Culture, Spirituality and Religious Literacy in Healthcare

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Afterward

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This section of the book is an afterward, providing a brief reflection upon the theme of this publication, drawing on the author's experience and knowledge on the subject, as well as the many contributions of this volume. This afterward continues with a discussion of some of the key and overlapping issues raised by different authors in this book, while it humbly makes a few recommendations about future trends.

A good starting point, as with any text, is to consider the definitional challenges we are facing. The terms 'religion', 'spirituality', or 'religious literacy' have all been contested. A clear definition or descriptor shared by different scholars or contexts is not available, yet various descriptors share similarities (Zinnbauer et al., 1997). For example, most definitions of the term 'religion' refer to an organised set of beliefs followed by a larger part of the population, while the term 'spirituality' refers to a more personal journey of meaning-making. This vagueness in the definition of these concepts has been described, by Bregman (2004), as beneficial, allowing policymakers, practitioners, researchers, and others to apply their meaning to any and every situation. For the purposes of this section, I am drawing on the definitions provided to me by health and social care professionals in research (Pentaris & Tripathi, 2022; Pentaris, 2019; 2016), a most fitting approach given the focus of this book.

That said, 'religion' is seen as an organised institution, offering a guided lifestyle and informing decision-making, while acting as a support system. 'Spirituality' is referred to as a personal journey, and the lived experience of religious beliefs – a personalised religion that supports individuals, families and communities to make sense of the world. These descriptors then support our construction of religious literacy, which refers to all faiths and none, and this section may use the term 'religion' alone or interchangeably with other terms to refer to all. Yet, different scholars, researchers, policymakers, practitioners or laypeople will have their own descriptors of these two concepts. With that in mind, this volume perceives both religion and spirituality as lived experiences, thus both can only be understood within the context in which we find them or their practice.

Reflections about religious literacy

Religious literacy is the knowledge and understanding of the beliefs, practices, and their cultural significance, as well as abilities to engage with them. It encompasses the ability to navigate religious and spiritual diversity, engage in respectful dialogue with individuals from different backgrounds, and comprehend the role of religion in society (Pentaris, 2019; Dinham and Francis, 2015). Religious literacy has become a crucial topic in academic and public discourses, as globalisation and immigration have led to greater religious and spiritual diversity in many parts of the world.

A crucial aspect of religious literacy is the historical and cultural context of different religions. Understanding the historical development of religions sheds light on the cultural and social significance of their practices, beliefs, and symbols. As Wiebe (2013) suggests, historical and cultural context is necessary to comprehend the complexity of religious diversity.

Appreciating religious diversity is also vital to religious literacy. This involves recognising the similarities and differences between different religious traditions, as well as understanding the diversity within each tradition – religious plurality (Pentaris, 2019). Prothero (2010) argued that recognising and respecting religious diversity is critical to peaceful coexistence in diverse societies. Similarly, religious literacy includes the ability to respectfully engage in dialogue with individuals from different religious or spiritual backgrounds, or the lack thereof. This requires understanding the beliefs, practices, and values of others and being able to express one's own beliefs and values in a respectful and constructive manner. Such arguments are not necessarily new but important to reiterate in new contexts. For example, Jackson (2013) opined that respectful dialogue across religious divides can foster greater understanding and social cohesion – an approach argued continuously in public discourse and policy to create inclusive environments for all.

The development of religious literacy, regardless of its context, provides many benefits, and these have been highlighted by various scholars, and in varied disciplines (e.g., Dinham, 2021; Chidester, 2019; Pentaris, 2019; Marcus, 2018; Padilla, 2015; Hedges, 2014; Jackson, 2013; Davie, 2000). For individuals, it can promote greater understanding and respect for others, and help individuals navigate a diverse and complex world. For communities, it can foster greater social cohesion and understanding, and help to promote peaceful coexistence. Additionally, religious literacy can be an important tool for addressing social and political issues related to religion, such as religious extremism, discrimination, and intolerance.

Religious literacy in healthcare

Religious literacy is essential in healthcare to provide culturally sensitive and person-centred care. As patients come from diverse backgrounds and hold various religious beliefs, healthcare providers must develop the right skills to understand how religious beliefs and practices can impact healthcare decisions, treatment plans, and overall

patient outcomes, all of which are points highlighted by Daniel Enstedt and Lisen Dellenborg in their editing of this volume.

Understanding patients' and/or family/friends' religious beliefs, spiritual identities, and faith not necessarily linked to religious denominations is crucial. Such beliefs and identities can influence health behaviours, decision-making, and attitudes towards medical treatments. For example, some religions prohibit certain medical treatments or procedures, such as blood transfusions or organ donations (Aldridge, 2018). Providers must understand these religious practices to respect patient autonomy and provide appropriate care. Religious literacy helps providers identify and address patients' spiritual needs, which are often neglected in medical care (Astrow, 2017) or health and palliative care (Pentaris and Thomsen, 2020). These spiritual needs may include prayer, counselling, or other forms of religious support that are integral to the patient's overall wellbeing.

Next, drawing on studies like Shahin et al. (2019), faith and spirituality or religious beliefs can impact patients' health behaviours, thus advancing religious literacy may increase the chances of positive patient outcomes. For instance, some religions promote specific health behaviours, such as abstaining from alcohol or drugs. Providers who understand these beliefs can encourage patients to adopt these behaviours and improve their health outcomes. Additionally, religious beliefs can provide patients with coping mechanisms that can help them manage pain, anxiety, and other health-related stressors (Chan and Sitek, 2021; Pentaris, 2019). Providers who understand these beliefs can incorporate them into treatment plans, thereby improving patient outcomes (Kaye, 2022; Lynch and Franklin, 2019; Astrow, 2017).

Furthermore, religious literacy can benefit both patients and healthcare providers. Providers who are religiously literate can build trust and rapport with their patients, leading to better patient satisfaction and adherence to treatment plans (Puchalski, 2014). Those who understand patients' religious beliefs can avoid cultural insensitivity or religious biases that can negatively impact patients' healthcare experiences. It is with religious literacy that healthcare professionals, and others, can improve their commitment to the often-problematic concept of cultural competence (Pentaris, 2019b) by complementing its position with an advanced understanding of the differences between religion and culture, as well as the demand for a lack of superiority in the exploration of both. Such an approach may make healthcare providers more effective in caring for patients, and their families or friends, from a diverse background (Eagle, 2016).

Yet, religious literacy is not merely a concept to explore in relation to professionals already in the field. Incorporating religious literacy into healthcare education is critical in preparing healthcare professionals to provide sensitive care, with a focus on the four main qualities for religiously and culturally sensitive support – informed decision-making, respect, adaptability, and non-judgmental practice (Pentaris and Christodoulou, 2021). Healthcare curricula should include courses on religious beliefs and practices of various patient populations to help students understand how these beliefs can impact healthcare

decisions and patient outcomes (Eagle, 2016). Healthcare providers should also receive ongoing training on religious literacy to stay informed about changes in religious practices and beliefs that may impact patient care, as well as the meaning those have for the different people they work with.

Issues raised in this book

This volume raises several significant questions and arguments in relation to how religious literacy is or could be negotiated in healthcare or social care settings. Some of the key issues raised include the tendencies for pragmatic and avoidant approaches in practice; the influence of spirituality and religiosity on the development of one's professional identity, thus acting as a resource; religion as a resource informing decision-making; the tendencies to make referrals to chaplains to meet spiritual needs of patients; religious literacy as an integral part of person-centred care; and the misbalance between the secularisation of institutions and the demand for adequate and appropriate response to religious or spiritual needs.

In chapter 2, in the first part of the book, Tone Lindheim explores religious literacy in nursing homes in Norway. This study reports on data from various healthcare workers and highlights that religious literacy and practices in nursing homes could be divided into two sections: traditional and basic needs. The author is recognising that patient needs in this area may refer to chaplain services or prayers (I.e., traditional) or dietary requirements or other daily care (I.e., basic needs). This divide is certainly recognised elsewhere in research (Lalani, 2020; Pentaris, 2019; Timmins and Caldeira, 2017) but what we ought to focus on is the consequences of it. If needs are simply divided into traditional and basic, the former becomes a more religious endeavor which professionals will shy away, and thus often such services are referred to chaplains alone (Pentaris and Tripathi, 2020), regardless of the patients' (or their family or friends) preferences. That said, basic needs like meals and daily care become a practical task which professionals respond to via pragmatic approaches (Pentaris and Thomsen, 2020).

This is further emphasised by Lisen Dellenborg and Daniel Enstedt in chapter 3, wherein the authors argue that the Swedish care system tends to routinely refer to chaplaincy services when more existential or religious matters arise, but other services in the setting may respond to basic needs. Such practices lead to further pragmatic approaches, which often rely on what Pentaris and Thomsen (2020) called factualist perspectives – leading to professionals simple expanding reading and knowledge about specific religions, without the development of an understanding of those in the context and the sense of plurality discussed by authors such as Dinham (2020).

Worth noting, in relation to the traditional needs referred to in this volume, is that, albeit the significance of impact that chaplaincy services have in care, there remains the limitation of those being restricted to the faith tradition, as put by Erika Willander in chapter

6 of this book. This is further recognised in Liefbroer et al.'s (2017) review of interfaith spiritual care.

In the same chapter, Lindheim reports on further findings highlighting an avoidant approach to religious or spiritual needs in nursing homes, while Dellenborg and Enstedt, in chapter 3, also recognise this approach in practice. According to Pentaris and Thomsen (2020, p.654), an avoidant approach refers to 'avoiding to engage with cultures or religions and nonreligion to limit the risk of associating with something that is unknown and which professionals feel uncertain about'. This book, overall, recognises elements of this avoidant approach which merely highlights the uncomfortability of professionals when discussing this subject and the desire to avoid the risk of conflict when bringing up issues about religion.

Lindheim and Ólafsdóttir (in chapters 2 and 5, respectively, drawing on the Norwegian and Icelandic contexts respectively) highlight that religion and spirituality can be approached as resources and thus religious literacy is a set of knowledge and skills that can enhance assets in practice. First, there is a demand to recognise minoritised groups among professionals, and how those identities may offer expertise when working with religiously minoritised groups but also enhance other professionals' perspectives and skills in the area. In addition to that, religion and spiritual identities may offer a framework for decision-making, both for professionals and patients, which should be considered when planning care for an individual, adding value to the principles of person-centred care (also see De la Porte, 2016). Albeit the importance of this point that may be closing in on an argument for Aristotelean ethics, Ólafsdóttir's findings about religiosity or relevant identities informing the decision to become a midwife are important but may pose further challenges in the future. If religious identity provides inherent values for developing a duty of care, then the question is whether those can be learned by those not abiding by religious beliefs but provide care.

Furthermore, a few contributors in this book opine that the lack of balance between secularised institutions, religious or secular (using the term loosely here) professionals and patients with religious and/or spiritual needs is a real issue and a barrier to successfully developing religious literacy. Dinham and Francis (2015) emphasised that religious literacy can only be understood in the context in which we find it, and this is an important sentiment to the potentiality for developing religious literacy. In addition to that, I have argued elsewhere (Pentaris, 2019) that religious literacy needs to be both assessed and developed on three separate levels, with the potential need for a fourth. The first three refer to 1) the foundations of an institution – for example, hospice care has in its fabric religion and belief, 2) the organisational level, referring more to policies and procedures, as well as the space and architectural matters, and 3) the professional, who often is influenced by or subjected to organisational demands as an employee. The fourth level may refer to a profession's degree of religious literacy. Of course, considering religious literacy across these different levels is a highly complex scenario, and it is more than common that what we find is a higher degree of religious literacy among

professionals, for example, than organisations; an issue highlighted poignantly in this book.

Some of the contributors in this volume, including Emma Lundberg, argue that religious literacy is part of person-centred care, thus even more pressing to advance the former among professionals. This is an important recognition but limited to the possibility of person-centred care in the context, which requires a focus on the person's preferences, values and needs, tailoring care towards those. An important part of this conversation, also referred to by Lundberg, is that of a value-based approach in the development of religious literacy (found in the Religious Literacy in Hospice Care model – Pentaris, 2019). A value-based approach includes self-awareness, self-understanding, interpersonal skills, and empathy; all of these areas lead to a better understanding of oneself and personal values, and how they influence interactions with others, which eventually inform the interactions with the information shared by others. In this case, religious literacy is inclusive of developing an understanding of the meaning that religious and/or spiritual values have for a person, and thus support them in the best way possible, a point also highlighted in chapter 12 of this book. Enstedt considers the forms of lived religion in Sweden and highlights the need for a deeper understanding of religion, non-religion and spirituality, as well as the increasing diversity of all. The intent of developing appropriate approaches in this area in healthcare is underpinned by the need for more awareness and empathy.

Future directions

This volume raises significant points and recognises pre-existing and new challenges in the premises of Nordic contexts and contemporary healthcare and related settings. The focus on religious literacy is clear and threads across the book, while few contributors refer to religion, culture and spirituality interchangeably. This is not uncommon in literature about this topic, yet not the most helpful approach. The conformity of culture, spirituality and religion might continue to accentuate challenges that health and social care are facing. Specifically, there appears to be a demand to divide these aspects and explore them separately before putting them back together. The problematic consensus of *cultural competence,* for example, for anything related to identities (e.g., disability, religion, culture, sexuality, gender, etc.) can often lead to a checklist approach to diversity that does not truly address issues of equity and justice. Similarly, such approaches result in forms of tokenism that do not truly focus on the issues at hand (Danso, 2018; Kirmayer, 2012). Exploring religion, culture and spirituality all together will simply continue to result in the need for heightened cultural competence among professionals, avoiding, thus, the complex and multilayered circumstances in which we find these identities. With that in mind, it appears to be of absolute importance that research should continue to explore religion and religious identities of patients, families and/or friends in healthcare and related settings, for all the reasons laid out in this book, but also for the purposes of developing distinct evidence that will inform practices and policies better.

Research alone does not suffice though when attempting to make amends of a historical gap in the abilities to appropriately respond to religion and belief. The issues raised in this volume and elsewhere in literature are not immune to structural, foundational, legislative and social circumstances. Crisp (2017), for example, in her edited collection of works about religious literacy, curated contributions emphasising the lowered religious literacy in the public domain and societies on the whole. Healthcare is one part of an (eco)system (i.e., society) working (sometimes) harmoniously with its different parts being influential to the others. In this case, education, familial learning, politics, as well as law inject knowledge or the lack thereof in relation to religious diversity and plurality. When early education lacks the capacity to ensure that society develops into a well-informed entity about such diversity (Dinham and Shaw, 2017), it is only natural that individuals moving into tertiary education will lack the expectation to develop such skills and thus might not question the lack of such material into their curriculum. This results in professionals lacking the right skills and abilities, or self-awareness that can support developing the right degree of empathy when working with people of diverse and plural backgrounds. In other words, we may need to seriously reconsider education and training around diversity from an early age, enabling people to ask questions and respectfully engage with material of non-conforming sources. Of course, such suggestions will only bring results in healthcare in over twenty years from writing this text, thus more attention needs to be paid to the current workforce.

As argued by many scholars, including myself, the sector's investment in training and Continuing Professional Development CPD programmes focusing on presenting more information about more religions will not result in improved practices and religious literacy. Instead, such approach tends to accentuate the problematic power dynamics found between dominant and non-dominant groups; arguing the position of 'us' and the 'others'. Religious literacy is not aimed at this and should not facilitate an infrastructural setup that allows a sense of superiority to emerge. To the contrary, religious literacy via a value-based approach seeks to support people's development of humility, allowing them to see themselves as equals to others, facilitating thus an inclusive environment of support and learning, rather than the tendency for problem-solving approaches in practice (Pentaris, 2018). Perhaps where we are failing is not in the willingness to become more inclusive but the right approaches to developing the skills required. Supervision and reflection are key aspects of professional development, yet not commonly seen among professionals in the sector, when often supervision refers to case management with a focus on the patient rather than the professional.

Another area that requires attention and which can potentially support with the increased understanding in this area is that of interdisciplinary explorations of religious literacy. Not unlike this volume, much of research has a specific disciplinary focus, or might be inclusive of a few health professions (e.g., nurses, midwives, physicians). However, if we are to better tackle the controversy and tensions between secularised spaces and religious practices, we ought to consider more carefully how health and social sciences can, for example, work together with architecture, business and management. It is of

utmost importance that such synergies are forged to assist with future initiatives in research, theory and practice, as well as policymaking. Alternatively, siloed work will merely continue to recognise challenges but fail to make effective suggestions to tackle them.

Lastly, when examining religious literacy, we ought to be placing more value on cross-country learning, without necessarily ignoring the context-specific applicability of knowledge. This volume is one such good attempt to share knowledge across geographical boundaries and in the Nordic countries, with applicability in other parts of Europe, yet more work is needed in this area. Cross-country learning is important for several reasons, but when thinking about religion in relation to global phenomena and their impact on local levels, Vasconcelos et al. (2017) have argued that without cross-country learning we cannot achieve wider goals. Their argument is founded on the benefits of knowledge-sharing networks and partnerships between countries. Kucharska and Erickson (2016) highlight the benefits of cross-country learning in education and healthcare and argue the need for knowledge-sharing initiatives in the sector.

The most important reasons why we ought to integrate cross-country learning in our practices and approaches are well-known but often exercised locally only. First, cross-country learning results in the sharing of best practices; it allows countries to share successful policies, programmes, and practices with each other. This can help to improve outcomes in areas such as health, education, and social services. Next, learning about other countries and their unique cultural, economic, and political contexts can help individuals and organisations to gain a deeper understanding of the global landscape. This can be especially important for healthcare organisations looking to expand their services within and outside of their limitations. Additionally, cross-country learning promotes collaborations. In other words, it can foster collaboration and partnerships between individuals, organisations, and governments in different countries. This can lead to joint research and development initiatives, knowledge-sharing networks, and joint policymaking efforts.

In the face of the ongoing challenges and changing societal circumstances, diversity and its recognition will only continue to increase. Such diversity and plurality are not only seen among patients in healthcare, but also among professionals. The latter may be an invaluable source of information that has been under-explored, misunderstood, or undermined at times. Perhaps there is a need to start exploring religious literacy not only regarding how professionals and organisations can best respond to religion, belief and spiritual needs of patients and their families or friends. It may be time to start considering more carefully how to improve religious literacy with the aim for religiously diverse professionals to be better accommodated and supported within secular organisations.

Before I close this afterward, I wish to throw in another hint linking to religious literacy, and something of desperate need for research and exploration in policy and practice. In 2018, I completed work on the impact of the lack of religious literacy in end-of-life care (Pentaris, 2018). Such impact often aligns with the definitions of spiritual abuse (Ellis et

al., 2022). It is, in other words, rather critical that we start emphasising not the lack of religious literacy, but how that impacts on individuals and what it means. Spiritual or religious abuse can take extreme forms and be found in practices of cults, but it can also be found in hospital wards when patients' worldviews are undermined or negated because of the pragmatic or avoidant approaches, also highlighted in this book. Interdisciplinary and bold research is of high demand to better respond to these scenarios.

References

Aldridge, J. (2018). Religion, spirituality, and health care: Social, ethical, and practical considerations. *Journal of Religion and Health,* 57(6): 2266-79.

Astrow, A. B. (2017). The importance of addressing patients' spiritual needs in medical settings. *The American Journal of Hospice & Palliative Care,* 34(1): 4-8.

Bregman, L. (2004). Defining spirituality: Multiple uses and murky meanings of an incredibly popular term. *Journal of Pastoral Care & Counseling*, *58*(3), 157-167.

Chan, W. A., & Sitek, J. (2021). Religious Literacy in Healthcare. *Religion & Education*, *48*(1), 102-120.

Chidester, D. (2019). *Religion: material dynamics*. University of California Press.

Crisp, B. R. (Ed.). (2017). *The Routledge handbook of religion, spirituality and social work*. Taylor & Francis.

Danso, R. (2018). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work*, *18*(4), 410-430.

Davie, G. (2000). *Religion in modern Europe: A memory mutates*. Oxford University Press on Demand.

De la Porte, A. (2016). Spirituality and healthcare: Towards holistic peoplecentred healthcare in South Africa. *HTS Teologiese Studies/Theological Studies*, *72*(4), 1-9.

Dinham, A. (2020). *Religion and belief literacy: Reconnecting a chain of learning*. Policy Press.

Dinham, A., & Francis, M. (Eds.). (2015). *Religious literacy in policy and practice*. Policy Press.

Dinham, A., & Shaw, M. (2017). Religious literacy through religious education: The future of teaching and learning about religion and belief. *Religions*, *8*(119), 1-13.

Eagle, C. T. (2016). *Developing religious literacy in health care providers.* AMA.

Ellis, H. M., Hook, J. N., Zuniga, S., Hodge, A. S., Ford, K. M., Davis, D. E., & Van Tongeren, D. R. (2022). Religious/spiritual abuse and trauma: A systematic review of the empirical literature. *Spirituality in Clinical Practice*, *9*(4), 213-231.

Hedges, P. (2014). Is Christianity the Only True Religion: A Theology of Radical Openness to Religious Others*, Interreligious Insight*, *12*(2), 34-42.

Jackson, R. (2013). Religious literacy: What it is, why it matters, and how to achieve it. Wiley-Blackwell.

Kaye, M. F. (2022). Intercultural Training, Interfaith Dialogue, and Religious Literacy: Minority Groups in the Israeli Health-Care System. In Tadros, M. (ed.) *What About Us? Global Perspectives on Redressing Religious Inequalities*, Institute of Development Studies. Pp. 29-50.

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural psychiatry*, *49*(2), 149-164.

Kucharska, W., & Erickson, G. S. (2023). Tacit knowledge acquisition & sharing, and its influence on innovations: A Polish/US cross-country study. *International Journal of Information Management*, *71,* 102647-102671

Lalani, N. (2020). Meanings and interpretations of spirituality in nursing and health. *Religions*, *11*(9), 428-442.

Liefbroer, A. I., Olsman, E., Ganzevoort, R. R., & van Etten-Jamaludin, F. S. (2017). Interfaith spiritual care: A systematic review. *Journal of Religion and Health*, *56*, 1776-1793.

Lynch, M. A. M., & Franklin, G. V. (2019). Health literacy: An intervention to improve health outcomes. In *Strategies to Reduce Hospital Mortality in Lower and Middle Income Countries (LMICs) and Resource-Limited Settings*. IntechOpen.

Marcus, B. P. (2018). *Religious literacy in American education*(pp. 56-72). Oxford: Oxford University Press.

Padilla, N. (2015). Religion and the Secular State in Argentina. *Religion and the Secular State: National Reports*, *2*.

Pentaris, P. (2019a). *Religious literacy in hospice care: Challenges and controversies*. Routledge.

Pentaris, P. (2019b). Religion, belief, and spirituality in health care. *Handbook of health social work*, 279-301.

Pentaris, P. (2018). The marginalization of religion in end of life care: signs of microaggression?. *International Journal of Human Rights in Healthcare, 11*(2), 116-128.

Pentaris, P. (2016). *Religious literacy in end of life care: challenges and controversies* (Doctoral dissertation, Goldsmiths, University of London).

Pentaris, P., & Thomsen, L. L. (2020). Cultural and religious diversity in hospice and palliative care: a qualitative cross-country comparative analysis of the challenges of health-care professionals. *OMEGA-Journal of Death and Dying*, *81*(4), 648-669.

Pentaris, P., & Tripathi, K. (2022). Palliative Professionals' Views on the Importance of Religion, Belief, and Spiritual Identities toward the End of Life. *International Journal of Environmental Research and Public Health*, *19*(10), 6031-6042.

Pentaris, P., & Tripathi, K. (2020). Religious/spiritual referrals in hospice and palliative care. *Religions*, *11*(10), 496-509.

Pentaris, P., & Christodoulou, P. (2021). Qualities of culturally and religiously sensitive practice: a cross-sectional study. *Journal of Palliative Care*, Online First, available at: https://journals.sagepub.com/doi/full/10.1177/08258597211050742

Prothero, S. (2010). *Religious literacy: What every American needs to know – and doesn't.* Harper Collins.

Puchalski, C. M. (2014). The FICA spiritual history tool# 274. *Journal of palliative medicine, 17*(1), 105-106.

Shahin, W., Kennedy, G. A., & Stupans, I. (2019). The impact of personal and cultural beliefs on medication adherence of patients with chronic illnesses: a systematic review. *Patient preference and adherence*, 1019-1035.

Timmins, F., & Caldeira, S. (2017). Assessing the spiritual needs of patients. *Nursing Standard (2014+)*, *31*(29), 47-53.

Vasconcelos, C., Silva, J., Calheiros, C. S., Mikusiński, G., Iwińska, K., Skaltsa, I. G., & Krakowska, K. (2022). Teaching Sustainable Development Goals to University Students: A Cross-Country Case-Based Study. *Sustainability*, *14*(3), 1593-1608.

Wiebe, D. (2013). Religious literacy: A historical and comparative perspective. University of Virginia Press.

Zinnbauer, B. J., Pargament, K. I., Cole, B., Rye, M. S., Butter, E. M., Belavich, T. G., ... & Kadar, J. L. (1997). Religion and spirituality: Unfuzzying the fuzzy. *Journal for the scientific study of religion*, 549-564.