Objective: The nature of cancer increases the spiritual needs of patients and necessitates the provision of holistic care for them. By trying to meet the spiritual needs of patients, oncology nurses can help them adapt, gain inner peace, and develop positive thoughts and attitudes. This study aimed to explore the consequences of spiritual care for cancer patients and oncology nurses from the perspective of the patients, family members, nurses, and other health-care team members.

Methods: The present qualitative study was conducted using conventional content analysis in 2016–2017. The data were collected through semi-structured deep interviews of the 18 participants.

Results: The theme extracted from the data was “spiritual growth” and comprised the major categories of “nurse’s spiritual development” and “patient’s spiritual development.” There were three subcategories in the nurse’s spiritual development and 11 subcategories in the patient’s spiritual development.

Conclusions: Spiritual care places the cancer patient and the oncology nurse on the path to spiritual growth. The achievement of peace by the patient and the nurse was a common consequence of spiritual care. It helps the nurse promote comfort and a sense of peace in the patient and eventually to obtain inner satisfaction. Considering the transcendental effects of spiritual care, a systematic plan should be devised to enhance sensitivity in oncology nurses and encourage them to make spiritual care a component of interventional plans.

Key words: Cancer, content analysis, oncology nurse, peace, spiritual care, spirituality
Introduction

The World Health Organization reported in 2011 that mortality resulting from cancer would be higher in the future than from all types of cardiovascular disease and stroke. Studies have shown that the incidence of cancer is increasing in low- and middle-income countries. The incidence of cancer, the nature of the disease, the prolonged treatments, and fear of the future launch the patient and family into a cycle of psychological problems. The patient focuses on disability and death, which had always been assumed to be a distant reality, and struggles to answer numerous questions. The process of searching for and trying to decipher the meaning of life begins. Under these conditions, the spiritual needs of the patient increase and if left unmet can cause spiritual distress and its resulting consequences.

Spirituality is the essence of being and an aspect of being human. This dimension refers to the way a person searches for meaning and purpose in life, as well as the relationship between himself and others, nature, and the sacred. Tanyi introduced spirituality as a person's search for meaning and purpose in life. He believes that spirituality contributes to a person's individual connection with choices, beliefs, and deeds of a religious nature in achieving a sense of genuine goodness and to motivate him. It helps the faith, power, and hope of the individual, which makes it able to withstand hardships and problems that go beyond the current one.

A review of related literature shows that spirituality is a human dimension and an internal phenomenon that is related to individual excellence, consciousness, sensitivity, and meaning in one's life. This concept is described by believing in God or a higher being and in communication with others. In some texts, the closeness and dependence of the relationship between spirituality and religion have been discussed. Religion, in addition to the internal beliefs of individuals about God, also relates to the formal structure of the society and includes religious practices such as attendance of religious places and membership in a religious group in the community. In the religious orders, especially those of Islam and Christianity, there are commands relating to God, relatives, and nature, which show the close connection between spirituality and religion. Islam is the religion of Muslims, which, they regard as submission to the will of God. The religion of Christianity is based on the teachings of Jesus Christ. Islam and Christianity are considered monotheistic religions.

Spiritual care means taking care to identify and respond to the spiritual needs of humans when faced with trauma, disease, sadness, and suffering. This care involves the need for meaning, self-worth, self-expression, and support for faith, prayer, sacraments, and religious practices.

Committed provision of holistic nursing to a patient sensitizes nurses to meeting the spiritual needs of a patient. Learning to live with a chronic disease like cancer is a process. Health-care providers can benefit from spirituality to emphasize the meaning and goal of a patient's life, inner faith, connection to a higher being, and cooperation with others. Thus, nurses as spiritual and psychological consultants are a valuable source of help and hope during the course of the disease. They can set the framework for adaptation by providing spiritual care and meeting the spiritual needs of their patients.

A review of the literature shows that quantitative and qualitative studies have been produced about spirituality and spiritual care in nursing. In some quantitative studies, the attitudes of the health-care team members to spiritual care have been examined. Other studies have focused on explaining the concept of spirituality and spiritual care. Several studies have also been performed on the factors affecting the provision of spiritual care to patients. Most of these studies evaluated the awareness and attitudes of nurses and patients to spiritual care for patients and the factors affecting it. Few studies have examined the consequences of spiritual care for cancer patients.

Previous studies have shown that spiritual care involved positive experiences for both the nurse and the patient. Zamanzadeh et al. found that patients and nurses have an interactive and positive effect on one another. Phelps et al. introduced the benefits of spiritual care as good support and effective and emotional presence of nurses for patients with cancer. Moeini et al. in Iran found a negative relationship between the good spiritual sense of nurses and obstacles to providing spiritual care. The greater the good spiritual sense of nurses, the greater was the expectation of spiritual care as part of their performance. One type of care advocated by Islam is the care which a person provides for other humans. Nurses care for other humans in their professional role. Their care influences both the patients and the nurses, setting the groundwork for their transcendence and empowerment.

Because exploring the consequences of spiritual care can be effective in the design, evaluation, follow-up, and modification of spiritual intervention plans, this study took a qualitative approach with the aim of exploring the consequences of spiritual care for cancer patients and oncology nurses from the perspective of the cancer patients, patient's family members, oncology nurses, and other health-care team members.

Methods

Conventional content analysis was used to explore the consequences of spiritual care for cancer patients and oncology nurses. The research was carried out on the
oncology wards of three educational hospitals affiliated with two medical universities. After obtaining the relevant permission from the universities and hospitals, the first author introduced herself to them and explained the objective of the research. She then invited qualified participants to join the study if they were willing to do so. After explaining the research objectives to the participants, the study procedure and voice recording were explained to them. Thereafter, oral and written informed consent forms were collected from the participants, and they were interviewed.

The participants consisted of seven cancer patients, two patients’ family members, and nine members of the health-care team (five nurses, four oncologists, and palliative medicine specialists) who were chosen using the purposeful sampling method.

Cancer patients of both genders at any stage of the disease who were at least 18 years of age entered the study. The participants had to have the ability to participate in the study and be interviewed. Oncology nurses and oncologists who had had at least 6 months of experience in oncology wards were chosen to be included in the study.

The data collection was done through semi-structured deep interviews using open-ended questions. To ensure the comprehensiveness of the information acquired, an interview guideline was used. The interview process started with general questions, and more detailed questions were asked according to the simultaneous analysis of the data and the responses of the participants. More detailed questions for patients included “Did you receive spiritual health care from your nurse during the hospitalization period?” “Please explain your experience of spiritual care during your hospitalization in oncology ward?” “How did these care experiences affect you?” “What changes did these care experiences create in you?” and “How did these care experiences affect your illness process?” Interview questions for family members included “Did your patient receive spiritual health care from the nurse during the hospitalization period in oncology ward?” “How can this type of care affect your patient?” and “How did these care experiences affect the process of improving illness in your patient?” Interview questions for oncologists included “Do patients in your ward receive spiritual interventions?” “How do these interventions affect the patient’s treatment process?” “How do these care experiences have an impact on the care provider? Please describe your experiences” Nurses’ interview questions included “Do you do spiritual health care for your patients apart from physical care?” “Please give an example about what type of spiritual care you provide?” “What effect do you think this caring has on your patients?” “What are your experiences with your patients?” and “What are the effects of these care experiences on yourself?”

The place and time of the interviews were chosen based on the agreement and permission of the participants. The duration of the interviews was 15–60 min, with 35 min being the average. Sampling and subsequent analysis of the data continued until data saturation, when there was no new code for creating categories and themes. After 15 interviews were performed, no new data were developed; however, three additional interviews were performed. Data analysis was done using conventional content analysis following the Graneheim and Lundman method. Content analysis is a research method for accurate and valid inference from the data provided in the text, which is done with the aim of describing a broad and rich phenomenon, through knowledge, insights, and facts about that phenomenon. When there is not enough information and knowledge about the phenomenon concerned, the conventional content analysis method is used. The conventional content analysis technique causes the direct acquisition of information from participants in the study without imposing preconceived categories or previous theoretical views. The knowledge generated from content analysis in this method is rooted in actual text data. In this research method, the researchers move from details to the whole and arrive at the desired results using inductive logic. Content analysis steps are as follows: (1) preparation steps: implementation of the whole interview, determination of the analysis unit, and determination of semantic units. (2) Organization steps: summarizing the semantic units, defining the initial codes, and classifying similar primary codes in more comprehensive categories. (3) Report steps: the results described by the content of the categories.

MAXQDA, a qualitative data analysis program (VERBI-Software MAXQDA 10 developed and distributed by VERBI Software based in Berlin, Germany) was utilized for qualitative data management. The text of the interviews was immediately typed and analyzed after each interview. The codes were extracted in this step. At each stage, each one was placed in subcategories and categories according to the similarities and differences in the data. The software provides the ability to move categories and codes. The analysis started with the first interview and continued until data saturation. The analysis unit in this study was the full text of all interviews with participants and semantic units included sentences or paragraphs selected from the text of the interviews. In the next step, a code was assigned to each key phrase and word. The same words from the participant (in vivo codes) or the same name as the sign of that phenomenon (constructed code) were used for encoding. Subsequently, conceptually similar codes were
subcategorized and a name was considered for each subcategory; with the emergence of each new code during the initial coding, it was placed in the subcategories with the largest in-common dimensions. During continuous comparative analysis, subcategories and codes were regularly compared with each other and were analyzed with data. Subsequently, similar and related subcategories were combined together to form a category.

To confirm the validity and acceptability of the data, the first author spent an extensive period of time on data collection and analysis. After implementation and coding of the interviews, the data were evaluated by the research team members. For verification of the data, the interviews were assessed by five participants (two patients, one family member, one oncology nurse, and one oncologist). Next, three specialists (with doctoral degrees in nursing and expertise in qualitative studies) studied the interviews, codes, and the extracted categories and themes. To confirm the reliability of the data, four external supervisors with doctoral degrees in nursing conducted a research audit. To determine data transferability in the research report, sufficient descriptive data were provided to allow readers to assess the application of the data to other areas.

### Ethical approval

The study was conducted in accordance with the Declaration of Helsinki and was approved by the Research Committee of the University (Ethics Code: IR.SBMUPHMN.1395.576). Informed written consent was obtained from all participants prior to their enrollment in this study.

### Results

#### Descriptive results

The seven cancer patients participating in the study were in different stages of the disease and with various types of cancer (breast, colon, jaw, pancreas, lung, and liver cancer). The health-care team members consisted of five oncology nurses, four oncologists, and palliative medicine specialists. The participant family members were one mother and one sister of a patient. All participants were Muslim, with the exception of one Christian family member. Table 1 shows the demographic characteristics of the participants.

#### Qualitative results

Out of the extracted codes, 14 subcategories, two main categories, and one theme were extracted [Table 2]. The main theme, according to the experiences of the participants in the study, was “spiritual growth,” which included the two categories of “spiritual development in the oncology nurses” and “spiritual development in the cancer patients.”

| Participants (numbers) | Age range (years) | Sex | Religion |
|------------------------|-------------------|-----|----------|
| Patients (7)           | 22-26             | 5 females, 2 males | Islam |
| Family members (2)     | 47-59             | 2 females | Islam (sister), Christian (mother) |
| Health care provider (9)| 28-58             | 5 females, 4 males | Islam |

Indeed, consequences of spiritual care in this study were “spiritual development” for the nurse and the patient, both of whom benefited from this type of care and its advantages.

The theme extracted from the study was “spiritual growth,” which suggests an inner and positive transformation in the cancer patient and the oncology nurse. Spiritual growth enhances an individual’s awareness of himself, others, and the surrounding world. It also allows the development of a positive attitude in life and of the surrounding environment. Spiritual growth improves understanding of the value of relations with others, which also increases the tendency to help others. As in spiritual care, both the cancer patient and oncology nurse experience change, thus both benefit from its advantages. An important skill in oncology nursing when providing high-quality care is the ability to communicate. Without establishing suitable and reliable communication, the nurse cannot care for the patient. After establishing communication, the patient can participate in his own care and treatment and take part in making decisions related to them.

The subcategory of peace is a very important gift for both the patient and the nurse to prepare them to follow the care plan.

Peace, joy, and hope, all together make inner satisfaction, and a spiritual person seeks them. Another consequence of spiritual care is acceptance of the disease, the treatment, and even the health-care team members. Acceptance is an important goal of nurses and other members of the health-care team because, through acceptance, many of the problems and challenges of the patients will be resolved. Patients can accept the prolonged aspects of care and treatment.

Patience, reliance on God, and recourse are transcendental consequences of spiritual care. Reliance on God diminishes human worries about the future. When the patient submits to divine providence and makes God their counselor, a strong sense of spirituality and inner peace grows in him. This consequence is very important for care, treatment, and follow-up, and thus, improvement.

Another consequence of spiritual care, especially in group care, is a diminished sense of loneliness and increased level of viewing the disease holistically. When a patient sees other patients of different ages, genders, and groups, he feels less isolated and sad.
Moosavi, et al.: Consequences of Spiritual Care

### Table 2: Theme, categories and subcategories

| Theme                  | Categories | Subcategories                          | Quotations                                                                                                                                                                                                                                                                                                                                                     |
|------------------------|------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Spiritual growth**   | Nurse’s spiritual development | 1. Spiritual self-awareness            | “A nurse who sees the dire conditions of a patient while caring for him can adopt one of two attitudes. The nurse can say, ‘I will help this patient to pass away as a more developed person.’ Alternatively, the nurse can say ‘I will help the patient to die and be free’ (N.n. 16).”                                                                                                                                 |
|                        |            | 2. Facilitation of communication       | “When a nurse is well-behaved, the patient can get along well with him/her and the nurse can better follow the patient’s plan of care” (N.n. 13).                                                                                                                                                      |
|                        |            | 3. Peace                               | “When you see that you have done something that has helped your patient to get better, you become motivated and find more energy to invest” (N.n. 13).                                                                                                                                                          |
| **Patient’s spiritual development** |            | 1. Peace                               | “When I see my around people do what they can to me, one makes food for me, one makes natural juice for me, one will help me in home work, I feel good and well” (P.n. 7).                                                                                                                                 |
|                        |            | 2. Joy                                 | “When the nurses are cheerful and happy, joke with us and have energy, it brings us joy and energy” (P.n. 4).                                                                                                                                                                                       |
|                        |            | 3. Hope                                | “I told myself that no test is Gordian knot and I just have to look for a solution.” (P.n. 8).                                                                                                                                                                                                       |
|                        |            | 4. Acceptance                           | “It was very unexpected, but I said that as it has possible treatment, I have to work hard to win” (P.n. 6).                                                                                                                                                                                        |
|                        |            | 5. Patience                             | “When I look at my family members, I say to myself, I have to endure this period,” (P.n. 1).                                                                                                                                                                                                          |
|                        |            | 6. Recourse                             | “I gradually came to the conclusion that God wants this to be the path my life follows. He has given me [this disease] and He will also treat it, I only rely on Him” (P.n. 3).                                                                                                                                 |
|                        |            | 7. Improvement                          | “When the mood, mind and family of the patient are considered, it is as if the patient revives, gains energy and gets well.” (Ph.n. 17).                                                                                                                                                                 |
|                        |            | 8. Seeing the disease as common         | “When I see many people involved in the ward or at group meetings, from a 20-year-old young man to an old man of 70 and women and men. I do not think that I’m only involved with this illness, and I’ve got all the misery in my head” (P.n. 4).                                                                                     |
|                        |            | 9. Gaining trust                        | When a nurse spends time learning about a patient and his condition and reports these to the specialist and colleagues, the patient will begin to relax and trust him/her” (N.n. 12)                                                                                                                     |
|                        |            | 10. Reduction of sense of loneliness    | “When I go along with my sister, we talk much and do the work, she will forget the time, I will not alone her.” (F.n. 9)                                                                                                                                                                              |
|                        |            | 11. Reduction of psychological distress  | “A group helps the patient to avoid dwelling on all the miseries that have befallen him. He sees that others are also affected; thus, he thinks less about his problems” (N.n. 10).                                                                                                                          |

### Discussion

This study has explored the consequences of spiritual care of cancer patients and oncology nurses from the perspectives of cancer patients, patient’s family members, oncology nurses, and other health-care team members. The theme extracted from the data was “spiritual growth” with two subcategories “nurse’s spiritual development” and “patient’s spiritual development,” which suggests deep inner changes in both the cancer patients and oncology nurses: A type of spiritual progress. This means that, for a nurse to reach this level of spiritual evolution and self-awareness when providing care and to intelligently consider the spiritual dimension and needs of the patient with awareness and respond to them, that the nurse must also focus on himself/herself and move along the path toward spiritual integrity, which is the ultimate goal of the creation of humans. It means that, by trying to meet the needs and challenges of patients and respond to their needs, they will help to revisit and positively change their own thoughts and the patient’s thoughts and attitudes.\(^{[27]}\)

The most important part of our qualitative study was showing the components of spiritual development. The inner nature of the nurse’s spiritual development was manifested in three components: spiritual self-awareness, facilitation of communication, and peace. The inner nature of the patient’s spiritual development was disclosed in 11 components: peace, joy, hope, acceptance, patience, recourse, improvement, seeing the disease as common, gaining trust, reduction of sense of loneliness, and of psychological distress. Cancer experience provides an opportunity for the patient and the oncology nurse to think about the meaning of life and faith and adjust their expectations of life.\(^{[8]}\) The results of Calhoun and Tedeschi’s study show that some people experience positive psychological changes after survival of stressful events, which can be due to events or learning to try to adapt to stressful events.\(^{[28]}\) When cancer occurs, questions arise about the meaning of life for the patient, which can be advantageous for correcting and strengthening spiritual beliefs. While witnessing pain and suffering in the patient, and his patience, reliance, and recourse, the oncology nurse will also experience a transformation, the outcome of which could be self-reflection, awareness, and positive spiritual change.\(^{[3,8]}\)

Addressing the spiritual aspects of humans and spiritual growth are among the characteristics of a complete human being. In this regard, Ghasempour listed human growth indices as thoughtfulness, wisdom, patience, moderation, seeking justice, having faith in God, reliance, affection, and sincerity. Some subcategories in the present study are in line with these indices. Thoughtfulness and wisdom refer to contemplation of the surrounding world and posing meaningful ontological questions.\(^{[29]}\)
Facilitating communication between the nurse and the patient in the form of a nurse’s sensitivity to the spiritual needs of the patient, and encouraging the patient to talk about concerns, objectives, interests, and fears, helps the nurse to identify and diagnose the problems of the patient in this area. The design of patient-centered care and patient participation in the care plan will help strengthen nurse–patient trust, and as a result, facilitate communication.[30] In a study conducted on spirituality and the process of death, the results showed that >45% of participants were concerned about their spiritual dimension. This is especially important at the end of life. One of the most important issues for providing spiritual care at the end of life is the ability to communicate, which makes it possible and practicable to provide other care.[31]

Another subcategory of this study is peace, both in the patient and the nurse. Peace means solving conflicts and individual success in adapting to stress.[32] Delgado reports that searching for the meaning of life and strengthening communication with others increases self-awareness and strength.[32,33] Yong et al. reported in their study that “spirituality” is important, not only to the patient but also to caregivers and affects their ability and willingness to provide this type of care.[34] The goal of nursing is to meet the patient’s needs and promote their safety and thereby provide comfort to the patient and family.[35] By providing spiritual care, according to the spiritual needs of the patient and considering holistic care, the quality of nursing care increases. Observing the comfort of the patient and the family enhances the nurse’s inner satisfaction, gratitude, and therefore, her peace of mind.[36] Peace, happiness, and hope make up inner satisfaction. Inner satisfaction is what a spiritual person is looking for.[37] In fact, spiritual self-care, which results from the consideration of the patient’s spiritual needs and nursing self-awareness, is spiritual care for the nurse, which can prevent her spiritual distress. Therefore, attention to spirituality and spiritual care is not just specific to the disease period, it is also important for healthy people.[34,38]

Another characteristic of the patient’s spiritual development is patience. Ghasempour states that patience is the context in which all human perfection grows. Patience and resilience enhance the existential capacity of humans to such an extent that adversity and hardship cannot exhaust them. The importance of patience becomes evident in the course of cancer when prolonged and numerous treatments must be tolerated.[29] Faith in and reliance upon God are aspects of spiritual development. Reliance on God means relegateing current and future affairs to God and submitting to His order, trusting in His plan. With faith in God and reliance upon Him, disappointment will not affect the patient and he/she will bear suffering and hardship more easily.[27,29] Self-awareness and spiritual self-care improve nursing confidence. Such a nurse is not only a model of confidence for the patient but also reinforces the patient’s confidence by expressing experiences and related stories.

Seeing the disease as common was another component of spiritual development based on the experiences of participants in the study. Ahmadi Faraz introduced the formation of the group as a healing item. They believed that the design and implementation of group spiritual care, in addition to reducing the sense of loneliness of patients, also helps participants to see the disease as a general issue. Observing similar people, and in fact, peers, expressing the experiences and stories of the improved individuals in the group will help improve the hope and recovery of patients and reduces their psychological distress.[27]

Other subcategories of this study were to reduce the sense of loneliness and of psychiatric distress in the patient. Breitbart reported in his study that spirituality and faith reduce depression in patients and increase the desire to communicate with others.[36] Phelps et al. introduced the presence of nurses as a source of support for the patient.[19] The ability to establish therapeutic communication in nurses with a patient is a kind of spiritual care that answers the spiritual needs of the patient in relation to others, in terms of spirituality. The experiences of participants in this study indicated that loving, patient attention, pleasure, and hearing and listening to patients talk reduced their loneliness and isolation. Yong et al. reported that good spiritual sense and integrity improved the professional performance of nursing managers who had undergone spiritual care training and noted that their occupational burnout significantly diminished.[34]

Although spiritual growth has been referred to as a consequence of spiritual care in other studies, in this study, the details of spiritual growth were identified. It can be discussed that paying attention to spirituality in nursing care increases both the individual dimension and the dimension of professional nursing performance. Therefore, attention to spirituality and spiritual care is not just specific to the disease period, it is also important for healthy people. Promotion of the individual dimension and positive spiritual changes can help to reduce the spiritual distress of nurses by improving spiritual self-care and prevent this distress. Changes in the individual dimension make it possible to improve the professional dimension, because the positive spiritual changes in the nurse and the ability for therapeutic communication help the nurse in designing a care plan proportional to the needs of the patient and with his participation. It also increases job satisfaction and decreases burnout.
Authorities should plan training to obtain spiritual competence and an organizational spiritual culture, to provide nurses with necessary skills for providing this care in addition to knowledge of the importance of spiritual care. Therefore, they can benefit from the consequences of the spiritual care, which is actually the goal of nursing care and the health care system. Considering the transcendental effects of spiritual care, a systematic plan should be devised to enhance sensitivity in oncology nurses and encourage them to make spiritual care a component of interventional plans.

One limitation of this research is the limited generalizability of the study findings based on the qualitative method. This was partially controlled for by the development of the research environment and diversity of participants for interviews that included cancer patients, oncology nurses, family members, and oncologists. Another limitation of this study was limited access to patients from other religions. Although the Christian patient did not participate in the study, the interview was carried out with the patient’s mother.

**Conclusion**

The findings of this qualitative study highlighted the consequences of spiritual care for cancer patients and oncology nurses through spiritual growth, which can be experienced by both, in the shape of spiritual development. The inner nature of the nurse’s spiritual development was manifested in three components, while the inner nature of the patient’s spiritual development was disclosed in 11 components. The achievement of peace by the patient and the nurse was a common consequence of spiritual development and helped the nurse to achieve his/her goal of providing comfort and a sense of peace to the patient. Spiritual growth and moving along the path toward integrity is facilitated by providing spiritual care and spiritual caring for others. Health policymakers and nurses should take steps to design training courses on the provision of spiritual care in the health-care system. These results can be applied to assess the effectiveness of nursing care and the positive consequences for cancer patients.

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There are no conflicts of interest.

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