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What is Spiritual Care?
Professional Perspectives on the Concept of Spiritual Care identified through Group Concept Mapping

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What is Spiritual Care?

Professional Perspectives on the Concept of Spiritual Care identified through Group Concept Mapping.

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Content:

Abstract

Objectives

The overall study aim was to synthesize understandings and experiences regarding the concept of Spiritual Care (SC). More specifically, to identify, organize, and prioritize experiences with the way SC is conceived and practiced by professionals in research and the clinic.

Design

Group Concept Mapping (GCM).

Setting

The study was conducted within a university setting in Denmark.

Participants

Researchers, students, and clinicians working with SC on a daily basis in the clinic and/or through research participated in brainstorming (n=15), sorting (n=15), rating, and validation (n=13).

Results

Applying GCM, ideas were identified, organized and prioritized online. A total of 192 unique ideas of SC were identified and organized into six clusters. The results were discussed and interpreted at a validation meeting. Based on input from the validation meeting a conceptual model was developed. The model highlights three overall themes: 1) "Spiritual care as an integral but overlooked aspect of healthcare" containing the two clusters *Spiritual care as a part of health care* and *Perceived significance*; 2) "Delivering Spiritual Care" containing the three clusters *Quality in attitude and action*, *Relationship*, and *Help and support*; and finally 3) "The Role of Spirituality" containing a single cluster.

Conclusion

Because spirituality is predominantly seen as a fundamental aspect of each individual human being, particularly important during suffering, spiritual care should be an integral aspect of healthcare, although it is challenging to handle. Spiritual care involves paying attention to patients' values and beliefs, requires adequate skills, and is realized in a relationship between healthcare professional and patient founded on trust and confidence.

Keywords

Patient Care, Medical Ethics, Palliative Care, Spirituality, Religion, Existentialism, Public Health

Strengths and limitations of this study

- One strength of this study of professionals' perspectives on what constitutes spiritual care in Denmark was that participants involved represented researchers, students and clinicians all addressing 'Existential and Spiritual Care' in their professional work.
- We employed a method that is recognized for the mapping of understandings of Spiritual Care: Group Concept Mapping, with more than required number of participants involved in all the research phases (data generation, analyses, validation of results, discussion) which also strengthening the validity and reliability of the study.
- The number of statements generated was high (appendix A) and despite removal of more than 40% of the ideas due to redundancy, the remaining number of ideas included in the analysis was close to recommended maximum of 200 statements (1). This strength implied the challenge of management of statements in the third phase of the analysis, a limitation we countered by paying close attention to rigorous methodology.
- Fewer statements might lower the richness of the material, but it also facilitates increased depth with the analytic process leading to the conceptual model.
- As this research project centred on *professional perspectives on spiritual care,* we only included professional users in the study, however, the need for the present study was identified by the base patient user panel of our research group that we consult ongoingly.

Background

The number of international research articles concerning spirituality and spiritual care (SC) and the relationship between spirituality and health have increased exponentially throughout the past decades (2). In the research literature, 'Spirituality' tends to be understood as a collective designation for the interior life with its convictions, practices, emotions and sources of meaning that are present as a source of hope and energy in every person (3-5). SC, on the other hand, is broadly understood as a type of care that addresses and seeks to meet existential and spiritual needs and challenges in connection with illness and crisis (3, 4, 6-16).

Research has shown that SC increases the quality of life of patients (17-27). Failure to provide SC leads to existential and spiritual distress, which may cause increased risk of depression and reduced health, with increased healthcare costs as a consequence (28). Spirituality is described as particularly important during a crisis, whether such spirituality involves religious convictions or just the open-mindedness towards 'more between heaven and earth' (29, 30). The growing research on SC has shown that life-threatening illness often leads to an intensification of spiritual considerations and needs. These intensify in step with the severity of disease as well as prospect of imminent death (31, 32). The same tendency is found in Denmark, one of the most secular cultures in the world, where research has shown a relationship between the severity of illness and increase in existential and spiritual needs and considerations (33). Consequently, there is a growing necessity to address spiritual needs among cancer patients who experience an immensely present fear of death (34). Particularly, senior cancer patients, have frequent experiences of 'existential loneliness' and feelings of 'invisibility', longing for opportunities to discuss death and spiritual needs with peers, hereby increasing their risk of isolation and depression (35).

Some of the reasons given for not prioritizing SC is lack of time and money. However, a recent US Harvard study suggests that it is not feasible to neglect SC The study compared two groups of dying persons, one group experiencing good SC from their team of therapists (rated on a Likert scale), the

other group experiencing less SC. The expenses for the patients experiencing less SC turned out to be twice as high as the expenses for the patients experiencing good SC care; for ethnical minorities and for religious people, the difference was even higher. The authors argue that the patients who receive limited SC experience more worries, anxiety, shortness of breath, pain etc. This increases the probability that, they will be hospitalized and die at intensive care units, instead of at home. Limited access to SC is not only a large strain on the dying persons and their relatives, it is also expensive for society in terms of added healthcare costs (36).

But what is the role of SC within cultures, that are more secular than the US culture? Research projects from Scandinavian research institutions have given an insight into Scandinavian patients' and relatives' spiritual needs (see publications at www.faith-health.org/?p=5592). The Scandinavian research projects show that illness activate often dormant spiritual needs. This seems particularly to be the case for Denmark, which international sociologists characterize as 'the least religious society in the world' (37). Religiosity is described as among the largest taboos in Denmark (38). Religion is of limited significance in the public domain and is very difficult to verbalize for Danes (39). This is, however, not the same as stating that Danes are non-believers. Anonymous surveys, such as Eurobarometer (2018), finds that only 9% of Danes describe themselves as 'atheists', 13% as 'non-believers/agnostics', whereas 75,4% describe themselves as 'believers/religious' (40). Approximately one third of the latter believe in a 'personal God', the rest in 'a higher power'. In many ways, Danes may figuratively be said to be the people in the world with the highest degree of 'passive' membership of the church, which can be activated in case of existential and spiritual needs. More than 76% of Danes are members of the Danish National Evangelical Lutheran Church (the world's highest degree of membership of any organized church), whereas only 2% go to church on a weekly basis (the world's lowest degree of religious practice). This 'membership' does not merely concern church attendance; it involves cultural, ethnical, and existential affiliation, and for many people symbolizes the belief that there is 'more between heaven and earth' without them retorting to active religion. Thus, the title of a PhD-thesis that investigates the spirituality of young Danes and Swedes in the Øresund region fittingly reads: "I'm a believer, but I'll be

damned if I'm religious" (41). This 'passive membership' can be activated if a person experiences a loss of control in connection with a crisis, especially illness, either of his own or in the nearest family. Nothing thus seems to move secular people to think about existential, spiritual and religious issues more than crisis and illness, and nowhere are people more confronted with illness, than at the hospital. And dying people, even in secular societies like Denmark, often have unmet ambivalent spiritual needs (27). *Because* spiritual and/or religious considerations seem tabooed and ambivalent in a secular society like Denmark, and because many Danes have limited language for these considerations there is a need for competent SC. Potentially many Danes will be existentially unprepared, when encountering suffering. This leads us to the question of what SC is.

Based on years of consensus processes and dialogue in Nordic Network for Faith and Health, including research and writing by the authors of the present article, we sought to approach the definitions and understandings through Group Concept Mapping (GCM) methodology (42-44). GCM methodology is a mixed method approach to generating and structuring ideas on a specific topic. During the GCM process, participants are involved in several steps of the research process and the final results are illustrated in maps where ideas on the specific topic are organized thematically.

Objective

Much uncertainty remains as to what the concept of Spiritual Care (SC) includes. We used a GCM approach to synthesize understandings and experiences regarding SC among members of a 'Spiritual Care Research Group' in Denmark. The objective was to identify, organize and prioritize experiences with the way SC is conceived and practiced by professionals in research and the clinic in a secular Danish context.

Methods

Participants

Researchers, students and clinicians connected to the 'Existential and spiritual care research group' at the Research Unit of General Practice (RUGP), Institute of Public Health at the University of Southern

Denmark (SDU) were invited to participate in the study. Participants were to fulfil the following inclusion criteria: 1. Having at least completed a master's degree AND 2. Having professional clinical experience with SC OR 3. Having professional research experience with SC.

Eighteen persons who met the inclusion criteria were identified and invited either through e-mail or personal contact. All were informed about the study design including participation in at least one of three elements: brainstorming, sorting and rating, and validation of data. Participation was not compensated. All eighteen persons agreed to participate. All participants gave information regarding age, gender, profession, employment, years working with SC as a clinician, and years working with SC as a researcher (Table 1).

Patient and Public Involvement.

As this research project centred on *professional perspectives on spiritual care,* we only included professional users in the study. However, the need for the present study became clear out of the base patient user panel of our research group that we consult ongoingly.

Study design and procedures

To address the aim of the study, Group Concept Mapping (GCM) (45-47) was applied. The following phases were included in the structured GCM process: (1) preparing for GCM, (2) generating the ideas (brainstorming), (3) structuring the statements (sorting and rating), (4) GCM analysis (data analysis), (5) interpreting the map (validation), and (6) utilization (developing a conceptual model)(48). These six phases provided a structure for the process (Figure I).

In general, GCM is based on a mixed methods participatory approach and the process may involve face-to-face group sessions, online participation or both (48). In this study, both were applied. Phases one to four were conducted on-line, whereas phase five took place during a face-to-face session. Brainstorming was completed using Microsoft Excel, whereas sorting, labelling, rating and generation of cluster rating map was performed using the CS Global Max software system (49) .

1. Preparing for GCM

Before initiating the data collection, a focus prompt was formulated and piloted. The final version was: *""In my professional perspective, SC is characterized by …."*

2. Generation of ideas (Brainstorming)

Through e-mail, participants were instructed to brainstorm with as many brief continuations as possible to the focus prompt using an attached Excel file. They were reminded to keep each sentence/idea short containing only one meaning (for instance "SC is an important aspect of palliative care"), and it was clarified that the word 'professional' related to both clinical and research-based perspectives. Participants forwarded their Excel file and an overall list of ideas was generated. Identical ideas were individually identified by the second and last author and removed after consensus was reached.

3. Structuring the Statements (Sorting and Rating)

Again, the participants received an e-mail containing information about the sorting and rating tasks as well as a link to online participation using CS Global Max software. The first task was to sort all the ideas generated during the brainstorm into clusters, and to label each cluster. This was an individual task performed according to individual preferences. Next, the participants rated the importance of each idea on a four-point ordinal scale; a score of one being *"Unimportant"* and a score of four being "*Very important*".

4. GCM analysis (data analysis)

Based on phases two and three, a Cluster Rating Map was generated using the CS Global Max software to be presented at the face-to-face validation meeting in phase five. For further information, see section on data analysis.

5. Interpreting the map (Validating)

At the validation session, the Cluster Rating Map was presented to the participants and they engaged in a group discussion, revising and interpreting the map, e.g. the number and content of derived clusters and the labels.

6. Utilization (Developing a Conceptual model)

Finally, the participants created a conceptual model based on the Cluster Rating Map generated using the CS Global Max software (phase four) and input from the validation session (phase five). For further information, see section on data analysis.

Data analyses

Participant characteristics

Participant data on age, gender, research experience, employment type and types of involvement in the GCM process were registered. Age and research experience were reported using median and interquartile range due to lack of normal distribution of the data. Data on gender, profession, employment and project involvement were presented in percentages. Analyses of participant data were performed using Microsoft Excel 365 ProPlus®.

Data from Group Concept Mapping

CS Global Max software was used to perform data analyses based on the ideas derived from the brainstorming. The analyses were conducted in several steps. First, ideas gathered were consolidated; if needed, identical ideas were removed, and ideas revised in order to clarify the meaning. The remaining ideas were then imported into CS Global Max in preparation for phases three and four.

Participant data from phase three were to be included in the cluster analysis if more than 75% of the ideas were sorted and if less than five ideas remained unrated. Based on the sorting and rating of these ideas (phase three), multidimensional scaling analysis and cluster analysis were performed in which related ideas were grouped into clusters (48). During this process, several cluster solutions were generated and the one that matched the data the best (i.e. the cluster solution representing sufficient details on the topic) was applied, creating the Cluster Rating Map (phase four). Within the multidimensional scaling analysis, the stress value is a statistic used to indicate 'goodness of fit'. A low stress value (<0.39) was used to determine congruence between the raw data and processed data (48). Based on the labels provided by the participants in phase three, cluster labels were suggested by CS

Global Max software. Besides illustrating the labelled clusters in relation to each other, the importance of ideas included in each cluster was also depicted by the number of layers in each cluster, based on median values for importance ratings given for each idea in the cluster.

The Cluster Rating Map was validated at the face-to-face validation meeting (phase five), revising the number and labels of clusters. The final conceptual model was generated based on this validated Cluster Rating Map, thematic analysis and consensus among participants. Thus, the participants analyzed the clusters and the included ideas to determine if the included ideas were placed in a cluster that best matched the meaning of the ideas and discussed to obtain consensus.

Results

All participants were involved in at least one of the three phases. In total, fifteen (83%) were involved in the brainstorming phase, fifteen (83%) in sorting and rating online only, and finally, thirteen (72%) participated at the validation meeting. Overall, ten (56%) were involved in all three phases. The number of participants involved in the study is on par with recommendations of core literature on the GCM methodology (50)

During the brainstorm phase, participants generated a total of n = 327 ideas. Identical ideas were identified and removed before 192 unique ideas were imported into the CS Global Max software for sorting and labelling. In the third phase, all participants sorted 100% of the ideas into between two to 21 clusters, and four participants (22%) left between one and five ideas unrated (n = 10). As the proportions of unsorted and unrated statements for each participant were below the predefined criteria, the 192 ideas were all included in the analyses (phase four). Cluster solutions from ten to six clusters were applied; the one with six clusters matched the data the best and was used to create the first Cluster Rating Map (Figure I). These initial six clusters contained between 23 and 49 ideas and were preliminarily labelled by CS Global Max, based on a variety of labels suggested by individual participants during phase three. The clusters represented ideas with varying importance, which is depicted by the height of each cluster. The most important ideas were placed in the highest clusters. A

total of n = 44 ideas (23%) with high importance (median ≥4) were identified across the six clusters. The multidimensional scaling analysis involved 24 iterations and revealed a low stress value of 0.3023.

Discussions at the face-to-face validation meeting (phase five) resulted in revision of the Cluster Rating Map. First, the participants decided to keep the same number of clusters but renamed four clusters. In the thematic analysis, the authors agreed on the cluster location of 96% (*n* = 185) of the ideas. Thus, seven ideas were moved between clusters. The final six clusters are presented in Table 2. The 192 ideas sorted into the final six clusters are presented in Appendix 1 (online supplemental material) along with median importance ratings for each idea. There is no additional data available.

The first cluster named *SC as a part of healthcare* contained 24 ideas e.g. "Attending one of the four aspects of health along with physical, psychological and social" suggesting that SC should be understood and practiced as a standard aspect of healthcare. The second cluster named *Perceived significance* contained 27 ideas capturing a broad spectrum of notions related to SC e.g. "Recognizing that SC can play a fundamental role in the healing process" but also that SC is not easy to grasp and practice in secular culture and that it, in order to be qualified, needs to be an integrated aspect of basic and continued learning in healthcare. The third cluster named *The role of spirituality* included 23 ideas about the nature and role of spirituality, e.g. "being an essential part of being human", recognizing that it may variously comprise patients´ existential, religious, and spiritual concerns. The fourth cluster named *Help and support* comprised 34 ideas that involved helping patients or a family to cope with existential, religious and/or spiritual issues such as hope and fear, and that SC involved "nonverbal relational communication" and that it requires "accepting any belief system my patients/their relatives/their caregivers may hold." The fifth cluster named *Quality in attitude and action* contained 35 ideas such as "being 'out in the open' with the patient even if I have no treatment or ailment for their disease" and that SC should be attentive and respectful towards patients' values and beliefs, something that basic inquiry into the patients background (including believes) may assist. The sixth cluster named *Relationship* included 49 ideas that all emphasized the importance and nature of relations in healthcare, e.g. "human

equality between health professionals and patients" underlining the importance of being aware of one's own weakness and fundamental values.

Based on the discussion and decisions at the validation meeting, a final conceptual model revealing what characterizes SC was developed (Figure II). The conceptual model encompassed six clusters reflecting vital aspects of SC. They clustered in three over-all themes: 1. SC as an integral but underdeveloped part of healthcare (involving two concepts), 2. Delivering SC (involving three concepts) and 3. The role of spirituality.

Table 1 - Participant characteristics (n=18)

Age, median (IQR)	47,5 (42,3 - 51,8)
Age, range	27 - 75
Women, n (%)	10 (56%)
Participated in brainstorm, n (%)	15 (83%)
Participated in sorting/rating, n (%)	15 (83%)
Participated in validation, n (%)	13 (72%)
Participated in both sorting/rating and validation, n (%)	11 (61%)
Research experience, years, median (IQR)	9,5 (2,8 - 10,8)
Research experience, years, range	1 - 44
Type of research experience, n (%)*	
Literature or bibliographic	2 (11%)
Qualitative	15 (83%)
Quantitative	11 (61%)
Both qualitative and quantitative	9 (50%)
Employment, n (%)*	
Research assistant	2 (11%)
PhD Student	2 (11%)
Post.doc.	4 (22%)
Research fellow	2 (11%)
Associate Professor	3 (17%)
Professor	1 (6%)
Physician or MD	6 (33%)
Chaplain	2 (22%)

* = Some participants contribute to this statistic more than once, why the sum does not equal 100%

Table 2

Description of the Final Six Group Concept Mapping Clusters of Understanding of Spiritual Care

Cluster	**Summary –** Content
1. Spiritual care as a part of healthcare Number of ideas: 24	**SC is a growing type of healthcare which goes beyond bio-physical and social needs and relates to patients' and relatives' existential and spiritual needs**. Health professionals (e.g. nurses, chaplains, psychologists, and medical doctors) often engage in interdisciplinary work with patients and relatives through dialogue about spiritual issues. SC is a particularly important aspect of rehabilitation, palliative care, and general practice.
2. Perceived significance Number of ideas: 27	**SC is an underprioritized aspect of healthcare and not perceived as relevant for all patients. It is also perceived as difficult to approach – especially in a secular country (e. g. Denmark).** It is a sphere of healthcare which, particularly in a multicultural and pluralistic context, calls for more attention: for example, in the fields of education, supervision and research. It is an area with the potential to relieve anxiety and suffering, and thereby support a holistic approach to healthcare.
3. The role of spirituality Number of ideas: 23	**Spirituality is an essential part of spiritual care. Spirituality may comprise both patients´ existential, spiritual and religious concerns into an existential frame of self-concept** It emphasizes the connection / relationship between an individual self (body, mind and spirit/soul) and that individual's self-transcending experiences, meaning and not rarely also sacred entities like oracles, prophets, spirits and/or deities (i.e. God). It is always embedded and understood within and with regard to the prevailing culture.
4. Help and support Number of ideas: 34	**SC involves supporting and helping patients when they face existential/spiritual/religious crises in healthcare.** This involves taking the time to explore the patients' spiritual history and not just their medical history; supporting both patients and relatives through active listening, and using dialogue to explore their thoughts, feelings and outlook on life; and assisting patients in finding meaning and purpose in the things they value, and, if possible, gaining inner peace and well-being.
5. Quality in attitude and action Number of ideas: 35	**SC is attentive and respectful towards patients' values and beliefs.** Healthcare professionals achieve this by acknowledging and supporting patients' personal dignity through empathic listening, and by offering comfort, compassion, love, and advice.
6. Relationship Number of ideas: 49	**SC requires relationships between healthcare professionals and patients that are characterized by empathy and trustworthiness. Healthcare professionals are aware of their responsibility for this relationship with the patient.** The professional encounter should be grounded in a committed and compassionate relationship. SC takes place when healthcare professionals are fully present and engaged in exploring the patients´ resources, allowing periods of silence in conversation, or holding the hands of a patient in need of a hand to hold.

Figure I: First Cluster rating map with 6 clusters (Uploaded).

Figure II: Conceptual Model (Uploaded). Three themes are presented. Green: Spiritual Care as an integral but underdeveloped part of healthcare. Blue: Delivering Spiritual Care. Red: The role of spirituality.

Discussion

Although substantial research documents the integral role of SC for high-quality patient-centered care there is much uncertainty as to what SC actually is and how it is best practiced. Accordingly, in this study a GCM approach was used to synthesize experiences among researchers, students and clinicians involved in an 'Existential and Spiritual Care Research Group' in Denmark. As mentioned in the Conceptual Model, three overall themes emerged: 1. Spiritual Care as an integral but underdeveloped part of healthcare, 2. Delivering Spiritual Care and 3. The role of spirituality.

Spiritual Care as an integral but underdeveloped part of healthcare (Green colour theme)

SC was found to be *a part of healthcare* (Cluster 1) and has continued to grow as an important theme, partly due to the enhanced focus on the interactions of biological, psychological and social issues in healthcare. We recognized that nurses, medical doctors, psychologists and chaplains already engage in existential and spiritual issues with their patients and that it is particularly true for palliative care, general practice and rehabilitation.

This finding resonates well with The World Health Organization, WHO, that identified spiritual problems among the dying as part of 'total pain' consisting of physical, psychological, social but also spiritual pain. According to WHO's definition of palliative care (2002), it is care that consists of treatment and care directed towards "total pain", i.e. care of all four aspects of pain, including patients' 'pains and other problems of both physical, psychological, psychosocial and existential/spiritual type' (51-53). WHO emphasizes that existential and spiritual beliefs have decisive impact on humans in crisis, and that providing existential and SC among patients with life-threatening, terminal conditions is a vital quality-of-life enhancing factor (54). Likewise, The World Organization of Family Doctors (WONCA) Europe has presented a *Wonca Tree* of Core Competencies and Characteristics of Family Medicine highlighting the holistic modelling that focuses on "physical, psychological, social, cultural and existential" aspects of care (55). Documents highlight the degree to which SC is part of patient-centred

care (56, 57). Like the WHO and WONCA, the Danish Quality Model underlines that the care and treatment of patients include incorporating existential and SC (58), and there is an increased focus on existential and spiritual needs included in the National Board of Health's "Professional guidelines for palliative efforts" (59) and "Recommendations for palliative efforts" (60). Despite these affirmations on all four aspects of health, of suffering and of pain, few documents speak of the existential and spiritual dimension of rehabilitation. Apart from patients' needs for both physical (61), psychological (62-65) and social rehabilitation (66), patients likewise may be in need of *existential and / or spiritual rehabilitation.* We thus permit ourselves to coin the concept of *existential and spiritual rehabilitation* to reflect the need for coping with the spiritual challenges following a cancer diagnosis involving meaning, generativity, hope, and, for some, faith in a higher being and in life after death. Such existential and spiritual rehabilitation may be of great importance, whether a person recovers from a disease, has just been diagnosed or is incurable.

Despite these affirmations, there was agreement (confirmed in the GCM data) that SC is the most underdeveloped and difficult aspect of patient-centered, holistic healthcare (Cluster 2). Danish as well as international studies indicate that both senior patients and Healthcare Professionals (HCPs) experience existential and spiritual needs as very difficult to address (17, 26, 67-74) and that these needs therefore remain largely unmet (75). This has consequences not only for the patients and HCPs, but also at the economic level through prolonged stays in hospitals (in particular ICUs) and hospices (36). One of today's largest societal health challenges is thus how to meet the existential needs of patients, in particular those challenged by life-threatening disease. *The European Association for Palliative Care* (EAPC) has appointed a Task Force for Spiritual Care. Here *Spiritual Care* is seen as care directed towards the spiritual needs which people may experience in case of severe illness with similar initiatives in other realms of healthcare (52).

There may be many reasons for this deficiency in modern healthcare: SC is hard to define, it involves personal values that are difficult to base on empirical evidence, and to put into general guidelines for

healthcare practice. In Denmark, where spiritual values are highly individualized and private, this might be difficult to an even greater extent. SC thus involves strategic leadership and proactive attention if it is to be implemented in a qualified and non-arbitrary manner (76).

Delivering Spiritual Care (Blue colour theme)

SC was found to provide help and support patients (Cluster 4) as they cope with existential, religious, and/or spiritual issues. This can be done among others by taking the patients' spiritual history alongside their medical history. Numerous tools have been developed for spiritual history taking, among which the FICA tool is the best-known (77). But it also involves a particular type of attitude, active listening fostering dialogue about things that matter deeply, supporting their reflections on values in life. Such personal attitudes and qualities are central to SC (Cluster 5) wherefore the delivery of SC can never be considered a task external to the person providing SC. German hospice chaplain Thomas Harding thus speaks of *Wahrnehmung* as a fundamental aspect of SC (78). The word *Wahrnehmung* is not directly translatable but literally means *to take true,* and this could well be said to be a core of SC: taking in and caring for the truth or essence of the other person. Although SC does not require religious studies with detailed insight into world religious beliefs, SC is *attentive* to the beliefs and values of patients supporting their dignity by means of empathic listening, and by offering comfort, compassion, love and advice.

Such qualities can only be achieved by means of what may be another innermost requirement of SC: Significant, enriching and trust-inspiring relationships between HCPs, patients and relatives (Cluster 6). In fact, research has identified spirituality as relational in its core, as the individual human being relates inwards, outwards and upwards - to self, to others and (for some) to the divine / transcendent (79), a tripartite movement that has been identified in patterns of mindfulness, meditation and prayer as well (80, 81). Such "healing" relationships are promoted by the HCP's empathic, non-judgemental and appreciative attitude towards the patient, that make the patient feel seen, heard and understood in his/her suffering, but furthermore by an awareness of mutuality in the relationship: that both patient and HCP is depending on one another's willingness to invest him/herself in the relationship and to share

in a common human vulnerability. Research indicate that HCPs' ability to relate to patients in the fullness of their humanity, rather than as to objects (i.e. as I-Thou, instead of I-It) (82) might be among the most important spiritual experiences of all (83). Recognizing the potential of experiences of mutuality in the relationship between HCPs and patients is not to deny that the HCP-patient relationship is inherently asymmetrical (84). It is pointing to an inter-human, relational dimension that enables the HCP to use his/her biomedical knowledge and technical competence as appropriately and meaningful as possible in a way that resonates with both the HCPs' and the patients' spirituality, regardless their potential differences. This in turn brings us to the third overall theme of the Conceptual Model of SC which impacts the understanding of the former two overall themes: The role of spirituality.

The role of spirituality (Red colour theme)

Spirituality was found to be an integral part of human life, comprising various patients' existential, spiritual, and religious concerns (Cluster 3). Spirituality is the connection between the different parts of the human being (body, mind and soul). This resonates with international incentives to define spirituality. EAPC thus defines spirituality as 'the dynamic dimension of human life regarding the way people (individuals and society) experience, express and / or seek meaning, purpose and transcendence, and the way they connect to the moment, to themselves, to others, to nature, to the important and / or the holy aspects' (85). This definition emerged from a consensus process and develops further a similar consensus-based definition in an American health professional context (22). Important to note is, that care is not *only* directed towards patients' individual existential perspectives or considerations, but towards exactly 'the dynamic dimension of human life', a dimension which other researchers summarize as a person's inner vitality and / or energy always at play as the foundation of what can bring us through a severe crisis (86).

In a mixed method study (87), 514 randomly selected adult Danes were asked which associations among 115 possible ones they related to the concept of spirituality. The respondents could tick off as many boxes as they would. Factor analyses indicated six clear nodes of understandings: 1. Wellbeing, 2. New

Age ideology, 3. A part of religious life, 4. A weak striving opposed to religiosity, 5. Inspiration in human life. A sixth association expressed a negative attitude to spirituality understood as 6. Selfishness. Also, our present study shows how *spirituality* covers a wide field where most of them may overlap, but also contain differences and tensions, which may in turn help explain, why SC is not easy to practice and integrate into healthcare. In many ways, attending to patients' needs for SC and spiritual rehabilitation calls for significant different training of HCPs than providing physical, psychological, and social rehabilitation.

Ironically, because spirituality constitutes a fundamental core aspect of each human being, it calls for SC to be a well-integrated aspect of healthcare (cluster 1), but it also makes it difficult to practice SC, because each individual has to be treated as a unique being with a unique kind of spirituality and with unique values associated to that spirituality. The fundamentality and universality of spirituality bear the paradox that it is fundamental to healthcare *and* at the same time difficult to provide.

Conclusion

The present Group Concept Mapping investigation has identified six clusters of understandings of SC that could be organized in three overall themes 1. Spiritual Care as an integral but underdeveloped part of healthcare, 2. Delivering Spiritual Care, and 3. The role of spirituality. Because spirituality in the common understanding is a fundamental aspect of each individual human being, SC should be an integral aspect of healthcare. Paradoxically, precisely because of this fundamentality, it is nevertheless also challenging to practice SC, as it involves the individual spirituality of the HCP, tuning in on the individual spirituality of the patient (or relative) and engaging care for needs for which there are no quick fixes but that require personal attunement and investment. The benefits of engaging in SC nevertheless seem plentiful, both for HCPs, patients and relatives.

Ethical considerations

According to Danish legislation, ethical approval as well as approval from the Danish Data Protection Agency was not required, as no subjects were exposed to medical interventions and/or devices and no sensitive data was collected. However, we have obtained approval (Approval Number 10.367, "Existential Patient Needs") of SDU RIO, the agency that handles all approvals on behalf of The Danish Data Protection Agency at our University of Southern Denmark, also with regards to GDPR. Informed consent was obtained, and all participants were informed about the right to withdrawal.

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Dissemination declaration

Dissemination to patient groups is not applicable as the article is not based on patient or HCP data, but instead based on a research expert panel developing the concept of spiritual care through Group Concept Mapping methodology. The insights from this research paper will however be made available through public and professional media to relevant groups of health professionals.

Data Sharing Statement

Danish interpretation of GDPR does not allow for the sharing of the data of this article in an open access format. However, researchers can contact the last author if interested in the data.

Author Contributions:

1. Niels Christian Hvidt - contributed with overall planning of research project together with Eva Elisabeth Ejlersen Wæhrens and Kristina Tomra Nielsen, contributed to all phases of data generation, contributed to most phases of analysis, wrote the first draft of the paper and contributed to all subsequent drafts of the paper.
2. Kristina Tomra Nielsen - contributed with overall planning of research project together with Eva Elisabeth Ejlersen Wæhrens and Niels Christian Hvidt, contributed to all phases of data generation, contributed to all phases of analysis, contributed to all drafts of the paper.
3. Alex Kappel Kørup - contributed to most phases of analysis, in particular demographics and modelling of Conceptual Model, and contributed to the writing of all drafts of the paper.
4. Christina Lange Prinds - contributed to most phases of analysis and to the writing of all drafts of the paper.
5. Dorte Gilså Hansen - contributed to most phases of analysis and to the writing of all drafts of the paper.
6. Dorte Toudal Viftrup - contributed to most phases of analysis and to the writing of all drafts of the paper.
7. Elisabeth Assing Hvidt - contributed to most phases of analysis and to the writing of all drafts of the paper.
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21. Eva Elisabet Ejlersen Wæhrens - contributed with overall planning of research project together with Niels Christian Hvidt and Kristina Tomra Nielsen, contributed to all phases of data generation, contributed to all phases of analysis, contributed to all drafts of the paper.

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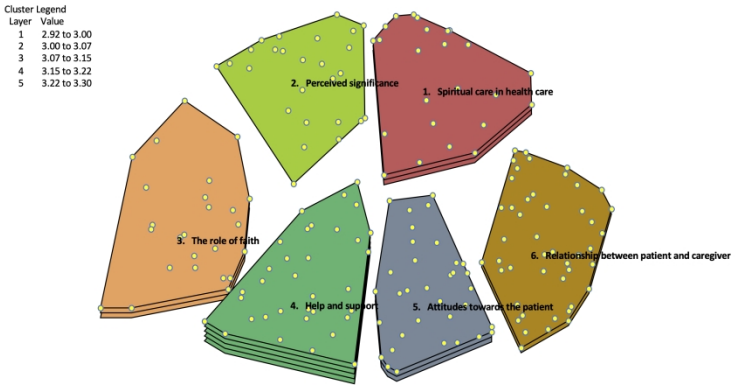

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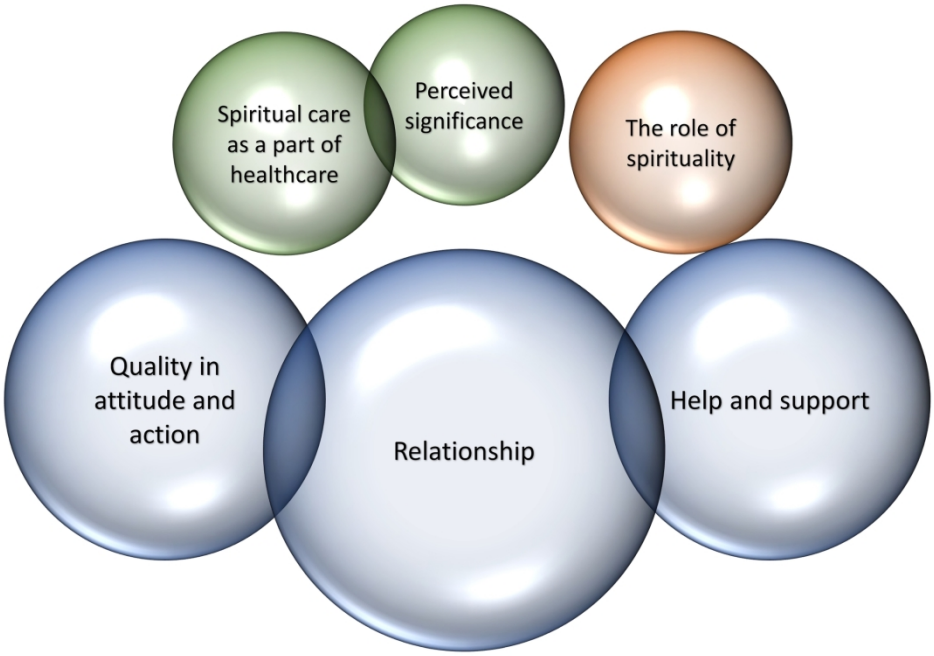

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Appendix 1 Ideas sorted into final 6 clusters

	Ideas #		Ratings of importance (median)
1. Spiritual care as a part of health care	1.	being an important part of general nursing	3
	2.	being an important part of general medicine	3
	3.	being a non-prioritized aspect in education of health professionals	3
	4.	being an important aspect in palliative care	4
	13.	being interdisciplinary	3
	27.	Knowing when to refer to a religious or psychological or psychiatric specialist when this is warranted	3
	29.	being an aspect of health care.	4
	34.	Attending one of the four aspects of health, along with physical, psychological and social	3
	43.	being increasingly important in modern healthcare	3
	59.	A way for health professionals to attend to problems outside the reach of conventional medicine	3
	96.	humanizing the clinic	3
	97.	highlighting the importance of an empathic approach to patients in health care	3
	98.	an insistence on taking the existential and religious thoughts, questions and dilemmas seriously in the health care context	4
	101.	a curiosity about how adherence to a religious faith influences overall health	3
	107.	being a type of care which goes beyond bio-physical and social needs	3
	112.	integrating an aesthetic dimension into health care activities	2,5
	118.	an issue relevant for both nurses and doctors	4
	122.	a field that may sometimes be given second, third or even lower priority in the health care system	3
	128.	an aspect of rehabilitation*	4
	129.	an aspect of palliative care*	4
	148.	being part of health care in general	4
	151.	being part of patient empowerment	3
	152.	being an area of growing focus national and international	3
Total n=24	175.	Being health promoting especially related to mental health	3
2. Perceived significance	5.	being important for many critically ill patients but not all*	3
	6.	being an individual care*	3
	7.	being a non-prioritized aspect of health care	3
	42.	being underprioritized in a materialism-oriented healthcare system	3
	44.	being something we do not know enough about.	3
	57.	being important for patients, relatives, caregivers and administrators alike.	3
	80.	Continuous and life-long learning of the professional	3
	82.	The ultimate patient-centered therapeutic activity	3
	85.	Using reflective practice in professional groups	3
	86.	Using supervision with supervisor and other supervisees*	3
	88.	Participating in appropriate continuing professional education	3
	89.	Recognizing that spiritual care can play a fundamental role in the healing process	4
	92.	Evidence-based and further developed in qualitative research	3
	95.	being of relevance in the broader context of society and public health	3
	106.	an exploration of health care from the perspective of humans as requiring meaning in life	4
	119.	an aspect of care that is not perceived relevant by all patients	3
	121.	some overlap with psychology, psychiatry	2
	124.	being difficult to many people	3
	149.	being thought by some to be 'not my area' and 'not part of the job'	3
	153.	being an area that needs more research in a secular context	3
	154.	being an area of unknown potential	3
	155.	being a difficult area to approach in a multicultural and pluralistic context	3
	156.	that it is difficult to approach the religious aspect actively in psychiatry	3

	157.	being in need of a definition or consensus in DK context	3
	158.	being a field relevant and present in many other areas than health	2
	161.	being something that involves all parties not 'just' the patient, relatives and health professionals	3
Total n=27	179.	Being a central part of a holistic approach	4
3. The role of spirituality	11.	involving relatives	3
	22.	Engaging issues of faith / spirituality when relevant	4
	39.	supporting patients' relatives in the process of giving birth to a new human.	3
	41.	being "out in the open" with the relatives, even if I have no treatment or ailment for the patients' disease.	3
	45.	Chaplains' support of patients and relatives	3
	52.	taking care of the spirit of the patient	4
	53.	taking care of the spirit of the relatives	3
	54.	taking care of the spirit of the caregivers	3
	69.	Taking care of body and soul of the client, including offering the possibility of prayer	3
	72.	Regular assessment of spiritual and existential concerns of the client	4
	74.	Emphasizing the seamless connections between mind and body	3
	83.	Empowering the patient	3
	94.	conversations between chaplain and pt/relatives providing an opportunity to see ones situation and oneself as valuable in the light of a christian theology	3
	105.	an attention to the "big" questions in life	3
	123.	Thoughts about why should I live any longer	3
	126.	relationship between man and God, man and Jesus, man and man	3
	127.	being closely related to physical and psychosocial well-being	3
	150.	being an essential part of being human	3
	162.	being not necessarily religious	4
	163.	having universal aspects	4
	164.	needing to take the cultural context into consideration	3
	171.	Care for the life grapple with what is fundamentally like to be a human being	4
Total n=23	173.	Responding to the human spirit	3
4. Help and support	9.	nonverbal, relational communication	3
	12.	always respecting the patient's choices	3
	15.	having the time to care	3
	25.	Accepting there are not always quick fixes	3
	30.	accepting any belief system my patients/their relatives/their caregivers may hold.	3,5
	31.	supporting my patient when subjected to a serious/worrisome diagnosis	3
	32.	supporting the relatives to a patient when subjected to a serious/worrisome diagnosis	3
	35.	supporting patients in the process of dying.	4
	36.	supporting patients in crisis of health, meaning or existence	4
	37.	supporting relatives in the process of the patient dying.	4
	38.	supporting patients in the process of giving birth to a new human.	3
	58.	An honest and respectful meeting of patient and health professional	4
	60.	Letting the religious values of the patient influence treatment and care	3
	61.	Supporting a meaningful interpretation of the disease by the patient	4
	62.	Accepting that the disease paradigms of patients may differ from that of health professionals	4
	63.	Helping patients understand trancendental experiences during their disease progress	3
	71.	Helping the client to cope with the situation	4
	75.	Being impartial, accessible and available to client of all faith/belief communities	4
	81.	Being ready to take the spiritual history of the client alongside their medical history	4
	84.	Looking after your own spiritual needs in many different ways	3
	90.	Helps us to find meaning and purpose in the things we value	3
	93.	Facilitates to understand and transform suffering	3
	110.	supporting the patient in unfolding life despite illness or suffering	4

	111.	supporting the patient in finding an inner feeling of well-being	4
	125.	care of happiness and sadness of life	3
	131.	Willingness to confront death non-evasively	4
	168.	offering a transformative perspective	3
	172.	Care of issues related to what humans live and die for	4
	176.	emphasizing existential communication with patients	4
	177.	attention to individuals' spiritual, religious and existential needs	4
	182.	Making time for listening to existential or religious thoughts	4
	184.	comforting the relatives to my patient when they are afraid and sad	3
	190.	taking the time to discuss existential or religious questions	4
Total n=34	191.	dealing with patients' questions, challenges, struggles, concerns etc. of an existential and/or religious nature related to health situations	4
5. Quality in attitude and actions	8.	verbal communication	3
	10.	Touching	2
	14.	being together with the patient	3
	17.	always respecting the patient's suffering	4
	20.	Mercy	3
	21.	Charity	3
	28.	Obtaining basic information about the patient's background, including meaning or faith orientations	3
	33.	asking my patients about how they feel.	4
	40.	being "out in the open" with the patient, even if I have no treatment or ailment for their disease.	3
	48.	Love	3
	49.	Approval	3
	50.	transforming fear	4
	55.	asking my colleagues how they feel	3
	56.	asking my colleagues how they make meaning of what's happening around them	3
	64.	Meeting the other as a human being	4
	66.	Acknowledge of the life situation of the client	3
	70.	Awareness of relationships with all creation	2
	73.	Being inclusive and accepting of human difference	3
	77.	An appreciation that all silences do not need to be filled immediately	3
	91.	Encouraging us to seek peace with ourselves, others and what lies beyond	4
	117.	stepping into the patients place	3
	139.	Helping to Induce hope	3
	140.	Helping to forgive	3
	141.	Helping to accept	4
	142.	Exploring the patient's needs	4
	160.	being inclusive rather than exclusive	3
	178.	being attentive of patients' non-verbalized needs	3
	180.	Offering help yet respecting a refusal	3
	183.	comforting my patients when they are afraid and sad	3
	185.	comforting the caregivers to my patient when they are afraid and sad	3
	186.	Offering advice and help yet respecting a refusal	3
	187.	trying to understand and learn about any belief system my patients/their relatives/their caregivers may hold.	3
	188.	Acknowledging and supporting the personal dignity of the client	3
	189.	making time for listening to existential or religious thoughts	4
Total n=35	192.	Addressing and being respectful to patient values and beliefs	4
6. Relationship	16.	human equality between health professionals and patients	3
	18.	being brave as a health professional	3
	19.	Sharing of your own self	3
	23.	A certain spirit with which we engage in our work	3
	24.	Showing empathy	3

	26.	Drawing on one's own spiritual resources to provide spiritual care	3
	46.	Tenderness	3
	47.	Understanding	3
	51.	holding the hands of a patient in need of a hand to hold.	3
	65.	Allowing periods of silence in conversation	3
	67.	Being an important dimension in the meeting between professional and patient*	3
	68.	Being able to learn from the client	3
	76.	Being wholly present with the client	3
	78.	Relationships are characterized by honesty	3
	79.	Active listening to the client - demanding concentration as well as sensitivity and skill	3
	87.	Always having a close introspective look at oneself i.e. witness approach	3
	99.	a curiosity about how thoughts about death influence overall health	3
	100.	a curiosity about how perceptions of a good life influence overall health	3
	102.	a curiosity about how religious practices can influence overall health	3
	103.	a curiosity about how differences in views on existential questions can influence the delivery of health care	3
	104.	a curiosity about how differences in views on existential questions can influence the reception of health care	3
	108.	Attention and presence	3
	109.	Sensitivity	3
	113.	dealing with the patient's preferences	3
	114.	integrating creativity and intentiveness in providing individualized care and treatments	2
	115.	being in doing	2
	116.	Trust	3
	120.	a field where professionals' boundaries should be respected, too*	3
	130.	being open-minded, inclusive, listening - not indicating	3
	132.	Being present	3
	133.	self-reflexivity	3
	134.	Curiosity	3
	135.	Openness	3
	136.	exploring the patient's resources	3
	137.	Awareness of own vulnerability	3
	138.	Offering yourself as relational resource	3
	143.	Exploring a patient's feelings of fullness	3
	144.	Offering a relational home	3
	145.	Helping towards finding a home world	3
	146.	Intersubjectivity	3
	147.	I-thou relationship	3
	159.	an openness to the importance of the individual worldview of patient and health professional	4
	165.	having the courage to being present in the midst of suffering	3
	166.	having to do with enabling the other to express his or her suffering	3
	167.	deep listening and allowing silence	3
	169.	relating to being able to sense the other	3
	170.	improvisation and openness to what is	3
	174.	Compassionate relationship	3
Total n=49	181.	Acknowledging and supporting the personal dignity of the client	3

* ideas that were moved from one cluster to another based on consensus at the validation meeting.

STROBE Statement—Checklist of items that should be included in reports of ***cross-sectional studies***

	Item No	Recommendation
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract Done – Title Page
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found Done – Abstract Page
Introduction		
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported Done – Background Page 1
Objectives	3	State specific objectives, including any prespecified hypotheses Done – Objectives Page 3
Methods		
Study design	4	Present key elements of study design early in the paper Done – Methods Page 4
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection Done – Methods Page 4
Participants	6	(*a*) Give the eligibility criteria, and the sources and methods of selection of participants Done – Participants Page 4
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable Done – Preparing for GCM Page 5
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group Done – Generation of Ideas Page 5
Bias	9	Describe any efforts to address potential sources of bias Done – Structuring the Statements
Study size	10	Explain how the study size was arrived at Done – Demographics Page 7
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why Done – Data from GCM – Page 7
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding
		(*b*) Describe any methods used to examine subgroups and interactions
		(*c*) Explain how missing data were addressed
		(*d*) If applicable, describe analytical methods taking account of sampling strategy
		(*e*) Describe any sensitivity analyses Done – Data from GCM – Page 7
Results		
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed
		(b) Give reasons for non-participation at each stage

		(c) Consider use of a flow diagram Done – Data from GCM – Page 7
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders
		(b) Indicate number of participants with missing data for each variable of interest Done – Data from GCM – Page 7
Outcome data	15*	Report numbers of outcome events or summary measures Done – Page 9
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included
		(*b*) Report category boundaries when continuous variables were categorized
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period Done – Results – Page 9
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses
Discussion		
Key results	18	Summarise key results with reference to study objectives Done – Discussion Page 13
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias Done – Methodological discussion Page 17
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence Done – Discussion Page 13
Generalisability	21	Discuss the generalisability (external validity) of the study results Done – Discussion Page 13
Other information		
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based Done – Statement of Funding Page 18

*Give information separately for exposed and unexposed groups.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.

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What is Spiritual Care?
Professional Perspectives on the Concept of Spiritual Care identified through Group Concept Mapping

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What is Spiritual Care?

Professional Perspectives on the Concept of Spiritual Care identified through Group Concept Mapping.

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Abstract

Objectives

The overall study aim was to synthesize understandings and experiences regarding the concept of Spiritual Care (SC). More specifically, to identify, organize, and prioritize experiences with the way SC is conceived and practiced by professionals in research and the clinic.

Design

Group Concept Mapping (GCM).

Setting

The study was conducted within a university setting in Denmark.

Participants

Researchers, students, and clinicians working with SC on a daily basis in the clinic and/or through research participated in brainstorming (n=15), sorting (n=15), rating, and validation (n=13).

Results

Applying GCM, ideas were identified, organized and prioritized online. A total of 192 unique ideas of SC were identified and organized into six clusters. The results were discussed and interpreted at a validation meeting. Based on input from the validation meeting a conceptual model was developed. The model highlights three overall themes: 1) "Spiritual care as an integral but overlooked aspect of healthcare" containing the two clusters *Spiritual care as a part of health care* and *Perceived significance*; 2) "Delivering Spiritual Care" containing the three clusters *Quality in attitude and action*, *Relationship*, and *Help and support*; and finally 3) "The Role of Spirituality" containing a single cluster.

Conclusion

Because spirituality is predominantly seen as a fundamental aspect of each individual human being, particularly important during suffering, spiritual care should be an integral aspect of healthcare, although it is challenging to handle. Spiritual care involves paying attention to patients' values and beliefs, requires adequate skills, and is realized in a relationship between healthcare professional and patient founded on trust and confidence.

Keywords

Patient Care, Medical Ethics, Palliative Care, Spirituality, Religion, Existentialism, Public Health

Strengths and limitations of this study

- One strength of this study of professionals' perspectives on what constitutes spiritual care in Denmark was that participants involved represented researchers, students and clinicians all addressing 'Existential and Spiritual Care' in their professional work.
- We employed a method that is recognized for the mapping of understandings of Spiritual Care: Group Concept Mapping, with more than required number of participants involved in all the research phases (data generation, analyses, validation of results, discussion) which also strengthening the validity and reliability of the study.
- The number of statements generated was high and despite removal of more than 40% of the ideas due to redundancy, the remaining number of ideas included in the analysis was close to recommended maximum of 200 statements. This strength implied the challenge of management of statements in the third phase of the analysis, a limitation we countered by paying close attention to rigorous methodology.
- Fewer statements might lower the richness of the material, but it also facilitates increased depth with the analytic process leading to the conceptual model.
- As this research project centred on *professional perspectives on spiritual care,* we only included professional users in the study, however, the need for the present study was identified by the base patient user panel of our research group that we consult ongoingly.

Background

The number of international research articles concerningspirituality and spiritual care (SC) and the relationship between spirituality and health have increased exponentially throughout the past decades.(1)In the research literature, 'Spirituality' tends to be understood as a collective designation for the interior life with its convictions, practices, emotions and sources of meaning that are present as a source of hope and energy in every person.(2-4)SC, on the other hand, is broadly understood as a type of care that addresses and seeks to meet existential and spiritual needs and challenges in connection with illness and crisis.(2, 3, 5-15)

Research has shown that SC increases the quality of life of patients.(16-26) Failure to provide SC is associated with existential and spiritual distress, which again is associated with risk of depression and reduced health,with increased healthcare costs as a consequence.(27)Spirituality is described as particularly important during a crisis, whether such spirituality involves religious convictions or just the open-mindedness towards 'more between heaven and earth'.(28, 29)The growing research on SC has shown that life-threatening illness often leads to an intensification of spiritual considerations and needs. These intensify in step with the severity of disease as well as prospect of imminent death.(30, 31) The same tendency is found in Denmark, one of the most secular cultures in the world, where research has shown a relationship between the severity of illness and increase in existential and spiritual needs and considerations.(32) Consequently, there is a growing necessity to address spiritual needs among cancer patients who experience an immensely present fear of death.(33) Particularly, senior cancer patients, have frequent experiences of 'existential loneliness' and feelings of 'invisibility', longing for opportunities to discuss death and spiritual needs with peers, hereby increasing their risk of isolation and depression,(34) especially during crisis such as the Covid-19 crisis.(35-37)

Some of the reasons given for not prioritizing SC is lack of time and money. However, a recent US Harvard study suggests that it is not feasible to neglect SC as patients who felt spiritually well-supported cost half of those who did not the last week prior to death; for ethnical minorities and for religious

people, the difference was even higher. The authors argue that the patients who receive limited SC experience more worries, anxiety, shortness of breath, pain etc. increasing the probability that they will be hospitalized and die at intensive care units, instead of at home. Limited access to SC is not only a large strain on the dying persons and their relatives, it is also expensive for society in terms of added healthcare costs.(38)

But what is the role of SC within cultures, that are more secular than the US culture? Research projects from Scandinavian research institutions have given an insight into Scandinavian patients' and relatives' spiritual needs (see publications at www.faith-health.org/?p=5592). The Scandinavian research projects show that illness activate often dormant spiritual needs. This seems particularly to be the case for Denmark, which international sociologists characterize as 'the least religious society in the world'.(39) Religiosity is described as among the largest taboos in Denmark, as religion is often relegated to the private sphere, partly inspired by trends in Lutheran thinking, partly inspired by natural science discourse and positivist philosophy.(40, 41) Religion is of limited significancein the public domain and is very difficult to verbalize for Danes.(42) This is, however, not the same as stating that Danes are non-believers. Anonymous surveys, such as Eurobarometer,(2018) finds that only 9% of Danes describe themselves as 'atheists', 13% as 'non-believers/agnostics', whereas 75,4% describe themselves as 'believers/religious'.(43) Approximately one third of the latter believe in a 'personal God', the rest in 'a higher power'. In many ways, Danes may figuratively be said to be the people in the world with the highest degree of 'passive' membership of the church, which can be activated in case of existential and spiritual needs. More than 76% of Danes are members of the Danish National Evangelical Lutheran Church (the world's highest degree of membership of any organized church), whereas only 2% go to church on a weekly basis (the world's lowest degree of religious practice). This 'membership' does not merely concern church attendance; it involves cultural, ethnical, and existential affiliation, and for many people symbolizes the belief that there is 'more between heaven and earth' without them retorting to active religion. Thus, the title of a PhD-thesis that investigates the spirituality of young Danes and Swedes in the Øresund region fittingly reads: "I'm a believer, but I'll be damned if I'm

religious".(44) This 'passive membership' can be activated if a person experiences a loss of control in connection with a crisis, especially illness, either of his own or in the nearest family. Nothing thus seems to move secular people to think about existential, spiritual and religious issues more than crisis and illness, and nowhere are people more confronted with illness, than at the hospital. And dying people, even in secular societies like Denmark, often have unmet ambivalent spiritual needs.(26)*Because* spiritual and/or religious considerations seem tabooed and ambivalent in a secular society like Denmark, and because many Danes have limited language for these considerations there is a need for competent SC. Potentially many Danes will be existentially unprepared, when encountering suffering. This leads us to the question of what SC is.

Based on years of consensus processes and dialogue in Nordic Network for Faith and Health, including research and writing by the authors of the present article, we sought to approach the definitions and understandings through Group Concept Mapping (GCM) methodology.(45-47) GCM methodology is a mixed method approach to generating and structuring ideas on a specific topic. During the GCM process, participants are involved in several steps of the research process and the final results are illustrated in maps where ideas on the specific topic are organized thematically.

Objective

Much uncertainty remains as to what the concept of Spiritual Care (SC) includes. The objective of this article was hence to identify, organize and prioritize experiences with the way SC is conceived and practiced by professionals in research and the clinic in a secular Danish context.

Methods

We used a GCM approach to synthesize understandings and experiences regarding SC among members of a 'Spiritual Care Research Group' in Denmark.

Participants

Researchers, students and clinicians connected to the 'Existential and spiritual care research group' at the Research Unit of General Practice (RUGP), Institute of Public Health at the University of Southern

Denmark (SDU)were invited to participate in the study. Thus, purposive sampling was applied. Participants were to fulfil the following inclusion criteria:1. Having at least completed a master's degree AND 2. Havingprofessional clinical experience with SC OR 3. Having professional research experience with SC.

Eighteen persons who met the inclusion criteria were identified and invited either through e-mail or personal contact. All were informed about the study design including participation in at least one of three elements: brainstorming, sorting and rating, and validation of data. Participation was not compensated. All eighteen persons agreed to participate. All participants gave information regarding age, gender, profession, employment, years working with SC as a clinician, and years working with SC as a researcher (Table 1).

Patient and Public Involvement.

As this research project centred on *professional perspectives on spiritual care,* we only included professional users in the study. However, the need for the present study became clear out of the base patient user panel of our research group that we consult ongoingly.

Study design and procedures

To address the aim of the study, Group Concept Mapping (GCM) (45-47)was applied. The following phases were included in the structured GCM process: (1) preparing for GCM, (2) generating the ideas (brainstorming), (3) structuring the statements (sorting and rating), (4) GCM analysis (data analysis), (5) interpreting the map (validation), and (6) utilization (developing a conceptual model).(48)These six phases provided a structure for the process (Figure I).

In general, GCM involvesa type of integrative mixed method participatory approach, combining qualitative and quantitative approaches to data collection and analysis. The processmay involve face-to-face group sessions, online participation or both.(47, 48) In this study, both were applied. Phasesone to four were conducted on-line, whereas phasefive took place during a face-to-face session.

Brainstorming was completed using Microsoft Excel, whereas sorting, labelling, rating and generation of cluster rating map was performed using the CS Global Max software system.(49)

1. Preparing for GCM

Before initiating the data collection, a focus prompt was formulated and piloted. The final version was: *""In my professional perspective, SC is characterized by …."*

2. Generation of ideas (Brainstorming)

Through e-mail, participants were instructed to brainstorm with as many brief continuations as possible to the focus prompt using an attached Excel file. They were reminded to keep each sentence/idea short containing only one meaning (for instance "SC is an important aspect of palliative care"), and it was clarified that the word 'professional' related to both clinical and research-based perspectives. Participants forwarded their Excel file and an overall list of ideas was generated. Identical ideas were individually identified by the second and last author and removed after consensus was reached.

3. Structuring the Statements(Sortingand Rating)

Again, the participants received an e-mail containing information about the sorting and rating tasks as well as a link to online participation using CS Global Max software. The first task was to sort all the ideas generated during the brainstorm into clusters, and to label each cluster. This was an individual task performed according to individual preferences. Next, the participants rated the importance of each idea on a four-point ordinal scale; a score of one being *"Unimportant"* and a score of four being "*Very important*".

4. GCM analysis (data analysis)

Based on phasestwo andthree, a Cluster Rating Map was generated using the CS Global Max software to be presented at the face-to-face validation meeting in phase five. For further information, see section on data analysis.

5. Interpreting the map(Validating)

At the validation session, theCluster Rating Map was presented to the participants and theyengaged in a group discussion, revising and interpreting the map, e.g. the number and content of derived clusters and the labels.

6. Utilization (Developing a Conceptual model)

Finally, the participants created a conceptual model based on the Cluster Rating Map generated using the CS Global Max software (phase four) and input from the validation session (phase five). For further information, see section on data analysis.

Data analyses

Participant characteristics

Participant data on age, gender, research experience, employment type and types of involvement in the GCM process were registered. Age and research experience were reported using median and interquartile range due to lack of normal distribution of the data. Data on gender, profession, employment and project involvement were presented in percentages. Analyses of participant data were performed using Microsoft Excel 365 ProPlus®.

Data from Group Concept Mapping

CS Global Max software wasused to perform data analyses based on the ideas derived from the brainstorming. The analyses were conducted in several steps. First, ideas gathered were consolidated; if needed, identical ideas were removed, and ideas revised in order to clarify the meaning. The remaining ideas were then imported into CS Global Max in preparation for phases three and four.

Participant data from phase three were to be included in the cluster analysis if more than 75% of the ideas were sorted and if less than five ideas remained unrated. Based on the sorting and rating of these ideas (phase three), multidimensional scaling analysis and cluster analysis were performed in which related ideaswere grouped into clusters.(48)During this process, several cluster solutions were generated and the one that matched the data the best (i.e. the cluster solution representing sufficient

details on the topic) was applied, creating the Cluster Rating Map (phase four). Within the multidimensional scaling analysis, the stress value is a statistic used to indicate 'goodness of fit'. A low stress value (<0.39) was used to determine congruence between the raw data and processed data.(48)Based on the labels provided by the participants in phase three, cluster labels were suggested by CS Global Max software. Besides illustrating the labelled clusters in relation to each other, the importance of ideas included in each cluster was alsodepicted by the number of layers in each cluster, based on median values for importance ratings given for each idea in the cluster.

The Cluster Rating Map was validated at the face-to-face validation meeting(phase five), revising the number and labels of clusters. The final conceptual model was generated based on this validated Cluster Rating Map, thematic analysis and consensus amongparticipants. Thus, the participants analyzed the clusters and the included ideas to determine if the included ideas were placed in a cluster that best matched the meaning of the ideas and discussed to obtain consensus.

Results

All participants were involved in at least one of the three phases. In total, fifteen (83%) were involved in the brainstormingphase,fifteen (83%) in sortingand rating online only, and finally, thirteen (72%) participatedat the validation meeting. Overall, ten (56%) were involved in all three phases. The number of participants involved in the study is on par with recommendations of core literature on the GCM methodology.(46)

During the brainstorm phase, participants generated a total of n = 327 ideas. Identical ideas were identified and removed before 192 unique ideas were imported into the CS Global Max software for sorting and labelling. In the third phase, all participants sorted 100% of the ideasinto between two to 21 clusters, and four participants (22%) left between one and fiveideas unrated (n = 10). As the proportions of unsorted and unrated statements for each participant were below the predefined criteria, the 192 ideas were all included in the analyses (phase four).Cluster solutions from ten to sixclusters were applied; the one with six clustersmatched the data the best and was used to create the

first Cluster Rating Map (Figure I). These initial six clusters contained between 23 and 49 ideas and were preliminarily labelled by CS Global Max, based on a variety of labels suggested by individual participants during phase three. The clusters represented ideas with varying importance, which is depicted by the height of each cluster. The most important ideas were placed in the highest clusters. A total of n = 44 ideas (23%) with high importance (median ≧4) were identified across the six clusters. The multidimensional scaling analysis involved 24 iterations and revealed a low stress value of 0.3023.

Discussions at the face-to-face validation meeting (phase five) resulted inrevision of theCluster Rating Map. First, the participants decided to keep the same number of clusters but renamedfour clusters.In the thematic analysis, the authors agreed on the cluster location of 96% (*n* = 185) of the ideas. Thus, seven ideas were moved between clusters. The final six clusters are presented in Table 2. The 192 ideas sorted into the final six clusters are presented in Appendix 1 (online supplemental material) along with median importance ratings for each idea. There is no additional data available.

The first cluster named *SC as a part of healthcare*contained 24 ideas e.g. "Attending one of the four aspects of health along with physical, psychological and social"suggesting thatSC should be understood and practiced as a standard aspect of healthcare. The second cluster named *Perceived significance* contained27 ideascapturing a broad spectrum of notions related to SCe.g. "Recognizing that SC can play a fundamental role in the healing process" but also that SC is not easy to grasp and practice in secular culture and that it, in order to be qualified, needs to be an integrated aspect of basic and continued learning in healthcare. The third cluster named *The role of spirituality* included 23 ideas about the nature and role of spirituality, e.g. "being an essential part of being human", recognizing that it may variously comprise patients´ existential, religious, and spiritual concerns. The fourth cluster named *Help and support* comprised34 ideas that involved helping patients or a family to cope with existential, religious and/or spiritual issues such as hope and fear, and that SC involved "nonverbal relational communication" and that it requires "accepting any belief system my patients/their relatives/their caregivers may hold." The fifth cluster named *Quality in attitude and action* contained 35 ideas such as

"being 'out in the open' with the patient even if I have no treatment or ailment for their disease"and that SC should be attentive and respectful towards patients' values and beliefs, something that basic inquiry into the patients background (including believes) may assist. The sixth cluster named *Relationship* included 49 ideas that all emphasized the importance and nature of relations in healthcare, e.g. "human equality between health professionals and patients" underlining the importance of being aware of one's own weakness and fundamental values.

Based on the discussion and decisions at the validation meeting, a final conceptual model revealing what characterizes SC was developed (Figure II). The conceptual model encompassed six clusters reflecting vital aspects of SC. They clustered in three over-all themes: 1. SC as an integral but underdeveloped part of healthcare (involving two concepts), 2. Delivering SC (involving three concepts) and 3. The role of spirituality.

Table 1 - Participant characteristics (n=18)

Age, median (IQR)	47,5 (42,3 - 51,8)
Age, range	27 - 75
Women, n (%)	10 (56%)
Participated in brainstorm, n (%)	15 (83%)
Participated in sorting/rating, n (%)	15 (83%)
Participated in validation, n (%)	13 (72%)
Participated in both sorting/rating and validation, n (%)	11 (61%)
Research experience, years, median (IQR)	9,5 (2,8 - 10,8)
Research experience, years, range	1 - 44
Type of research experience, n (%)*	
Literature or bibliographic	2 (11%)
Qualitative	15 (83%)
Quantitative	11 (61%)
Both qualitative and quantitative	9 (50%)
Employment, n (%)*	
Research assistant	2 (11%)
PhD Student	2 (11%)
Post.doc.	4 (22%)
Research fellow	2 (11%)
Associate Professor	3 (17%)
Professor	1 (6%)
Physician or MD	6 (33%)
Chaplain	2 (22%)

* = Some participants contribute to this statistic more than once, why the sum does not equal 100%

Table 2

Description of the Final Six Group Concept Mapping Clusters of Understanding of Spiritual Care

Cluster	**Summary –** Content
1. Spiritual care as a part ofhealthcare Number of ideas: 24	**SC is agrowing type of healthcare which goes beyond bio-physical and social needs and relates to patients' and relatives' existential and spiritual needs**. Health professionals (e.g. nurses, chaplains, psychologists, and medical doctors) often engage in interdisciplinary work with patients and relatives through dialogue about spiritual issues. SC is a particularly important aspect of rehabilitation, palliative care, and general practice.
2. Perceived significance Number of ideas: 27	**SC is an underprioritized aspect of healthcare and not perceived as relevant for all patients. It is also perceived as difficult to approach – especially in a secular country (e. g. Denmark).** It is a sphere of healthcare which, particularly in a multicultural and pluralistic context, calls for more attention: for example, in the fields of education, supervision and research. It is an area with the potential to relieve anxiety and suffering, and thereby support a holistic approach to healthcare.
3. The role of spirituality Number of ideas: 23	**Spirituality is an essential part of spiritual care. Spirituality may comprise both patients´ existential, spiritual and religious concerns into an existential frame of self-concept** Itemphasizes the connection / relationship between an individual self (body, mind and spirit/soul) and that individual's self-transcending experiences, meaning and not rarely also sacred entities like oracles, prophets, spirits and/or deities (i.e. God). It is always embedded and understoodwithin and with regard to the prevailing culture.
4. Help and support Number of ideas: 34	**SC involves supporting and helping patients when they face existential/spiritual/religious crises in healthcare.** This involves taking the time to explore the patients' spiritual history and not just their medical history; supporting both patients and relatives through active listening, and using dialogue to explore their thoughts, feelings and outlook on life; and assisting patients in finding meaning and purpose in the things they value, and, if possible, gaining inner peace and well-being.
5. Quality in attitude and action Number of ideas: 35	**SC is attentive and respectful towards patients' values and beliefs.** Healthcare professionals achieve this by acknowledging and supporting patients' personal dignity through empathic listening, and by offering comfort, compassion, love, and advice.
6. Relationship Number of ideas: 49	**SC requiresrelationships between healthcare professionals and patients that are characterized by empathy and trustworthiness. Healthcare professionals are aware of their responsibility for this relationship with the patient.** The professional encounter should be grounded in a committed and compassionate relationship. SC takes place when healthcare professionals are fully present and engaged in exploring the patients´ resources, allowing periods of silence in conversation, or holding the hands of a patient in need of a hand to hold.

Figure I: First Cluster rating map with 6 clusters (Uploaded).

Figure II: Conceptual Model (Uploaded). Three themes are presented. Green: Spiritual Care as an integral but underdeveloped part of healthcare. Blue: Delivering Spiritual Care. Red: The role of spirituality.

Discussion

Although substantial research documents the integral role of SC for high-quality patient-centered care there is much uncertainty as to what SC actually is and how it is best practiced. Accordingly, in this study a GCM approach was used to synthesize experiences among researchers, students and clinicians involved in an 'Existential and Spiritual Care Research Group' in Denmark. As mentioned in the Conceptual Model, three overall themes emerged: 1. Spiritual Care as an integral but underdeveloped part of healthcare, 2. Delivering Spiritual Care and 3. The role of spirituality.

Spiritual Care as an integral but underdevelopedpart of healthcare (Green colour theme)

SC was found to be *a part of healthcare*(Cluster 1) and has continued to grow as an important theme, partly due to the enhanced focus on the interactions of biological, psychological and social issues in healthcare. We recognized that nurses, medical doctors, psychologists and chaplains already engage in existential and spiritual issues with their patients and that it is particularly true for palliative care, general practice and rehabilitation.

This finding resonates well with The World Health Organization, WHO, that identified spiritual problems among the dying as part of 'total pain' consisting of physical, psychological, social but also spiritual pain. According to WHO's definition of palliative care,(2002)it is care that consists of treatment and care directed towards "total pain", i.e. care of all four aspects of pain, including patients' 'pains and other problems of both physical, psychological, psychosocial and existential/spiritual type'.(50-52)WHO emphasizes that existential and spiritual beliefs have decisive impact on humans in crisis, and that providing existential and SC among patients with life-threatening, terminal conditions is a vital quality-of-life enhancing factor(53). Likewise, The World Organization of Family Doctors (WONCA)Europe has presented a *Wonca Tree* of Core Competencies and Characteristics of Family Medicine highlighting the holistic modelling that focuses on "physical, psychological, social, cultural and existential" aspects of care .(54)Documents highlight the degree to which SC is part of patient-centred

care.(55, 56)Like the WHO and WONCA, the Danish Quality Model underlines that the care and treatment of patients include incorporating existential and SC,(57) and there is an increased focus on existential and spiritual needs included in the National Board of Health's "Professional guidelines for palliative efforts"(58) and "Recommendations for palliative efforts",(59). Despite these affirmations on all four aspects of health, of suffering and of pain, few documents speak of the existential and spiritual dimension of rehabilitation. Apart from patients' needs for both physical,(60) psychological (61-64) and social rehabilitation,(65) patients likewise may be in need of *existential and / or spiritual rehabilitation.* We thus permit ourselves to coin the concept of *existential and spiritual rehabilitation* to reflect the need for coping with the spiritual challenges following a cancer diagnosis involving meaning, generativity, hope, and, for some, faith in a higher being and in life after death. Such existential and spiritual rehabilitation may be of great importance, whether a person recovers from a disease, has just been diagnosed or is incurable.

Despite these affirmations, there was agreement (confirmed in the GCM data) that SC is the most underdeveloped and difficult aspect of patient-centered, holistic healthcare (Cluster 2). Danish as well as international studies indicate that both senior patients and Healthcare Professionals (HCPs) experience existential and spiritual needs as very difficult to address (16, 25, 66-73) and that these needs therefore remain largely unmet.(74) This has consequences not only for the patients and HCPs, but also at the economic level through prolonged stays in hospitals (in particular ICUs) and hospices.(38) One of today's largest societal health challenges is thus how to meet the existential needs of patients, in particular those challenged by life-threatening disease.*TheEuropean Association for Palliative Care* (EAPC) has appointed a Task Force for Spiritual Care. Here *Spiritual Care* is seen as care directed towards the spiritual needs which people may experience in case of severe illness with similar initiatives in other realms of healthcare.(51)

There may be many reasons for this deficiency in modern healthcare: SC is hard to define, it involves personal values that are difficult to base on empirical evidence, and to put into general guidelines for

healthcare practice.In Denmark, where spiritual values are highly individualized and private, this mightbe difficult to an even greater extent.SC thus involves strategic leadership and proactive attention if it is to be implemented in a qualified and non-arbitrary manner.(75)

Delivering Spiritual Care (Blue colour theme)

SC was found to provide help and support patients (Cluster 4) as they cope with existential, religious, and/or spiritual issues. This can be done among others by taking the patients' spiritual history alongside their medical history. Numerous tools have been developed for spiritual history taking, among which the FICA tool is the best-known.(76)But it also involves a particular type of attitude, active listening fostering dialogue about things that matter deeply, supporting their reflections on values in life. Such personal attitudes and qualities are central to SC (Cluster 5) whereforethe delivery of SC can never be considered a task external to the person providing SC. German hospice chaplain Thomas Harding thus speaks of *Wahrnehmung*as a fundamental aspect of SC.(77)The word *Wahrnehmung*is not directly translatable but literally means *to take true,* and this could well be said to be a core of SC: taking in and caring for the truth or essence of the other person. Although SC does not require religious studies with detailed insight into world religious beliefs, SC is *attentive* to the beliefs and values of patients supporting their dignity by means of empathic listening, and by offering comfort, compassion, love and advice.

Such qualities can only be achieved by means of what may be another innermost requirement of SC: Significant, enriching and trust-inspiring relationships between HCPs, patientsand relatives (Cluster 6). In fact, research has identified spirituality as relational in its core, as the individual human being relates inwards, outwards and upwards - to self, to others and (for some) to the divine / transcendent,(78) a tripartite movement that has been identified in patterns of mindfulness, meditation and prayer as well.(79, 80)Such "healing" relationships are promoted by the HCP's empathic, non-judgemental and appreciative attitude towards the patient, that make the patient feel seen, heard and understood in his/her suffering, but furthermore by an awareness of mutuality in the relationship: that both patient and HCP is depending on one another's willingness to invest him/herself in therelationship and to share

in a common human vulnerability.Research indicate that HCPs'ability to relate to patients in the fullness of their humanity, rather than as to objects (i.e. as I-Thou, instead of I-It) (81) might be among the most important spiritual experiences of all.(82)Recognizing the potential of experiences of mutualityin the relationship between HCPs and patientsis not to deny that the HCP-patient relationship is inherently asymmetrical.(83)It is pointing to aninter-human, relational dimension that enables the HCP to use his/her biomedical knowledge and technical competence as appropriately and meaningful as possible in a way that resonates with both the HCPs' and the patients' spirituality, regardless their potential differences. This in turn brings us to the third overall theme of the Conceptual Model of SC which impacts the understanding of the former two overall themes: The role of spirituality.

The role of spirituality (Red colour theme)

Spirituality was found to be an integral part of human life, comprising various patients' existential, spiritual, and religious concerns (Cluster 3). Spirituality is the connection between the different parts of the human being (body, mind and soul). This resonates with international incentives to define spirituality. EAPC thus defines spirituality as 'the dynamic dimension of human life regarding the way people (individuals and society) experience, express and / or seek meaning, purpose and transcendence, and the way they connect to the moment, to themselves, to others, to nature, to the important and / or the holy aspects'.(84) This definition emerged from a consensus process and develops further a similar consensus-based definition in an American health professional context.(21) Important to note is, that care is not *only* directed towards patients' individual existential perspectives or considerations, but towards exactly 'the dynamic dimension of human life', a dimension which other researchers summarize as a person's inner vitality and / or energy always at play as the foundation of what can bring us through a severe crisis.(85)

In a mixed method study,(86) 514 randomly selected adult Danes were asked which associations among 115 possible ones they related to the concept of spirituality. The respondents could tick off as many boxes as they would. Factor analyses indicated six clear nodes of understandings: 1. Wellbeing, 2. New

Age ideology, 3. A part of religious life, 4. A weak striving opposed to religiosity, 5. Inspiration in human life. A sixth association expressed a negative attitude to spirituality understood as 6. Selfishness. Also, our present study shows how *spirituality* covers a wide field where most of them may overlap, but also contain differences and tensions, which may in turn help explain, why SC is not easy to practice and integrate into healthcare. In many ways, attending to patients' needs for SC and spiritual rehabilitation calls for significant different training of HCPs than providing physical, psychological, and social rehabilitation.

Ironically, because spirituality constitutes a fundamental core aspect of each human being, it calls for SC to be a well-integrated aspect of healthcare (cluster 1), but it also makes it difficult to practice SC, because each individual has to be treated as a unique being with a unique kind of spirituality and with unique values associated to that spirituality. The fundamentality and universality of spirituality bear the paradox that it is fundamental to healthcare *and* at the same time difficult to provide.

Strengths and limitations

The use of GCM methodology in the present study is considered a strength Hence, GCM implies a structured approach mixingquantitative and qualitative methodology by combiningqualitative data generation(ie, ideas on a specific topic) and statisticalanalyses to support the structuring of data. Further, participants are involved throughout the entire research process (data generation, analyses, validationof results, discussion).This study was conducted with the purposeof synthesizing understandings and experiences regarding SC among members of a specific 'Spiritual Care Research Group'. Thus, the sample size was relativelysmall (n=18). However, according to GCM literature, tenpersons is generally considered to be minimum in order to perform a valid statistical analysis.(46)

Conclusion

The present Group Concept Mapping investigation has identified six clusters of understandings of SC that could be organized in three overall themes 1. Spiritual Care as an integral but underdeveloped part of healthcare, 2. Delivering Spiritual Care, and 3. The role of spirituality. Because spirituality in the

common understanding is a fundamental aspect of each individual human being, SC should be an integral aspect of healthcare. Paradoxically, precisely because of this fundamentality, it is nevertheless also challenging to practice SC, as it involves the individual spirituality of the HCP, tuning in on the individual spirituality of the patient (or relative) and engaging care for needs for which there are no quick fixes but that require personal attunement and investment. The benefits of engaging in SC nevertheless seem plentiful, both for HCPs, patients and relatives.

Ethical considerations

According to Danish legislation, ethical approval as well as approval from the Danish Data Protection Agency was not required, as no subjects were exposed to medical interventions and/or devices and no sensitive data was collected. However, we have obtained approval (Approval Number 10.367, "Existential Patient Needs") of SDU RIO, the agency that handles all approvals on behalf of The Danish Data Protection Agency at our University of Southern Denmark, also with regards to GDPR. Written informed consent was obtained, and all participants were informed about the right to withdrawal.

Disclosure of interest

All authors report no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years; no other relationships or activities that could appear to have influenced the submitted work.

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Dissemination declaration

Dissemination to patient groups is not applicable as the article is not based on patient or HCP data, but instead based on a research expert panel developing the concept of spiritual care through Group Concept Mapping methodology. The insights from this research paper will however be made available through public and professional media to relevant groups of health professionals.

Data Sharing Statement

Danish interpretation of GDPR does not allow for the sharing of the data of this article in an open access format. However, researchers can contact the last author if interested in the data.

Author Contributions:

NB – one of the particularities of the GCM methodology is that it allows for a large degree of active contribution of several collaborators to analysis and writing of a manuscript which is the case also in this article.

1. Niels Christian Hvidt - contributed with overall planning of research project together with Eva Elisabeth EjlersenWæhrens and Kristina Tomra Nielsen, contributed to all phases of data generation, contributed to most phases of analysis, wrote the first draft of the paper and contributed to all subsequent drafts of the paper.
2. Kristina Tomra Nielsen - contributed with overall planning of research project together with Eva Elisabeth EjlersenWæhrens and Niels Christian Hvidt, contributed to all phases of data generation, contributed to all phases of analysis, contributed to all drafts of the paper.
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5. DorteGilså Hansen - contributed to most phases of analysis and to the writing of all drafts of the paper.
6. DorteToudalViftrup - contributed to most phases of analysis and to the writing of all drafts of the paper.
7. Elisabeth AssingHvidt - contributed to most phases of analysis and to the writing of all drafts of the paper.
8. Elisabeth Rokkjær Hammer - contributed to most phases of analysis and to the writing of all drafts of the paper.
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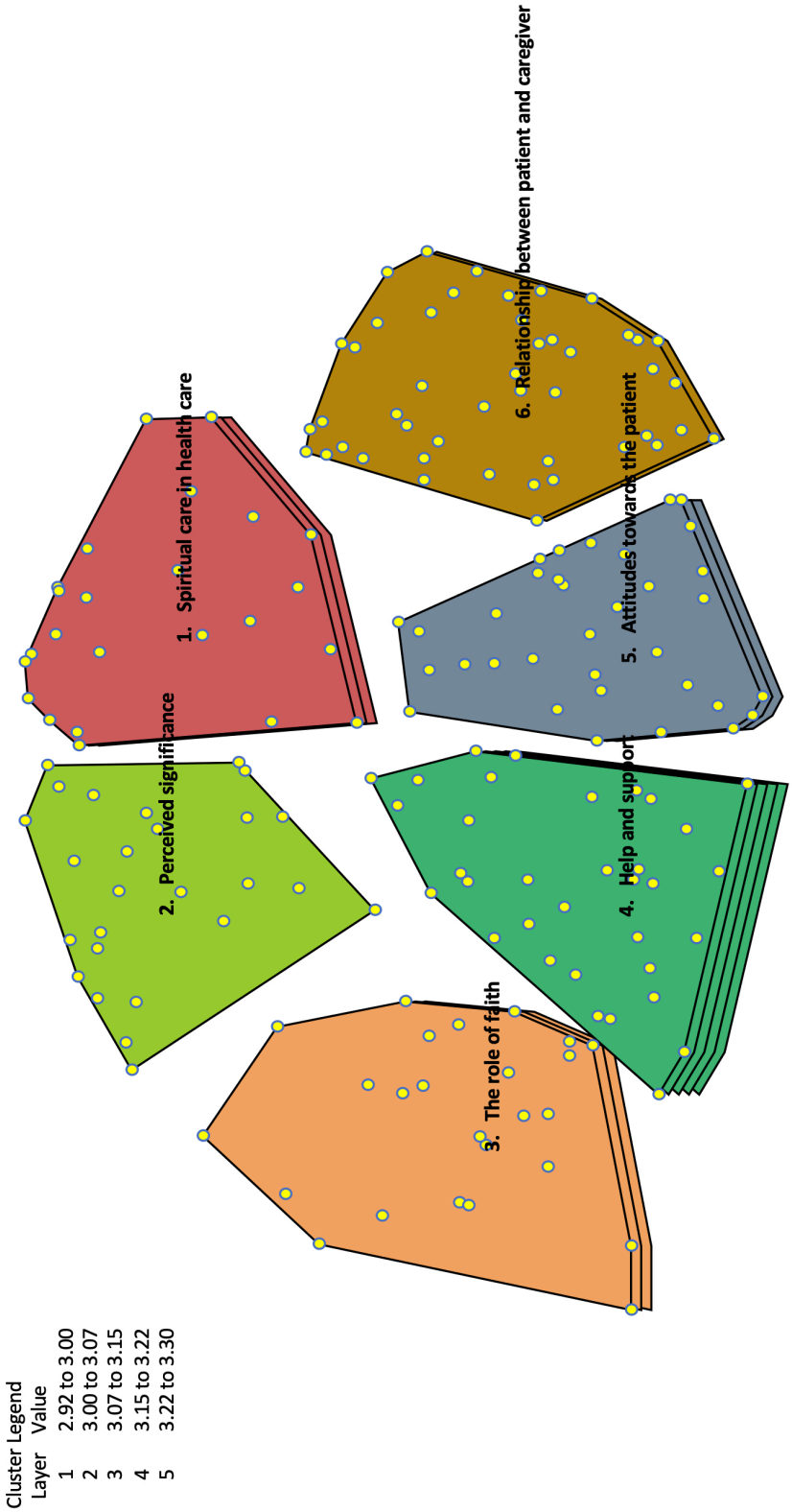
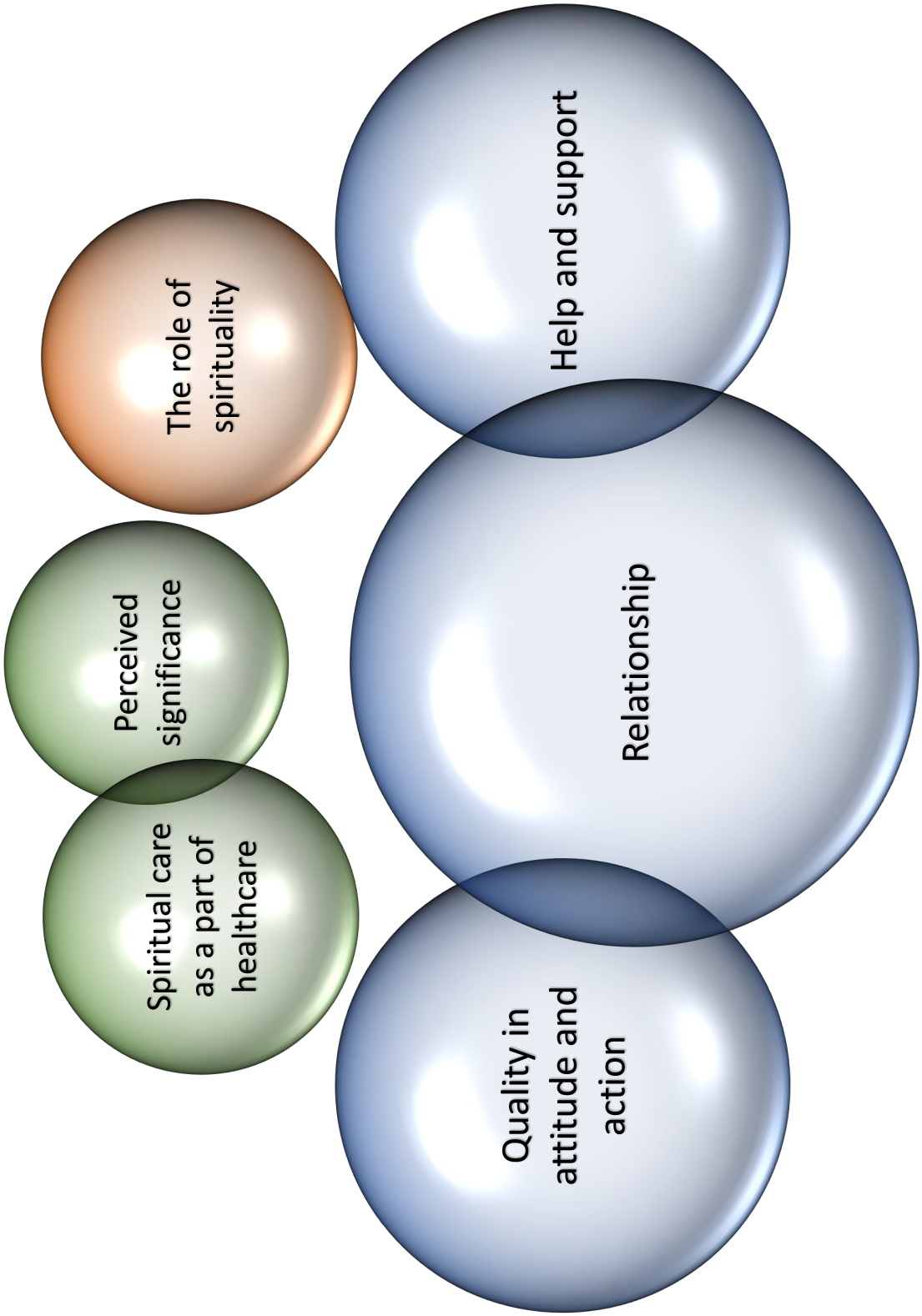

1. Spiritual care in health care
2. Perceived significance
3. The role of faith
4. Help and support
5. Attitudes towards the patient
6. Relationship between patient and caregiver
Cluster Legend
Layer Value
1 2.92 to 3.00
2 3.00 to 3.07
3 3.07 to 3.15
4 3.15 to 3.22
5 3.22 to 3.30


Help and support
The role of spirituality
Relationship
Perceived significance
Spiritual care as a part of healthcare
Quality in attitude and action

Appendix 1 Ideas sorted into final 6 clusters

	Ideas #		Ratings of importance (median)
1. Spiritual care as a part of health care	1.	being an important part of general nursing	3
	2.	being an important part of general medicine	3
	3.	being a non-prioritized aspect in education of health professionals	3
	4.	being an important aspect in palliative care	4
	13.	being interdisciplinary	3
	27.	Knowing when to refer to a religious or psychological or psychiatric specialist when this is warranted	3
	29.	being an aspect of health care.	4
	34.	Attending one of the four aspects of health, along with physical, psychological and social	3
	43.	being increasingly important in modern healthcare	3
	59.	A way for health professionals to attend to problems outside the reach of conventional medicine	3
	96.	humanizing the clinic	3
	97.	highlighting the importance of an empathic approach to patients in health care	3
	98.	an insistence on taking the existential and religious thoughts, questions and dilemmas seriously in the health care context	4
	101.	a curiosity about how adherence to a religious faith influences overall health	3
	107.	being a type of care which goes beyond bio-physical and social needs	3
	112.	integrating an aesthetic dimension into health care activities	2,5
	118.	an issue relevant for both nurses and doctors	4
	122.	a field that may sometimes be given second, third or even lower priority in the health care system	3
	128.	an aspect of rehabilitation*	4
	129.	an aspect of palliative care*	4
	148.	being part of health care in general	4
	151.	being part of patient empowerment	3
	152.	being an area of growing focus national and international	3
Total n=24	175.	Being health promoting especially related to mental health	3
2. Perceived significance	5.	being important for many critically ill patients but not all*	3
	6.	being an individual care*	3
	7.	being a non-prioritized aspect of health care	3
	42.	being underprioritized in a materialism-oriented healthcare system	3
	44.	being something we do not know enough about.	3
	57.	being important for patients, relatives, caregivers and administrators alike.	3
	80.	Continuous and life-long learning of the professional	3
	82.	The ultimate patient-centered therapeutic activity	3
	85.	Using reflective practice in professional groups	3
	86.	Using supervision with supervisor and other supervisees*	3
	88.	Participating in appropriate continuing professional education	3
	89.	Recognizing that spiritual care can play a fundamental role in the healing process	4
	92.	Evidence-based and further developed in qualitative research	3
	95.	being of relevance in the broader context of society and public health	3
	106.	an exploration of health care from the perspective of humans as requiring meaning in life	4
	119.	an aspect of care that is not perceived relevant by all patients	3
	121.	some overlap with psychology, psychiatry	2
	124.	being difficult to many people	3
	149.	being thought by some to be 'not my area' and 'not part of the job'	3
	153.	being an area that needs more research in a secular context	3
	154.	being an area of unknown potential	3
	155.	being a difficult area to approach in a multicultural and pluralistic context	3

	156.	that it is difficult to approach the religious aspect actively in psychiatry	3
	157.	being in need of a definition or consensus in DK context	3
	158.	being a field relevant and present in many other areas than health	2
	161.	being something that involves all parties not 'just' the patient, relatives and health professionals	3
Total n=27	179.	Being a central part of a holistic approach	4
3. The role of spirituality	11.	involving relatives	3
	22.	Engaging issues of faith / spirituality when relevant	4
	39.	supporting patients' relatives in the process of giving birth to a new human.	3
	41.	being "out in the open" with the relatives, even if I have no treatment or ailment for the patients' disease.	3
	45.	Chaplains' support of patients and relatives	3
	52.	taking care of the spirit of the patient	4
	53.	taking care of the spirit of the relatives	3
	54.	taking care of the spirit of the caregivers	3
	69.	Taking care of body and soul of the client, including offering the possibility of prayer	3
	72.	Regular assessment of spiritual and existential concerns of the client	4
	74.	Emphasizing the seamless connections between mind and body	3
	83.	Empowering the patient	3
	94.	conversations between chaplain and pt/relatives providing an opportunity to see ones situation and oneself as valuable in the light of a christian theology	3
	105.	an attention to the "big" questions in life	3
	123.	Thoughts about why should I live any longer	3
	126.	relationship between man and God, man and Jesus, man and man	3
	127.	being closely related to physical and psychosocial well-being	3
	150.	being an essential part of being human	3
	162.	being not necessarily religious	4
	163.	having universal aspects	4
	164.	needing to take the cultural context into consideration	3
	171.	Care for the life grapple with what is fundamentally like to be a human being	4
Total n=23	173.	Responding to the human spirit	3
4. Help and support	9.	nonverbal, relational communication	3
	12.	always respecting the patient's choices	3
	15.	having the time to care	3
	25.	Accepting there are not always quick fixes	3
	30.	accepting any belief system my patients/their relatives/their caregivers may hold.	3,5
	31.	supporting my patient when subjected to a serious/worrisome diagnosis	3
	32.	supporting the relatives to a patient when subjected to a serious/worrisome diagnosis	3
	35.	supporting patients in the process of dying.	4
	36.	supporting patients in crisis of health, meaning or existence	4
	37.	supporting relatives in the process of the patient dying.	4
	38.	supporting patients in the process of giving birth to a new human.	3
	58.	An honest and respectful meeting of patient and health professional	4
	60.	Letting the religious values of the patient influence treatment and care	3
	61.	Supporting a meaningful interpretation of the disease by the patient	4
	62.	Accepting that the disease paradigms of patients may differ from that of health professionals	4
	63.	Helping patients understand trancendental experiences during their disease progress	3
	71.	Helping the client to cope with the situation	4
	75.	Being impartial, accessible and available to client of all faith/belief communities	4
	81.	Being ready to take the spiritual history of the client alongside their medical history	4
	84.	Looking after your own spiritual needs in many different ways	3
	90.	Helps us to find meaning and purpose in the things we value	3
	93.	Facilitates to understand and transform suffering	3

	110.	supporting the patient in unfolding life despite illness or suffering	4
	111.	supporting the patient in finding an inner feeling of well-being	4
	125.	care of happiness and sadness of life	3
	131.	Willingness to confront death non-evasively	4
	168.	offering a transformative perspective	3
	172.	Care of issues related to what humans live and die for	4
	176.	emphasizing existential communication with patients	4
	177.	attention to individuals' spiritual, religious and existential needs	4
	182.	Making time for listening to existential or religious thoughts	4
	184.	comforting the relatives to my patient when they are afraid and sad	3
	190.	taking the time to discuss existential or religious questions	4
Total n=34	191.	dealing with patients' questions, challenges, struggles, concerns etc. of an existential and/or religious nature related to health situations	4
5. Quality in attitude and actions	8.	verbal communication	3
	10.	Touching	2
	14.	being together with the patient	3
	17.	always respecting the patient's suffering	4
	20.	Mercy	3
	21.	Charity	3
	28.	Obtaining basic information about the patient's background, including meaning or faith orientations	3
	33.	asking my patients about how they feel.	4
	40.	being "out in the open" with the patient, even if I have no treatment or ailment for their disease.	3
	48.	Love	3
	49.	Approval	3
	50.	transforming fear	4
	55.	asking my colleagues how they feel	3
	56.	asking my colleagues how they make meaning of what's happening around them	3
	64.	Meeting the other as a human being	4
	66.	Acknowledge of the life situation of the client	3
	70.	Awareness of relationships with all creation	2
	73.	Being inclusive and accepting of human difference	3
	77.	An appreciation that all silences do not need to be filled immediately	3
	91.	Encouraging us to seek peace with ourselves, others and what lies beyond	4
	117.	stepping into the patients place	3
	139.	Helping to Induce hope	3
	140.	Helping to forgive	3
	141.	Helping to accept	4
	142.	Exploring the patient's needs	4
	160.	being inclusive rather than exclusive	3
	178.	being attentive of patients' non-verbalized needs	3
	180.	Offering help yet respecting a refusal	3
	183.	comforting my patients when they are afraid and sad	3
	185.	comforting the caregivers to my patient when they are afraid and sad	3
	186.	Offering advice and help yet respecting a refusal	3
	187.	trying to understand and learn about any belief system my patients/their relatives/their caregivers may hold.	3
	188.	Acknowledging and supporting the personal dignity of the client	3
	189.	making time for listening to existential or religious thoughts	4
Total n=35	192.	Addressing and being respectful to patient values and beliefs	4
6. Relationship	16.	human equality between health professionals and patients	3
	18.	being brave as a health professional	3
	19.	Sharing of your own self	3
	23.	A certain spirit with which we engage in our work	3

	24.	Showing empathy	3
	26.	Drawing on one's own spiritual resources to provide spiritual care	3
	46.	Tenderness	3
	47.	Understanding	3
	51.	holding the hands of a patient in need of a hand to hold.	3
	65.	Allowing periods of silence in conversation	3
	67.	Being an important dimension in the meeting between professional and patient*	3
	68.	Being able to learn from the client	3
	76.	Being wholly present with the client	3
	78.	Relationships are characterized by honesty	3
	79.	Active listening to the client - demanding concentration as well as sensitivity and skill	3
	87.	Always having a close introspective look at oneself i.e. witness approach	3
	99.	a curiosity about how thoughts about death influence overall health	3
	100.	a curiosity about how perceptions of a good life influence overall health	3
	102.	a curiosity about how religious practices can influence overall health	3
	103.	a curiosity about how differences in views on existential questions can influence the delivery of health care	3
	104.	a curiosity about how differences in views on existential questions can influence the reception of health care	3
	108.	Attention and presence	3
	109.	Sensitivity	3
	113.	dealing with the patient's preferences	3
	114.	integrating creativity and intentiveness in providing individualized care and treatments	2
	115.	being in doing	2
	116.	Trust	3
	120.	a field where professionals' boundaries should be respected, too*	3
	130.	being open-minded, inclusive, listening - not indicating	3
	132.	Being present	3
	133.	self-reflexivity	3
	134.	Curiosity	3
	135.	Openness	3
	136.	exploring the patient's resources	3
	137.	Awareness of own vulnerability	3
	138.	Offering yourself as relational resource	3
	143.	Exploring a patient's feelings of fullness	3
	144.	Offering a relational home	3
	145.	Helping towards finding a home world	3
	146.	Intersubjectivity	3
	147.	I-thou relationship	3
	159.	an openness to the importance of the individual worldview of patient and health professional	4
	165.	having the courage to being present in the midst of suffering	3
	166.	having to do with enabling the other to express his or her suffering	3
	167.	deep listening and allowing silence	3
	169.	relating to being able to sense the other	3
	170.	improvisation and openness to what is	3
	174.	Compassionate relationship	3
Total n=49	181.	Acknowledging and supporting the personal dignity of the client	3

* ideas that were moved from one cluster to another based on consensus at the validation meeting.

STROBE Statement—Checklist of items that should be included in reports of ***cross-sectional studies***

	Item No	Recommendation
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract Done – Title Page
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found Done – Abstract Page
Introduction		
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported Done – Background Page 1
Objectives	3	State specific objectives, including any prespecified hypotheses Done – Objectives Page 3
Methods		
Study design	4	Present key elements of study design early in the paper Done – Methods Page 4
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection Done – Methods Page 4
Participants	6	(*a*) Give the eligibility criteria, and the sources and methods of selection of participants Done – Participants Page 4
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable Done – Preparing for GCM Page 5
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group Done – Generation of Ideas Page 5
Bias	9	Describe any efforts to address potential sources of bias Done – Structuring the Statements
Study size	10	Explain how the study size was arrived at Done – Demographics Page 7
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why Done – Data from GCM – Page 7
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding
		(*b*) Describe any methods used to examine subgroups and interactions
		(*c*) Explain how missing data were addressed
		(*d*) If applicable, describe analytical methods taking account of sampling strategy
		(*e*) Describe any sensitivity analyses Done – Data from GCM – Page 7
Results		
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed
		(b) Give reasons for non-participation at each stage

		(c) Consider use of a flow diagram Done – Data from GCM – Page 7
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders
		(b) Indicate number of participants with missing data for each variable of interest Done – Data from GCM – Page 7
Outcome data	15*	Report numbers of outcome events or summary measures Done – Page 9
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included
		(*b*) Report category boundaries when continuous variables were categorized
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period Done – Results – Page 9
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses
Discussion		
Key results	18	Summarise key results with reference to study objectives Done – Discussion Page 13
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias Done – Methodological discussion Page 17
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence Done – Discussion Page 13
Generalisability	21	Discuss the generalisability (external validity) of the study results Done – Discussion Page 13
Other information		
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based Done – Statement of Funding Page 18

*Give information separately for exposed and unexposed groups.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.