Author’s response to reviews

Title: Effectiveness of spiritual care training to enhance spiritual health and spiritual care competency among oncology nurses

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Author’s response to reviews:

PCAR-D-19-00175, entitled "Effectiveness of spiritual care training to enhance spiritual health and spiritual care competency among oncology nurses"

Dear Shane Sinclair, Paul Galchutt, and Ana Soto Rubio,

Thank you for your letter and for the reviewers’ comments concerning our manuscript. According to the comments and suggestions, we have revised the relevant parts of the manuscript and are resubmitting the manuscript. We also responded point by point to the comments from the editor and the reviewers as shown below, and all changes are marked in red in the revised version of the manuscript.

Thank you very much for considering our revised manuscript. We look forward to hearing from you at your earliest convenience.

With kindest regards,

Yanli Hu, Miaorui Jiao, and Fan Li

Responses to Dr. Paul Galchutt (Reviewer 1):

Paul Galchutt (Reviewer 1): This paper contains new findings for the field produced by methods and state of the science. Below are notes on some matters to be addressed.

Summary: The overall findings of this project are encouraging and contribute to the field regarding educating nurses concerning spiritual health and spiritual care competencies.

1. Study Design and Analysis: Under section 2.2.2, there a few matters to be addressed. First, in the sentence referencing Yao Jianan et al, I would recommend removing the end of the sentence,
"…and so on." Second, adding some detail about the duration to importantly determine the dose of the "spiritual care training classes," "case sharing sessions," and "the personal growth book discussion." Also, were these trainings incorporated into the workday somehow? Were these additional sessions beyond the workday? Knowing more detail would help with feasibility and acceptability exploration. Third, when writing about the "experimental group protocol," it is cited that "in-depth interviews" occurred and that from these interviews data is offered about the perceptions of the nurses. Yet, there is no evidence of qualitative data analysis. This is problematic for this manuscript as nowhere is it mentioned that this study endeavors into a mixed method methodology design with the use of both quantitative and qualitative methods. If this was a part of the ethical research protocol, it needs to be included in all aspects of this manuscript. Fourth, quotes are offered within this 2.2.2 section absent of any citations. Please insert them. Within the Results section, there appears to be some misspellings of "dementia" (dimension), "spiritual" (spiritual), and "controled" (controlled). There also appears to be an important typo regarding statistical significance within the last sentence of the Results section, perhaps P&lt;0.05?

Response to Dr. Paul Galchutt comment No. 1: Thank you very much for your encouragement and for your valuable suggestions. First, we have removed "…and so on" from the end of the sentence according to your suggestion.

Second, we have added details about the duration to determine the dose of the "spiritual care training classes", "case sharing sessions", and "the personal growth book discussion". We have revised our manuscript (Methods section, line 178, page 9) as follows (marked in red):

2.Methods

2.2.2. Drafting of the intervention protocol

(1) Study group protocol. The intervention group participated in the one session/month concentrated study organized by the hospital in the same period as the control group. In addition, all members of the study group concentrated on the training for two sessions, once every six months, five days/session, eight hours/day. The lecturers were senior teaching supervisors of clinical spiritual care education and pastoral counselling in Hong Kong. After the centralized training, organized activities occurred twice a month, including one case sharing, three hours; personal growth reading activities, one session, two hours each session, including two books in the training period: "You Can Heal Your Life"(Louise Hay, US) and "Being Mortal: Medicine and What Matters in the End"(Atul Gawande, US).

Third, as you guessed, the "spiritual care training classes" of these trainees were incorporated into the workday and approved by the hospital nursing manager for continuing education. The team members participating in the training attended two weeks of special spiritual care group study every year. The time of the "case sharing sessions" was the time the nurses used to study the seminar. The "personal growth book discussion" time was after dinner on every Wednesday, and this session was the only one of the training programme that was outside of the workday. So far, this programme has been suitable for the spiritual care training at the hospital. At present, this programme is still being adopted by the hospital for continuous training. We have revised our manuscript (2. Methods section, line 187, page 9) as follows (marked in red):
2. Methods

...  

2.2.2. Drafting of the intervention protocol

The time and place of the event were fixed. The "spiritual care training classes" of this training were incorporated into the workday and approved by the hospital nursing manager for continuing education. The team members participating in the training attended two weeks of special spiritual care group study every year. The time of "case sharing sessions" was the time used for the monthly seminar. The "the personal growth book discussion" time was after dinner every Wednesday, and this session was the only one of the training programme that was outside the workday. Each activity was led by a spiritual care training team leader responsible for organizing and implementation. The team leader had three deputy senior titles and a clinical head nurse who had obtained the qualification of a national second-level counsellor. This protocol included life-and-death education, suicide prevention strategies, end-of-life care, spiritual growth, spiritual care cognition and practice, etc. (see Additional file 1: Table 2).

Fourth, perhaps we were mistaken in the expression of "in-depth interviews", and we apologize for this. We did collect some nurses' opinions on spiritual care through interviews and group discussions, and some of them are quoted here, but the topics of interviews and discussions are centred on "whether it is necessary to conduct spiritual care training for nurses". Therefore, these topics are not equivalent to the main content of the present article, "The effect of spiritual care training". Furthermore, this part of the work was completed before we carried out this research, and the work that has been completed in this part of the study was not a part of the ethical research protocol. Therefore, we have not included the main content of that part of the methodology in this article, nor can we define our interviews and discussions as a qualitative approach because these were not in-depth interviews in the strict sense. In addition, we intend to include that part in another research paper as part of another ongoing study. We have revised our manuscript (2. Methods section, line 147, page 7) as follows (marked in red):

2. Methods

...  

2.2.2. Drafting of the intervention protocol

...  

The spiritual care training protocol was drafted based on a literature review, expert recommendations, and the results of a current status survey.

Finally, thanks very much for your reminder. We have inserted the missing citations in Section 2.2.2. Within the Results section, we have corrected the misspellings of "demention" (dimension), "spirial" (spiritual), and "controled" (controlled), and the manuscript language was revised by AJE. The attached "editing certificate" certifies that the manuscript was edited by AJE. Finally, as you noted, there was an important typo regarding statistical significance in the last sentence of the Results section; the correct phrasing is P<0.05, and we have revised it in the manuscript. Thanks again for your reminder.

2. Tables/Figures: With Table 1, please note somehow, I presume, that all nurse participants are female. This would, ideally, be noted here with your tables helping communicate your research "story." This, of course, reflects external validity and your ability to generalize these findings
beyond regions and cultures who evidence male/men within their nursing workforce. Also, within Table 1, it would be helpful to have additional information regarding the category, "Religion." It is unclear what the binary "yes/no" category means. I do not remember this being mentioned in the text of the manuscript. Because of the experimental nature of this study, it would have been helpful to have a table illustrating both the experimental and control groups along with their pre-/post- scores in one table, even if this means creating the table in a landscape orientation. I sense it helps enhance the impact of your findings.

Response to Dr. Paul Galchutt comment No. 2: Thank you for your valuable questions and comments, which will be of great guiding value for our subsequent follow-up studies. As you stated, all nurse participants in the current study were female. At present, most of the employees who work in nursing work are women because of China's cultural background. Of course, there are a few men in China who are currently working in nursing, but the number of male nurses in our hospital is particularly small, the study is in the form of voluntary registration, and the present study did not recruit male nurses. We will consider deliberate inclusion of males in subsequent studies. In China, most people have no religious beliefs. In the present study, seven of our nurses had religious beliefs, six of whom believed in Christianity and one of whom believed in Buddhism. We have added the additional information regarding the category "Religion" to the manuscript according to your advice (see Additional file 1: Table 1) as follows (marked in red):

Table 1  Comparison of demographic characteristics between nurses in the two groups

<table>
<thead>
<tr>
<th>Religion</th>
<th>7</th>
<th>5</th>
<th>0.49</th>
<th>0.48</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (Christianity, 6; Buddhism, 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Finally, we have added a table illustrating both the study and control groups along with their pre-/post-scores in one table (see Additional file 2: Table 4)

3.Introduction/Discussion: Within the introduction, "spiritual well-being" is listed parenthetically immediately following "spiritual health." If you are equating these two terms, I recommend a sentence of explanation regarding why you sense the construct of spiritual well-being is the same as spiritual health. Also, within the introduction, the verb "overcome" is used in reference to limitations and adversity. Navigating this word (overcome) within some contexts communicates that the limitations or adverse circumstances have been eliminated or annihilated by virtue of personal agency or action. Unless this word is part of a copyrighted definition, I would commend the consideration of alternative verbs such as adjust or adapt as in "...ability to adapt to adversity." In the second paragraph, when addressing the purpose of spiritual care, I would recommend a connecting word such as "additionally" to your second sentence regarding the purpose as the first sentence begs for a citation. Within the second sentence concerning the purpose of spiritual care, the word "alleviate" is used. Like "overcome," the word, "alleviate," communicates that an emotional challenge can be completely and consistently resolved with spiritual care. Perhaps less polarized terms such as "mitigate," or "address" could be used.

Response to Dr. Katerina Marcoulides comment No. 3: Thank you for your thoughtful reminder. In the Chinese cultural context, the meaning of the terms "spiritual well-being" and "spiritual health" is the same. This is also consistent with the general view that "spiritual health is considered as one of six equally important dimensions of wellness". Please see the references
provided below for details. We have provided a sentence of explanation regarding why we sense the construct of spiritual well-being is the same as spiritual health. (1. Introduction section, line 51, page 3) as follows (marked in red):

1. Introduction
Although the debate on 'defining' spirituality [1, 2] is long-standing, spiritual health (also known as spiritual well-being: in the Chinese cultural context, the construct of spiritual well-being is the same as spiritual health [3, 4], and this is also consistent with the general view that "spiritual health is considered as one of the important dimensions of wellness [5]") in the present...

We have carefully read some of the literature. We agree with your point of view and have changed the verb "overcome" to "adapt to" (1. Introduction section, line 58, page 3, marked in red). In the second paragraph, we have added the connecting word "additionally" to the second sentence and added a reference to the first sentence (1. Introduction section, line 81, page 4, marked in red). Within the second sentence concerning the purpose of spiritual care, what you said is very convincing. The word "alleviate" used is not very appropriate here. Therefore, we have used the word "mitigate" instead according to your suggestion (Introduction section, line 82, page 4, marked in red). Thank you very much for your help in clarifying the meaning of these expressions, which will also be very helpful for our future essay writing.

Response to Ana Soto Rubio (Reviewer 2):

Ana Soto Rubio (Reviewer 2): The research is relevant and it aims to contribute to a field that would greatly benefit from this type of studies.

1. The introduction is well written. It would benefit from adding some quotes in order to know where the authors extracted the information from (More specifically, assertions in lines: 56-58; 62; 65-69; 72-75; 77-81; and 93-97).

Response to Dr. Ana Soto Rubio comment No. 1: First, thank you for you encouragement. Second, thank you for your review and valuable comments regarding our manuscript. These comments are all valuable and have been very helpful for revising and improving our paper, and they also provide important guidance for our research.

We have modified every point that you raised according to your suggestions. We have added quotes to the assertions in lines 56-58, 62, 65-69, 72-75, 77-81, and 93-97 (marked in red). Please review the manuscript again.

2. Objectives of the study: The objectives of the study should be clearly stated. In lines 100-102 there is a statement of what the authors hope to find, but it includes finding results regarding variables that are not being measured in the study, like physical health. A better and specific formulation of the objectives of study should be included.

Response to Dr. Ana Soto Rubio comment No. 2: Thank you for your valuable questions and suggestions. We have stated the objectives of the study more clearly (Introduction section, line 102, page 5) as follows (marked in red):

1. Introduction
...As a consequence, scientifically based and effective intervention protocols must be drafted to boost nurses' levels of spiritual care. The aim of this study was to evaluate the effects of a spiritual care programme for oncology nurses. We investigated whether nurses gain benefits
from this training such as positive changes in their spiritual health and higher levels of spiritual care competencies.

3. Methods: in lines 117-118 is stated that the assertion expressed in lines 114-117 needs to be discussed in light of the literature. Please, either discuss it in light of the literature, or clarify.

Response to Dr. Ana Soto Rubio comment No. 3: We apologize for our negligence. Thank you for the reminder. The sentence "Of course, that needs to be discussed in light of the literature" is superfluous. Our aim is to describe the conditions of our Chinese nurses' work practices and our experience and to determine our inclusion criteria on this basis. We have corrected this mistake (2. Methods section, line 119, page 6).

4. There are some minor errors that should be revised, like the use of the word "criterias" in line 119, instead of criteria. Line 125 is redundant with line 118 regarding signing the informed consent. In line 134 is stated that the statistical expert was part of the intervention team, does this mean that he/she participated in the intervention process? As a trainer? I guess the statistic expert participated in the analysis of the data but not in the intervention process. Please, clarify.

Response to Dr. Ana Soto Rubio comment No. 4: Thank you for your careful review and for helping us find the incorrect spelling and omissions in our writing. We have revised some minor errors and submitted the manuscript to AJE for revision. We have deleted the redundant part regarding signing the informed consent. As you noted, a statistics expert participated in the analysis of the data but not in the intervention process. Even though she was part of the study team, she did not participate in the intervention process. We have clarified this point in the manuscript (Methods section, line 121, page 6) as follows (marked in red):

2.2.1 Establishment of an intervention team
The members of the intervention team consisted of two palliative nursing education experts from Hong Kong and three clinical head nurses who specialize in spiritual care. In addition, one statistical expert with statistical analysis skills was recruited who participated in the analysis of the data but not in the intervention process.

5. The procedure section is clear and well described. The content of the intervention section is clear; but it would be useful to know some of the findings in which this contents are based on; for example, it is not clear what "law of attraction" (line 189) means, and where do these contents come from, why they are included in the intervention protocol. This should be very clear in the introduction section: why this aspects were included in the intervention, and based on what.

Response to Dr. Ana Soto Rubio comment No. 5: Thank you for your reminder. We have explained what "law of attraction" means, the origin of this term, and why this concept is included in the intervention protocol. The law of attraction means that when thoughts are concentrated in a certain field, people and things related to this field will be attracted to a person with certain qualities. This concepts indicates how spiritual tools can be used to change one's mindset from a fearful one to a more confident positive approach to the world. There are two main reasons for us to use the law of attraction. One is to enable nurses to concentrate on learning spiritual care and to improve the training effect of nurses. The other is that this approach can also be applied to spiritual care for patients. We have clarified these points in the manuscript (1. Methods section, line 211, page 10) as follows (marked in red):

"Of course, that needs to be discussed in light of the literature"
2.2.3. The content of the intervention
The content of the spiritual care education curriculum included a group pledge and the sharing of feelings, empathy training, positive spiritual education fostering personal growth, reflective logs, the law of attraction (the law of attraction means that when thoughts are concentrated in a certain field, people and things related to this field will be attracted to a person with certain qualities [56]; this conception helps one to find stability and security in a changing and challenging world [57] and shows how one person can use spiritual tools to change one's mindset from a fearful one into a more confident positive approach to the world [58, 59]), suicide prevention, end-of-life care, and life-and-death education.


6. The assertion in lines 226-227 would benefit from a quote that clarifies on what it is based on. Same goes for assertion in line 230 (regarding validity and reliability being excellent, please provide some data supporting this).
Response to Dr. Ana Soto Rubio comment No. 6: Thank you for your reminder. We have added the corresponding references to these assertions (Methods section, line 253, page 12) as follows (marked in red):

2.4.2 Spiritual Well-being Scale
The Spiritual Well-being Scale is a spiritual health scale developed by the Taiwanese scholars Ya-chu Hsiao et al. [60] based on a sample consisting of nurses. This scale comprises 24 questions across five dimensions: bonding with others, searching for meaning, overcoming adversity, religious faith, and self-knowledge. This scale has a Cronbach α coefficient of 0.93, with subscale values ranging from 0.77 to 0.89 [61]. The scale's use has reached a level of maturity, and it has been steadily optimized.

7. Lines 231-231: please, provide some information regarding how the research team did this division into three dimensions, based on which aspects? Was some statistical analysis carried out for this?
Response to Dr. Ana Soto Rubio comment No. 7: Thank you for your helpful suggestions. We have provided information regarding how the research team determined the division into three dimensions, the aspects the division was based on, and the relevant statistical analysis (Methods section, line 260, page 13) as follows (marked in red):

2.4.3. Spiritual Care Competency Scale
Leeuwen et al. drafted this scale [47]; it contains 27 items across six dimensions, is scored using a five-point Likert scale, and has excellent validity and reliability [47]. The Chinese version was translated and culturally localized by the study team with the permission of Dr. Leeuwen. It was evaluated using the EFA and CFA method [34] and was divided into three dimensions using factor analysis based on the conceptual framework of the original scale: assessment, implementation, professionalization, and quality improvement of spiritual care (AIPI); personal
and team support (PTS); and attitudes towards patient spirituality and communication (ATPSC). The Cronbach α coefficients of these dimensions were 0.93, 0.92, and 0.89, respectively [34].

8. Regarding the statistical methods, t-test is appropriate, but it is also important to calculate the size effect and not only to take into consideration the p value. Also, in order to compare more than one value ANOVAS are recommended.

Response to Dr. Ana Soto Rubio comment No. 8: We have added the size effect (SE) to the t-test in the manuscript (Methods section, line 272, page 13) as follows (marked in red and see Additional file 2: Table 3 and Table 4).

2.5. Statistical methods
IBM SPSS 23.0 was used for data analysis. We employed independent samples testing to compare the two groups' preintervention test scores. The paired-samples t-test was used to compare the preintervention and postintervention scores of the two groups, and the independent samples t-test was used to compare the postintervention scores of the two groups; P<0.05 was considered significant, and the eta squared (()) was used to evaluate the effect sizes of the intervention.

We used the t-test to compare the t-tests and calculated the t-values. When comparing the differences between the groups, the paired t-test was used to calculate the difference, d. Our main purpose was to compare the differences between the dimensions of the Spiritual Health Scale and the Spiritual Care Competency Scale and the scores of the total scores between the intervention group and the control group after intervention without comparing the dimensions (more than one value) within the same indicator. The ANOVA was therefore not used in the present study.

9. Results:
Between-group comparisons of the spiritual health and spiritual care competency:
Please, in lines 147-249 write if this assertion is before or after the intervention. Also, provide data of the comparison between groups before and after intervention. This is important because in table 1 the initial values of "spiritual health" and "spiritual care competency" are different for both groups before the intervention, with p<0.05. Please, include this in the results, comment and clarify. Comparison between the pre-intervention 252 and post-intervention spiritual health and spiritual care competency scores of the nurses in the experimental group: Please, also include the comparison between pre-intervention and post-intervention scores for the control group, and not only for the experimental group.

Response to Dr. Ana Soto Rubio comment No. 9: Thank you for your kind reminder; we apologize for our negligence. We have described this assertion as arising before or after the intervention (Results section, line 284, page 14) and provided data on the comparison between groups before and after the intervention (see the Additional file 2: Table 4). We have also included the comparison between preintervention and postintervention scores for the control group (see Additional file 2: Table 3).

10. The discussion section includes assertions that are not based on the results included in this study, like the one in lines 284-286; 289-291. Also, there are some sentences formulated in future, similar to hypothesis, that could be included as future lines of research, future questions to be answered, but not as discussions or conclusions derived from the data provided (lines 296-304 and line 309).
Response to Dr. Ana Soto Rubio comment No. 10: Thank you for your very valuable suggestions, which have provided very important guidance for our future thesis writing. We have adjusted and revised this part according to your suggestion and included it the limitations section and the directions for future research (4. Discussion section, line 377, page 18) as follows (marked in red).

4.4. Research limitations and future research
All participants in this study included nurses in various departments of a single cancer hospital......

Future research may focus on the following aspects: First, through the spiritual care training programme, expert instruction may boost the nurses' perceptions of spirituality. Moreover, nurses who were originally unfamiliar with spiritual concepts became conscious that everyone has a spiritual nature and uncovered their own spiritual nature. Second, in this case, it was easier for the trainees to reveal their inner thoughts in front of trusted team members, and this process also might strengthen their ties with their colleagues and help them find positive resources and strength that they may use to cope with problems, thereby facilitating their spiritual growth while providing a platform for ongoing learning that benefited the nurses' spiritual care competencies. Third, nurses with spiritual care experience will value the opportunity for a healthy life even more and will show greater tolerance for the challenges that they encounter. During the process of helping patients find meaning in life and overcoming adversity, nurses will also gain a greater ability to make their lives meaningful and overcome adversity, which will make this process mutually influencing and mutually reinforcing. As a consequence of the practical experience needed to assess patients' spiritual needs in a real-world environment and provide spiritual care to patients, in addition to the positive feedback that the results of spiritual nursing brings nurses, nurses' spiritual care competencies and personal spiritual well-being will continue to improve. Future research may evaluate these potential benefits for nurses.

11. In lines 311-316 is described the goals of the study, but here are included variables that are not measured or analysed in this study, like "to inspire search for positive life goals" or to be a "behaviourally healthy person". Again, stating the goals of the study at the end of the introduction would help to have really clear the goals and variables of the study. Response to Dr. Ana Soto Rubio comment No. 11: We have deleted some inappropriate content that describes the research goals and stated the goals of the study at the end of the introduction. Please review it again.

12. Assertions in lines 319-323 need a quote, to state where this information comes from. Which are the previous studies that support these? Response to Dr. Ana Soto Rubio comment No. 12: We have added quotes to the assertions in lines 319-323. (4. Discussion section, line 342, page 17) as follows (marked in red):

4.3. Clinical relevance
Motivated by the growing importance placed on the provision of spiritual care to patients, research on spiritual care has recently increased [34]. However, although previous research has shown that both patients and their family members have great spiritual needs and that medical personnel must show concern for and satisfy these needs, this issue has not received sufficient
attention in nursing practice [37, 62]. One obstacle to spiritual care practice is that nurses—the chief healthcare providers—are insufficiently prepared to take on this role because of their inadequate education in this area [28-31, 43, 45].

13. In line 331 authors talk about how this intervention could help maintain the physical health of the nurses. Again, there is no data regarding physical health of the participants and, therefore, no conclusion can be derived on this regard. Authors can propose this as a future line of research. Response to Dr. Ana Soto Rubio comment No. 13: Thank you for your kind reminder. We have removed these less relevant contents.

14. Clinical significance: in Lines 320-322 authors state that "...this research has found that both patients and their family members have great spiritual needs..." This study only analyses data from nurses, therefore it can not have found that patients and family members have great spiritual needs. Response to Dr. Ana Soto Rubio comment No. 14: Thank you for your kind reminder. This confusion was caused by our description error. In fact, what we want to express is that previous research has shown that "...this research has found that both patients and their family members have great spiritual needs...", and we have revised it in the manuscript (4. Discussion section, line 343, page 17) as follows (marked in red):

4.3. Clinical relevance
Motivated by the growing importance placed on the provision of spiritual care to patients, research on spiritual care has recently increased [34]. However, although previous research has shown that both patients and their family members have great spiritual needs and that medical personnel must show concern for and satisfy these needs, this issue has not received sufficient attention in nursing practice [37, 62]. One obstacle to spiritual care practice is that nurses—the chief healthcare providers—are insufficiently prepared to take on this role because of their inadequate education in this area [28-31, 43, 45].

15. In Table 1, instead of experimental group it reads study group. Along the document the groups are called experimental and control, please, correct accordingly. Also, the title of the table is "Comparison of demographic characteristics 1 between nurses in the two groups", but data regarding Spiritual health and spiritual care competency is also included, and this variables are not demographic. Response to Dr. Ana Soto Rubio comment No. 15: Thank you for your questions and valuable suggestions. We have corrected all erroneous descriptions accordingly (changing "experimental group" into "study group" in Table 1 and in the manuscript). Additionally, we have moved some of the contents (data regarding spiritual health and spiritual care competency) in Table 1 to another table (Table 4), ensuring that the title of Table 1 is consistent with the content (see Additional file 1: Table 1 and Additional file 2: Table 4).

Finally, regarding Table 2, I really appreciate that the authors describe the contents of the intervention protocol, I think this is fundamental and definitely a good thing about this article. There is something that caught my attention, though: The definition of spirituality that the authors provide in lines 51-55 is very respectful will the personal values of each person, and the authors also recognize the importance of addressing "THEIR perception of spirituality" (line 275), and also in Unit 6: End of life care authors include
"an understanding of one's own viewpoint concerning different death events and the ability to maintain a neutral position", but some contents like those described in Unit 2, 1.a Knowing of one self, some Christian perceptions are included; and it calls my attention because 80 out of 92 participants informed that they had no religion. Some concern also arises regarding the transcultural validity of the intervention regarding Contents of Unit 2, 2.a; 2.c; 2.d... where assertions such as "Illness comes from the mind: Anxiety and fear will cause the functioning of qi in our bodies to shut down, thereby impeding circulation of life force, whereas joy and serenity cause the qi to function freely, enabling our life force to flow freely and create an energy field, preventing illnesses from drawing near" are made. Please, include some reflections about the cultural limitations of this intervention.

Response to Dr. Ana Soto Rubio comment No. 16: As you stated, the spirituality and spiritual care that we provide is very respectful of the personal values of each person. A core element of spiritual and spiritual care training is learning to respect. This includes respecting the diversity of the patients' spiritual needs and understanding the nurse's own attitude towards spirituality, his own perception of spirituality, and cross-cultural awareness and care for patients of different cultural backgrounds (including the religious beliefs of the nurse himself and the patient he/she cares for). Therefore, it is important to know oneself. Although, as you know, the vast majority of Chinese people do not have religious beliefs (80 out of 92 participants reported that they had no religion in the present study), this does not mean they have no religious consciousness. Moreover, a small number of patients are also Christian or Buddhist, and a poor understanding of believers by healthcare professionals may lead to impaired communication in the healthcare setting, resulting in distress. Awareness of these concerns may help healthcare providers to minimize distress among their both religious and nonreligious patients. Therefore, after careful consideration and discussion, we included some Christian perceptions.

Your comment is very reasonable. In addition, this part of the contents of Section 2, 2.a, 2.c, and 2.d is indeed a combination of the unique elements of Chinese culture and the content of intervention with Chinese cultural characteristics. We have included some reflections about the cultural limitations of this intervention and revised our manuscript (Introduction section, line 51, page 3) and (Discussion section, line 368, page 18) as follows (marked in red):

4.4. Research limitations and future research

All participants in this study included nurses in various departments of a single cancer hospital. Furthermore, to facilitate the continued provision of spiritual care training to all nurses, a considerable portion of these participants consisted of head nurses or nursing staff members in their respective departments. As a consequence, most of the nurses in this study were senior personnel with over seven years of experience. Although these individuals had a certain degree of representativeness, some uncertainty remains concerning the effectiveness of the intervention protocol when applied to nurses with less seniority. Subsequent research should therefore examine the effectiveness of the training protocol in the case of less experienced nurses. In addition, certain contents of the intervention (such as "Illness comes from the mind: Anxiety and fear will cause the functioning of qi in our bodies to shut down, thereby impeding circulation of life force, whereas joy and serenity cause the qi to function freely, enabling our life force to flow freely and create an energy field, preventing illnesses from drawing near") is a combination of the unique elements of Chinese culture and the content of intervention with Chinese cultural characteristics. The transcultural validity of the intervention requires further consideration and verification.
ChüniLeu Y C, Chan Y C, Wong N Y. The relationships between religious beliefs and teaching among mathematics teachers in Chinese mainland, Taiwan and Hong Kong. [M]// HOW CHINESE TEACH MATHEMATICS: Perspectives from Insiders. 2015.


Finally, thank you again for your recognition and encouragement of our research work and for your valuable comments. We tried our best to improve the manuscript and to make appropriate changes. Here, we have listed some of these changes, which are marked in red in the revised paper. We sincerely appreciate the work of the editors and reviewers and hope that the corrections will be met with approval.

Thank you again for considering our manuscript, which is very important to us. We are currently conducting further research in this area. Thank you for your thorough review, which has provided us with a better understanding of similar research methods and issues that warrant attention, which are very meaningful for our research.

Best regards,
Fan Li