their understanding of the content of spiritual care	More than religiousness

3. Results

The results of the analytical process portray the headline how healthcare professionals understand spiritual care with four themes: (1) caring for the whole person; (2) having a personal touch; (3) seeing the person behind the diagnosis, and (4) more than religiousness. Together, these describe healthcare professionals' understanding of spiritual care in the nursing home.

3.1. Caring for the Whole Person

Every participant had their own personal understanding of spiritual care and what it meant to them. Some participants had not, at any time, heard about spiritual care in any setting. Several had come across this expression but could not describe what it was. Participants to whom spiritual care was unknown, however, told many stories about how they provided care for their patients, and Sayid, who is a healthcare support worker, said:

> *"I had a regular shift with a patient one day and he was somehow in great physical pain since he just had surgery (. . .) And then he said he wished he could pray to God. Then I explained to him, we do not have to be physically ready to pray, but that you can pray while you are in bed, God can hear you anyway".*

According to this story, the participant had no problem facilitating the patient's religious needs, but this participant had not thought of this as spiritual care, he had not once heard the words *spiritual care*, but he refered to this religious safeguarding as *good care*. To provide *good care* was a term many participants spoke of after hearing the definition of spiritual care. Moreover, Sayid described good care as,

> *"To meet all the needs of the patient. That I would say is good care".*

The understanding that to provide good care meant the meeting of all the patients' needs was mutual for several participants. Those with a pre-understanding of spiritual care understood it as an essential part of what they call good daily care. They also described their understanding of spiritual care as one dimension of whole-person care and an essential part of good care. Whole-person care was described as caring for all the patients' needs. Therefore, spiritual care was often understood as being everything from taking a walk with the patients, doing activities, or sitting holding their hands and having existential conversations. This broad understanding of spiritual care was something several participants agreed upon. Notably, in all the interviews, whether they had a preunderstanding of spiritual care or not, they all described the importance of giving and providing whole-person care, a care that took care of the whole human being. Moreover, those who had a pre-understanding of spiritual care agreed that it was an essential dimension in whole-person care. In this spiritual dimension, participants understood providing spiritual care as facilitating care with compassion and love. This meant, several of the interviewees understood the spiritual

care dimension of whole-person care as being everything they provided or facilitated beyond practical, mandatory tasks. Ingrid, who is a Registered nurse, underlined this with her comments:

> *"And I think that in a way [spiritual care] means a lot. It's not just about faith and doubt etc. But it is to see and be seen. It is hearing and being heard. What goes (. . .) I think it's like it's all that goes beyond the purely practical that we are going to do with the patients."*

3.2. Having a Personal Touch

Several of the participants described sensing and being aware of the patient's needs as essential in providing spiritual care. They spoke about this in various ways, and one described how she gave care that was the same as she would provide for her own mother. The participants who had a pre-understanding of spiritual care were four registered nurses, one occupational therapist, and the chaplain. They all spoke of spiritual care as a well-known theme and a natural part of how they, as professionals, provided whole-person care. Nevertheless, they had a different understanding and perspective of spiritual care in the clinical context and how it emerged in daily care situations. When discussing their understanding of spiritual care in the clinical context, the healthcare professionals talked about situations where they, tried to support patients with seeking meaning and coping with existential challenges. They, as professionals, tried to be sensitive listeners and having a sense of what is occurring in different situations was an essential part of spiritual care. The participants agreed that understanding these situations has to do with each healthcare professional's personality. In the focus group, Sara described her colleague Nora and why she was good at facilitating spiritual care:

> *"Nora: I cannot say why I'm good at it.*
>
> *Sara: I know something about it, I think. And it has to do with the fact that Nora, is genuinely interested in people, and that is the basis of it, there is a lot there. (...) And Nora is a person who is very fond of people."*

According to this conversation from the focus group, being good at facilitating spiritual care has to do with being genuinely interested in people. The participants in the individual interviews spoke of the importance of being interested in people as well. Moreover, they mentioned their childhood and how they were raised was influential in their methods of providing care. Furthermore, a healthcare professionals' background and childhood were something that the people in the focus group spoke about as essential factors in how one understands and addresses the patients' spiritual needs. The study participants spoke of a particular type of personality and that person was often good at listening and sensing what the patient needed. Winita, an assistant nurse explained that she cares for patients as she would for her mother or grandmother, but according to her, this was not an attitude shared by everyone. A few said that because of their religion or Karma, they *must do good*; this resulted in them caring deeply for all their patients. Some participants explained that because they could not care for their own family due to war in their home country, they wanted to care for the older people in Norway. All these participants from different backgrounds agreed that in their career, personality was essential in providing spiritual care and understanding the spiritual dimension.

3.3. Seeing the Person Behind the Diagnosis

When the participants described their understanding of spiritual care, they spoke of their relationship with the patient and that it was meaningful. They spoke of caring with compassion as necessary in their relationship with the patients. In this relationship, the participants had an understanding that being a sensitive listener and sensing all the nonverbal communication in their daily conversations with the patients was critical. They described this as *seeing the person behind the illness and diagnosis* and thinking about who this person had been earlier in life. And Nora, another assistant nurse in the focus group, commented:

> *(...) We must see behind the disease; we must see this person. What has life been like? She has been a good wife, mother, grandmother, great-grandmother, but now she is ill, and perhaps a bit mischievous, but we must put that aside and look behind. Yes, be warm and show empathy.*

When the participants were attempting to see the person behind the diagnosis, they wanted to understand the patient's life stories, how life had affected the patient, and how this could be a resource for providing daily care. They said they asked the patient or their relatives about their life stories and what they wished and needed. When the participants spoke with the patient about their lives and roles in society, they sometimes expressed that they felt the society had forgotten them and that their life stories no longer had any meaning. The feeling of being forgotten by the society made the patients feel less valued. Therefore, some participants often reminded the patients that they were, however, essential to their loved ones and their life stories were still important. There was a positive reaction to this support. It was believed that this type of caring care and safeguarding was an expression of spiritual care and actively demonstrates to the patient that they are not just another patient, but that who they were, and are now, is essential. Nora reflected on this:

> *"I think in a way, our patients, [when you think of spiritual care as a part of the care], you give something extra to the care situation, of course, all their physical, all the needs are met. You find out what they bring with them from their history and take care of them in relation to that (. . .). And that they experience that we see and hear them, and feel unique, just as they are, in the present."*

During the interviews, it was discussed why spiritual safeguarding, like in the story above, was vital in a nursing home and they explained for whom it was most beneficial. They described situations when the patients had become agitated or restless. Moreover, some spoke of spiritual care as being fundamental in a nursing home context because patients lose much of their identity when they enter the institution. Several participants talked about the institutionalization of patients and that this process made them lose their integrity. Therefore, spiritual care appears to have a prominent role in nursing homes. Sara, who is a nurse leader, highlighted this point:

> *"Spiritual care is always important, throughout life, but it is essential when you are in a nursing home; you lose a bit of yourself, of your identity when moving into an institution: Their home, their things, life in general. Then we must manage to get a grip of what they need from the spiritual part."*

According to interviewees, what the patients needed spiritually, varied: from physical care, a hug, or-more emotional support. The participants gave varying descriptions and thoughts on what they understood the patient's spiritual needs were. Some understood safeguarding the spiritual dimension as spiritual care when they, as professionals in daily care situations, showed the patient dignity, and gave the patients hope. There was a general agreement that safeguarding and providing spiritual care was a task for all nursing home staff, and every member of the staff working at nursing home should be able to take care of, and facilitate, spiritual care. However, according to some of the subjects in our study, the ability to do this and understand and sense what care the patients required was not something everyone had in their personality. Although this was not something that they talked about in the different wards, the participants all had opinions on which healthcare professionals in their ward *had it in them* and who did not. Because of this some of the focus group members believed that facilitating spiritual care was not something that everyone could do, as seen in these reflections by Harald, the chaplain, and Kristin, a registered nurse, in the focus group:

> **Kristin:** I think everyone should have it as a task. Nevertheless, not everyone has the natural ability to think about it. (...) some have it more in them by nature, I think.

Harald: I think the same because it is unrelated to a specific professional group. Even though I am here as a chaplain, I will only focus on it. Because here I think they need competence in what we are going to do (...).

3.4. More than Religiousness

The professionals who participated in our study came from various religious and cultural backgrounds. Several came from a traditional Norwegian background, a few were labour immigrants, and a couple were refugees. Their religious views included Muslim, Christian, and agnostic. Some members of the group talked about religion as an essential part of their life, a few did not define themselves as religious, while others spoke of religion as culture. Despite many of them defining themselves as religious, they had not reflected on the religious aspect of daily care or that the patient had a religious/spiritual side. Even though the first thing they thought of when they heard the word spiritual care was religion. The recurring factor was that they had not thought of the fact that the patients had religious needs, such as praying and reading the Bible. Additionally, they commented that they did not know where to find information about the patients' religious views. One participant said she has asked the patient's next of kin to find out about their religious views. Despite this, many of those we interviewed had an understanding that religion was necessary for patients and an integral part of giving whole-person care and that sometimes religion helped the patient become calm. However, several nurses spoke of a shift in how they understood spiritual care today and what they had learned about spiritual care in nursing school. In the focus group, they had the following dialogue:

Sara: Immediately when I heard the word spiritual care, I thought of religion, (. . .) i.e., Christianity for most, but also other religions, but that is not what I really mean by spiritual care (. . .).

Nora: Me to, religion was the first thing that struck me, but I soon found out that it was more than that, that it was the existential needs too.

Tone: I also thought of religion when I heard it, but yes, it is so much more (. . .).

Kristin: I went to a religious Nursing school in Norway, and there was this with physical and mental, spiritual, and social needs important, so at that time, then I remember that it was more connected to religion. I did not think there was a focus on spiritual care being more than religion at that time then, but it has, just as it has changed, that there has been more understanding around spiritual care (. . .) I feel that there has not been so much focus on it, I have missed that focus. The physical needs have been so clear (. . .) the mental aspect, it has been so clear, but the spiritual has been a bit unclear, the spiritual, we have somehow. I think it was about religion, but it was in the beginning when I finished my training as a nurse, but then you understand, when you get more experience, that spiritual care is much more.

Kristin, an experienced nurse presented a picture of the change in her understanding of spiritual care. Moreover, other participants described a change in how they understood spiritual care from being only about religion to becoming much more. The nurses reflected on this change during the interview, both in the focus group and individual interviews. The nurses thought that their long experience in healthcare made a difference in how they understood spiritual care. They connected it to the importance of the ability to reflect on different life-changing events, both in their own lives and in the patient's lives.

4. Discussion

In the present study, an attempt was made to portray healthcare professionals' understanding of spiritual care. The results revealed four themes of how spiritual care was understood within a nursing home setting.

Participants understood spirituality as an integrated dimension of whole-person care and related it to how one copes with changes in health and suffering (Bergbom et al.

2021; Eriksson 2002). At the same time, several people did not acknowledge the spiritual dimension, and after hearing the definition from EAPC (2021), they understood spiritual care as being equal to *good care*. Sayid, the participant who encouraged the patient to pray in his bed, understood what he provided as good care, not spiritual care. Good care was described as personalized care where they managed to be sensitive listeners, to be present, to provide touch and maintain daily activities (eating, go for a walk etc.). Good care, as described by nursing home staff in this study, can be seen as more than just being there for the patient, where the core of their nursing is care (Eriksson 1997). During the interviews, and in the analytical process, an important issue was raised concerning whether there is a difference between spiritual care and good fundamental care. In this study, spiritual care was described as care for the whole human being, as one dimension of whole-person care with body, mind, and soul (Eriksson 1997). At the same time, providing spiritual care is considered hard to address because of a lack of time, competence, and understanding (Ødbehr et al. 2014). Nevertheless, the essential factor is that healthcare professionals working with older people acknowledged that the patient has a spiritual side, and this dimension includes both existential challenges, value-based considerations, and religious considerations (EAPC 2021), irrespective of whether they think of it as spiritual care or good care.

Spiritual care was, furthermore, understood as healthcare professional showing compassion, love, and mercy; care that was provided with a personal touch. Regardless, several participants mentioned that not all colleagues had the same natural capacity for giving care with compassion, love, and mercy. They described this care as being the opposite of good care, an uncaring care, where only mandatory tasks were done, and healthcare professionals neglected the patients' needs. These results support the idea that *uncaring care* is when patients are not treated as "real people", meaning their dignity may be violated (Råholm and Eriksson 2001). Accepting and understanding patient needs are vital characteristics for caregivers. Personal skills and characteristics, such as acceptance, a fondness for people, and providing a personal touch, seem to be essential when providing spiritual care, good care and entering a caring communion with the patient (Eriksson 1997). When understanding spiritual care as good care, one can understand the communion that the healthcare professional and patient enter into is a *caring communion*, with the spiritual dimension included. When healthcare professionals enter into a caring communion with the patient, a willingness and a sense of responsibility to do good for others are essential for good caring (Eriksson 1997). Having a personal touch was provided when healthcare professionals emphasized, accepted, and understood patient needs with compassion, love, and mercy. Several people in our study indicated that caring seemed to come naturally for them, and that care can be understood as a natural phenomenon for the human being (Bergbom et al. 2021). This suggests that people who have a natural ability to show compassion, love, and mercy, are more able and better prepared to provide and care for patient spiritual needs and provide good care (Eriksson 1997). According to the results, those with no pre-understanding of spiritual care somehow managed to provide and take care of patient spiritual needs by using their own personal touch.

In addition, spiritual care was understood as care where the healthcare professional tried to see the person behind the diagnosis, and took care to see what the patient needed in relation to their life story, culture, religion and what non-verbal signs told them (Lucchetti et al. 2019). Interestingly, some commented that they did not recognize this as providing spiritual care. Those who had a pre-understanding of spiritual care agreed that all professionals must see the person behind the diagnosis and recognize and meet the patients' spiritual needs. This is in line with the caritative theory's understanding that safeguarding spiritual care is something that all professionals must do, irrespective of their own religious and spiritual attitudes (Eriksson 1997). However, according to Eriksson (1997), whether one addresses it as spiritual care or a care where they try to see the person behind the diagnosis, one must acknowledge the spiritual dimensions to provide *spiritual care*. In this current research, there was a recurring feature of those who told of how

they provided care by trying to see the person behind the diagnosis, all having a holistic worldview developed from their own spirituality, life and work experiences, childhood, and cultural experiences (Batstone et al. 2020; Giske and Cone 2015). After analysing the data, it was clear that the nursing staff safeguarded patient spiritual needs, but they did not always acknowledge the spiritual dimension by using the words spiritual care. According to previous research, what is vital for the patient is that the healthcare professionals see the whole person, and have conversations with the patient concerning meaning, identity, death, and shame (Gautam et al. 2019; EAPC 2021). From this we can see that participants who try to see the person behind the diagnosis provide and safeguard spiritual care for patients in the nursing home. Nevertheless, to understand what the spiritual dimension means, healthcare professionals need a deeper comprehension of the meaning behind the word spiritual care.

The people in this study understood spiritual care as being more than religiousness but describing what it was precisely proved challenging. Several of the interviewees felt like a shift in how they understood spiritual care, during their time as a professional care giver. From only being about religiousness, in nursing school, to a more broad and liberal understanding of the term. Regardless, all participants agreed that caring for the religious element of a patients spiritual care is as important as caring for the social, physical, and mental sides (de Moura Scortegagna et al. 2018). Therefore, within secularized countries like Norway, one can say that healthcare professionals fulfil the mission for the different white papers and governmental guidelines (Ministry of Health and Care Services 2009; Meld. St. nr. 15 (2017–2018); The dignity guarantee 2011), however, this view depends on how you define spiritual care. The results from the current study seem to illustrate healthcare professionals understanding spiritual care in a broader way than seen in similar studies (Ødbehr et al. 2014). Indeed, based on the findings from other secular countries (La Cour et al. 2012) the word *spirituality* has a broad definition. In a secularized country like Norway, spiritual care seems to be open enough in meaning for people to hold their own interpretation and understanding of it. The equivalent of *spirituality* in the Norwegian language is perhaps too broad, or too vague which could explain why healthcare professionals find it hard to address and comprehend, especially within a Norwegian context (Ødbehr et al. 2014). Though the group members in this study were able to reflect effectively on the different dimensions of spiritual care, this was perhaps because their long experience in care gave them sufficient language to undertake such a task.

This study was built on the assumption that spiritual care competency in nursing homes was low. Yet, the main finding, and most unexpected result, was that competency was abundant. Having said this, the healthcare professionals in this study did not think of it as spiritual care, and they had different perspectives on what spiritual care constituted. However, the Norwegian word for spiritual care seemed to be an unknown word for some participants, while, those who had heard of it found it hard to describe or not broad enough to apply to the Norwegian nursing home context, in fact the expression "*åndelig omsorg*" seems ill-fitted to this context (Kleiven et al. 2021). According to La Cour et al. (2012), how one understands spirituality depends on the individual. Therefore, we can say it is not possible to define what spiritual care is, and that spiritual care, for those who have not heard of the spiritual dimension, can be understood as caring care. If healthcare professionals are aware of the spiritual dimension of care, they can reflect easily on what it entails in their daily life and in everyday care settings. We support the opinion that in order to facilitate and take care of patient spiritual needs and resources, it requires adequate education (Lewinson et al. 2015; Kuven and Giske 2019). To enable and develop spiritual care, it is important that the professional culture and the leaders of a nursing home foster an awareness of spirituality and create a working environment that is open to spiritual matters (Giske and Cone 2015). Likewise, healthcare professionals must have a good relationship with the patient to provide and safeguard spiritual care and enter a

caring communion. There was general agreement in this research that one could not omit the spiritual dimension of care when seeking to deliver whole-person care.

5. Conclusions and Relevance for Clinical Practice

This study aimed to identify healthcare professionals' understanding of spiritual care in one nursing home in Norway. Based on qualitative content analysis of eight individual interviews and one focus group interview with healthcare professionals, it was concluded that healthcare professionals with different religious and cultural backgrounds understand spiritual care as an essential part of everyday nursing. Safeguarding spiritual care is not just a task for nurses, but for all nursing home personnel, meaning that all staff must have the ability to learn that the patient has spiritual needs. The results indicate that healthcare professionals have a broad and liberal understanding of the word spiritual care. This research clearly illustrates that spiritual care is often an unknown concept for assistant nurses and healthcare support workers. Moreover, it raises the question regarding the difference between good fundamental care and spiritual care. Based on these conclusions, further research is needed to better understand the difference or distinction between these two elements of care. In addition, leaders, and others responsible for delivering care, must consider providing education on the different dimensions of care with a specific emphasis on raising awareness of spiritual care in the entire workforce. This is for those working in nursing homes, leaders and teachers of nurses and assistant nurses, and others who are involved in older person care.

Methodological Considerations

The trustworthiness of this study was realized as it was based on the framework of Lincoln and Guba (1985); it therefore had credibility, dependability, confirmability, and transferability. Credibility was achieved by obtaining written informed consent. Participation was voluntary, and both oral and written information was provided. Permission to use an audio recorder was requested orally. All participants signed a written informed consent form and were informed that they could withdraw from the study at any time. Anonymity and data protection were ensured. Dependability was achieved by the last author, who was not involved in the data collection and evaluated and confirmed themes and sub-themes during the analytical process. Confirmability was ensured by using two different techniques to collect data. Individual interviews were chosen because some interviewees might not know what spiritual care was and would feel uncomfortable in a focus group. The use of focus groups with leaders was to understand the thoughts of individuals in leadership roles at the nursing home. Additionally, there was a pre-understanding that the leaders understood spiritual care. To ensure transferability, all quotes were translated directly from Norwegian to English. All participants worked in a Norwegian context; therefore, the results were based on the Norwegian word for spiritual care, *åndelig omsorg*. Because of this, the results may not be transferable to other non-secularized countries. However, there are religious and non-religious persons working in older people care in all parts of the world. Consequently, findings will hopefully be relevant internationally. The research was conducted in one nursing home, which is a limitation. However, nursing homes in Norway and other countries in Europe are similar in design and approach; this means the findings will be relevant to other contexts. The understanding and analysis of the word spiritual care as being the same as good care or caring care can be considered a weakness, and it might seem like a thin line to conclude that spiritual care is the same as good fundamental care. However, one must understand that how one defines spiritual care seems to be private and personal. Nevertheless, it is the researcher's interpretation that it can be understood as spiritual care. The whole analytical process was reviewed and discussed among all the authors, and a consensus was reached to ensure trustworthiness. Thus, the content analysis was a process of constantly moving between reading the scripts from interviews and trying to understand the underlying meaning in what was said in the interviews. One important question and a starting point that arose during the interviews was: *what*

is spiritual care versus good care? This question emerged during the data analysis because the participants were unfamiliar with the concept of spiritual care. This question was a "companion" throughout the research analysis to the end of this process; thus, it became a part of the researchers' pre-understanding and can be found inherent in the analysis.

Author Contributions: Conceptualization, M.M., W.M. and L.R.; methodology, M.M. and L.R.; software, M.M.; validation, M.M., W.M. and L.R.; formal analysis, investigation, resources, data curation, visualization, and project administration, M.M.; writing—original draft preparation, M.M., W.M. and L.R.; writing—review and editing, M.M.; supervision, W.M. and L.R. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: This study was approved by the Data Protection Official for Research at the Norwegian Social Science Data Services (NSD) (ref: 681064).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Acknowledgments: We would like to thank the nursing home participants.

Conflicts of Interest: The authors declare no conflict of interest.

References

Batstone, Elizabeth, Cara Bailey, and Nutmeg Hallett. 2020. Spiritual care provision to end–of–life patients: A systematic literature review. *Journal of Clinical Nursing* 29: 3609–24. [CrossRef] [PubMed]

Bengtsson, Mariette. 2016. How to plan and perform a qualitative study using content analysis. *NursingPlus Open* 2: 8–14. [CrossRef]

Bergbom, Ingegerd, Dagfinn Nåden, and Lisbet Nyström. 2021. Katie Eriksson's caring theories. Part 1. The caritative caring theory, the multidimensional health theory and the theory of human suffering. *Scandinavian Journal of Caring Sciences*, 1–9. [CrossRef]

Bruce, Steve. 2011. *Secularization: In Defence of an Unfashionable Theory*. Oxford: Oxford University Press.

de Moura Scortegagna, Helenice, Nadir Antonio Pichler, and Lúcia Fernanda Fáccio. 2018. The experience of spirituality among institutionalized elderly people. *Revista Brasileira de Geriatria e Gerontologia* 21: 293–300. [CrossRef]

Den Norske Kirke (the Norwegian Church). 2021. Inn-og Utmeldinger i Koronaåret-Enrollments and Withdrawals in the Corona Year. Available online: https://kirken.no/nb-NO/om-kirken/aktuelt/inn-%20og%20utmeldinger%20i%20korona%C3%A5ret/ (accessed on 26 October 2021).

EAPC. 2021. EAPC Task Force on Spiritual Care in Palliative Care. Available online: https://www.eapcnet.eu/eapc-groups/reference/spiritual-care/ (accessed on 8 October 2021).

Eriksson, Katie. 1997. Caring, spirituality and suffering. In *Caring from the Heart: The Convergence of Caring and Spirituality*. Edited by Mary Simone Roach. New York: Paulist Press.

Eriksson, Katie. 2002. Caring science in a new key. *Nursing Science Quarterly* 15: 61–65. [CrossRef] [PubMed]

Eriksson, Katie, Unni Å Lindström, and vårdvetenskap Åbo akademi Institutionen för. 2003. *Gryning: II: Klinisk Vårdvetenskap*. Vasa: Institutionen för vårdvetenskap, Åbo Akademi, vol. 2.

Eriksson, Katie, I. Charles, E. Joan, and A. Karl. 2006. *The Suffering Human Being*. Chicago: Nordic Studies Press.

Gadamer, Hans-Georg. 2003. Forforståelsens filosofi. In *Utvalgte Hermeneutiske Skrifter*. Oslo: Cappelen Akademisk Forlag.

Gadamer, Hans-Georg. 2010. *Sannhet og Metode: Grunntrekk i en Filosofisk Hermeneutikk "Truth and Metode". Wahrheit und Methode Grundzüge einer philosophischen Hermenutik*. Oslo: Pax.

Gautam, Sital, Stephen Neville, and Jed Montayre. 2019. What is known about the spirituality in older adults living in residential care facilities? An Integrative review. *International Journal of Older People Nursing* 14: e12228. [CrossRef]

Giske, Tove, and Pamela H. Cone. 2015. Discerning the healing path–how nurses assist patient spirituality in diverse health care settings. *Journal of Clinical Nursing* 24: 2926–35. [CrossRef] [PubMed]

Giske, Tove, and Pamela H. Cone. 2019. Å ta vare på heile mennesket. In *Handbok i Åndeleg Omsorg [Caring for the Whole Person. Handbook of Spiritual Care]*. Oslo: Det Norske Samlaget.

Graneheim, Ulla, and Berit Lundman. 2004. Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today* 24: 105–12. [CrossRef]

Holmberg, Åse, Per Jensen, and Dagfinn Ulland. 2017. To Make Room or Not to Make Room: Clients' Narratives About Exclusion and Inclusion of Spirituality in Family Therapy Practice. *Australian and New Zealand Journal of Family Therapy* 38: 15–26. [CrossRef]

ICN (International Council of Nurses). 2021. *The ICN Code of Ethics for Nurses*. Geneva: International Council of Nurses.

Kleiven, Tormod, Bart Cusveller, Marianne Rodriguez Nygaard, Stefica Miksic, Adam Boughey Boughet, and Wilfred McSherry. 2021. What do we mean by spirituality and spiritual care. In *Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care: Through Innovative Education and Compassionate Care*. Edited by Wilfred McSherry, Adam Boughey and Josephine Attard. Cham: Springer International Publishing.

Krueger, Richard A., and Mary Anne Casey. 2014. *Focus Groups: A Practical Guide for Applied Research*. Thousand Oaks: Sage Publications.

Kuven, Britt Moene, and Tove Giske. 2019. Talking about spiritual matters: First year nursing students' experiences of an assignment on spiritual conversations. *Nurse Education Today* 75: 53–57. [CrossRef]
La Cour, Peter, Nadja Hørdam Ausker, and Niels Christian Hvidt. 2012. Six understandings of the word 'spirituality'in a secular country. *Archive for the Psychology of Religion* 34: 63–81. [CrossRef]
Lewinson, Lesline, Wilfred McSherry, and Peter Kevern. 2015. Spirituality in pre-registration nurse education and practice: A review of the literature. *Nurse Education Today* 35: 806–14. [CrossRef] [PubMed]
Lewinson, Lesline, Wilfred McSherry, and Peter Kevern. 2018. "Enablement"—Spirituality Engagement in Pre-Registration Nurse Education and Practice: A Grounded Theory Investigation. *Religions* 9: 356. [CrossRef]
Lincoln, Yvonna, and Egon G. Guba. 1985. *Naturalistic Inquiry*. Thousand Oaks: Sage.
Lindstrøm, Nystrøm, and Joan E. Zetterlund. 2018. Theory of Caritative Caring. In *Nursing Theorists and Their Work*. Edited by Martha Raile Alligood. St. Louis: Elsevier, pp. 140–63.
Lucchetti, Giancarlo, Mario Fernando Prieto Peres, and Rodolfo Furlan Damiano. 2019. *Spirituality, Religiousness and Health: From Research to Clinical Practice*. Cham: Springer.
McSherry, Wilfred, Linda Rykkje, and Susan Thornton. 2021. Spiritual Care and Dignity in Old Age. In *Understanding Ageing for Nurses and Therapists*. New York: Springer, pp. 39–49.
Meld. St. nr. 15. 2017–2018. Leve Hele Livet—En Kvalitetsreform for eldre//A Full Life-All Your Life—A Quality Reform for Older Persons Edited by Helse-og omsorgsdepartementet//Ministry of Health and Care Services. Available online: https://www.regjeringen.no/contentassets/196f99e63aa14f849c4e4b9b9906a3f8/en-gb/pdfs/stm201720180015000engpdfs.pdf (accessed on 14 December 2021).
Ministry of Health and Care Services. 2009. Rett til Egen tros- og Livssynsutøvelse//Right to one's Own Beliefs and Views. Available online: https://www.regjeringen.no/no/dokumenter/i-62009-rett-til-egen-tros--og-livssynsu/id587577/ (accessed on 14 December 2021).
Mlinar Reljić, Nataša, Zvonka Fekonja, Sergej Kmetec, Wilfred McSherry, Blanka Kores Plesničar, and Majda Pajnkihar. 2021. Family members' experiences with the spiritual care of older people living with dementia in nursing homes: A phenomenological hermeneutical study. *Nursing Open* 8: 2932–41. [CrossRef] [PubMed]
Nystrøm, Lisbet, Unni Lindstrøm, Joan Zetterlund, and Martha Alligood. 2021. *Nursing Theorists and Their Work*. St. Louis: Elsevier.
O'Brien, Mary, Karen Kinloch, Karen E. Groves, and Barbara A. Jack. 2019. Meeting patients' spiritual needs during end–of–life care: A qualitative study of nurses' and healthcare professionals' perceptions of spiritual care training. *Journal of Clinical Nursing* 28: 182–89. [CrossRef] [PubMed]
Ødbehr, Liv, Kari Kvigne, Solveig Hauge, and Lars Johan Danbolt. 2014. Nurses' and care workers' experiences of spiritual needs in residents with dementia in nursing homes: A qualitative study. *BMC Nursing* 13: 12. [CrossRef]
Råholm, Maj-Britt, and Katie Eriksson. 2001. Call to life: Exploring the spiritual dimension as a dialectic between suffering and desire experienced by coronary bypass patients. *International Journal of Human Caring* 5: 14. [CrossRef]
Rykkje, Linda. 2016. Forståelse av åndelighet og åndelig omsorg for gamle mennesker–en hermeneutisk studie. *Nordisk Tidsskrift for Helseforskning* 12: 49. Available online: https://septentrio.uit.no/index.php/helseforsk/article/download/3780/3681 (accessed on 18 January 2022).
Rykkje, Linda, and Maj-Britt Råholm. 2014. Understanding Older Peoples' Experiences of Dignity and its Significance in Caring—A Hermeneutical Study. *International Journal for Human Caring* 18: 17–26. [CrossRef]
Rykkje, Linda, Katie Eriksson, and Maj-Britt Riholm. 2011. A qualitative metasynthesis of spirituality from a caring science perspective. *International Journal of Human Caring* 15: 40–53. [CrossRef]
Rykkje, Linda, Katie Eriksson, and Maj_Britt Råholm. 2013. Spirituality and Caring in old Age and the Significance of Religion—A Hermeneutical Study from Norway. *Scandinavian Journal of Caring Sciences* 27: 275–84. [CrossRef]
Rykkje, Linda, Margrethe Bakstad Søvik, Linda Ross, Wilfred McSherry, Pamela Cone, and Tove Giske. 2021. Educational interventions and strategies for spiritual care in nursing and healthcare students and staff: A scoping review. *Journal of Clinical Nursing*, 1–25. [CrossRef]
Santos, Lucivalda Barbosa, Tânia Maria de Oliva Menezes, Raniele Araújo de Freitas, Marta Gabriele Santos Sales, Ana Luíza Barreto de Oliveira, and Amélia Maria Pithon Borges Nunes. 2021. Care for the spiritual dimension provided by caregivers in a nursing home. *Revista Brasileira de Enfermagem* 75: 1–7. [CrossRef]
Selman, Lucy Ellen, Lisa Jane Brighton, Shane Sinclair, Ikali Karvinen, Richard Egan, Peter Speck, Richard A. Powell, Ewa Deskur-Smielecka, Myra Glajchen, and Shelly Adler. 2018. Patients' and caregivers' needs, experiences, preferences and research priorities in spiritual care: A focus group study across nine countries. *Palliative Medicine* 32: 216–30. [CrossRef] [PubMed]
Statistics Norway (SSB). 2021. NATIONAL POPULATION PROJECTIONS, 2020–2100: A Historic Shift: More Elderly than Children and Teenagers. Statistics Norway (SSB). Available online: https://www.ssb.no/en/befolkning/artikler-og-publikasjoner/a-historic-shift-more-elderly-than-children-and-teenagers (accessed on 8 December 2021).
Steinhauser, Karen, George Fitchett, George F. Handzo, Kimberly S. Johnson, Harold G. Koenig, Kenneth I. Pargament, Christina M. Puchalski, Shane Sinclair, Elizabeth J. Taylor, and Tracy A Balboni. 2017. State of the science of spirituality and palliative care research part I: Definitions, measurement, and outcomes. *Journal of Pain and Symptom Management* 54: 428–40. [CrossRef] [PubMed]
The Dignity Guarantee. 2011. *Forskrift om en verdig Eldreomsorg*. Oslo: Lovdata.

Torskenæs, Kristina, Mary H. Kalfoss, and Berit Sæteren. 2015. Meaning given to spirituality, religiousness and personal beliefs: Explored by a sample of a Norwegian population. *Journal of Clinical Nursing* 24: 3355–64.

Urstad, Sivert Skålvoll. 2017. The religiously unaffiliated in Norway. *Nordic Journal of Religion and Society* 30: 61–81. [CrossRef]

Veloza-Gómez, Mónica, Lucy Muñoz de Rodríguez, Claudia Guevara-Armenta, and Sandra Mesa-Rodríguez. 2017. The Importance of Spiritual Care in Nursing Practice. *Journal of Holistic Nursing* 35: 118–31. Available online: https://ezproxy.vid.no/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=123676634&site=ehost-live (accessed on 8 December 2021).