Spirituality, Spiritual Care and Spiritual Well-being amongNurses and Patients

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Abstract: *The need to take into consideration spirituality in provision of care is assuming a great importance. However, many fields have long been troubled by a lack of conceptual clarity about the nature of spirituality itself. This gave rise to the researcher's interest on spiritual care in nursing. The study utilized a descriptive quantitative design. This research study aimed to explore the perception of both the staff nurse and the patient on (a) spirituality and spiritual care and (b) spiritual well-being using the standardized tool of Spirituality and Spiritual Care Rating Scale[1] and the Spiritual Assessment Scale[2]. The study was conducted at Saint Louis University – Hospital of the Sacred Heart (SLU-HSH) between April 2015 to April 2016. Results shows that nurses and patient have good perception of spirituality, spiritual care and spiritual well-being but still patients have higher perception compared to nurses because illness plays an important role.*

I. Introduction

Spiritual care in nursing is a topic that is often vague, misunderstood and neglected. Spiritual care is defined as the attitude of caring for patients in an integral and individual way, helping them find their spiritual well-being, is only possible within the scope of this relational context[3].The researcher believes that spiritual well-being cannot be achieved by simply addressing the physical needs of the patients; it needs spirituality to attain spiritual well-being. As a nurse, being spiritually aware makes it easier to assess a client needing spiritual care and as a result, the nurse helps the patient attain spiritual well-being. A review of literature shows that when a patient has a lower spiritual well-being, they have lower acceptance of the disease process. McNulty, Livneh and Wilson (2004) assessed the spiritual well-being of patients with multiple sclerosis; they found a significant correlation between psychosocial adaptation with uncertainty and both dimensions of spiritual well-being. Higher levels of perceived uncertainty and decreased reliance on spiritual well-being were associated with lower levels of psychosocial adaptation[4].For centuries, the nurse – patient relationship has been unique and individualized. Both patient and nurse bring into the partnership a multiplicity of personal life variables, including such factors as demographics, family history, illness experience and spiritual orientation[2]. Furthermore, Reed's Self – Transcendence Theory states that:

"Inherent, gradual, non – linear developmental process, resulting in increased awareness of dimensions greater than the self and expansions of personal boundaries within intrapersonal, interpersonal, transpersonal, and temporal domains."[5].

This theory provides a framework where the development of complex health concerns heightens awareness of increased personal mortality and vulnerability. Increased vulnerability triggers an increase in self-transcendence that enhances the ability to expand individual boundaries intra-personally (increased sensitivity to self, one's values, philosophy), interpersonally (relationships to others and the environment), temporally (relate past and future to a meaningful present), and trans-personally (connect to dimensions beyond the physical world)[6].The outcome of self – transcendence is well-being, which is a sense of feeling whole and healthy based on personal criteria[8]. The caring relationship between the nurse and the patient is fundamental to nursing theory and practice; it is a special kind of a human care relationship, a union with another person, in high regard for the whole person and his or her being-in-the-world[6]. Studies of Haugan, Rannestad, Hammervold, Garåsen and Espnes (2012) and Haugan and Innstrand (2012) concluded that self –transcendence significantly associates with emotional, functional, social, physical and spiritual well-being as well as depression[8,9]. These two studies support the relationship of self – transcendence and spirituality.

II. Material And Methods

This descriptive comparative study was done on critically ill patients and critical care nurses of Saint Louis University – Hospital of the Sacred Heart located in Baguio City, Philippines from April 2015 to April 2016. A total of 60 respondent from aged $\geq$ 21 years old during the study.

Study Design: Descriptive Quantitative Study

Study Location: Saint Louis University – Hospital of the Sacred Heart (SLU-HSH), located in Baguio City, Philippines, is a 180 - bed capacity with an average daily census for critically ill patients of 28 to 29. There was 112 staff nurses in the hospital and 35 of which were assigned in areas with critical patients.

Study Duration: March 2015 to April 2016.

Sample size: 60 respondents

Sample size calculation: A purposive sample was selected to obtain a range of perspectives relating to spiritual care. One of the strengths of this sampling method is that participants chosen or included have knowledge and experiences of the phenomenon in question[10]. The participants consisted of thirty nurses and thirty patients, a total of sixty (N=60).

Subjects & selection method: Nurse respondents were critical care nurses who have experienced taking care of patients with spiritual care needs. While patient respondents were critically ill and may have manifested the need for spiritual care. The researcher opted to have the same sample size for nurses and patients.

Inclusion criteria for nurses:
1. Registered nurses with at least two (2) years of experience as a bedside care nurse;
2. Nurses were assigned in any of the following units: Coronary Ward and Intensive Care Unit, Medical Intensive Care Unit, Surgical Intensive Care Unit and Palliative Nurses.
3. Handled critically ill patients; and
4. Must consent freely.

Inclusion criteria for patients:
1. Patients must be 18 years old and up.
2. Patients must have a normal state of consciousness during data collection
3. Patients with diagnosed with the following: cancer (newly diagnosed, stage two and terminal stage), pre and post-surgical patients (newly amputated due to burns secondary to electrocution and for removal of tongue due to cancer) and stroke.

Procedure methodology

There were two tools for data collection that was applied in this study. The researcher adapted with permission from the authors of the Spirituality and Spiritual Care Rating Scale (SSCRS)[1] and the Spiritual Assessment Scale (SAS)[2].

Spirituality and Spiritual Care Rating Scale (SSCRS) was developed by McSherry and Draper (1997), the scale contains a total of 17 items and the subsections 'spirituality and spiritual healing', religiosity', and 'personal care'[1]. The scale is a 5 – point Likert – type scale. Reverse scoring was used for four items in the scale (including spirituality involves only going to church/place of worship; spirituality is not concerned with a belief and faith in God or supreme being; spirituality does not include art, creativity and self-expression; and spirituality does not apply to atheists or agnostics).

The second tool, Spiritual Assessment Scale (SAS) is a standardized instrument that measures the construct of spiritual well-being, that contains 21 items organized into three subscales: Personal Faith (PF), seven items; Religious Practice (RP), seven items; and Spiritual Contentment (SC), seven items (O'Brien, 2011). The tool provided a broad overview of the participant's personal faith beliefs, the type of spiritual support one receives from religious practices and the type and degree of spiritual contentment or distress one is experiencing. The 21 – item scale is organized with Likert – type scale response categories (SA – Strongly Agree, A – Agree, U – Uncertain, D – Disagree, SD – Strongly Disagree) following each item to facilitate administration[2]. A five-point scale was used to assess the participants' spiritual well-being.

Both the SAS and SSCRS are standardized instruments. The reason for using a pre – validated instrument is to increase the reliability and validity of the survey. As stated above, the Cronbach coefficient of both the SAS and SSCRS are acceptable[1,11,12]. Pilot testing was not done because of the use of a pre validated instruments. As a first step, it is always recommended to do a literature search on previously used validated questionnaires that can be administered in similar settings and capture variables that are of interest according to the study hypothesis. These questionnaires do not need to be tested for reliability and results can be compared for different studies and combined for meta- analysis[13].

After obtaining the ethical review and permission to conduct, the researcher looked for possible participants. When participants were identified, the researcher provided them the informed consent and explained what the research study is. After obtaining consent, the researcher asked the participants most convenient time to conduct the data gathering. The nurses opted to do the data gathering an hour before or after their duty. Most of the data gathering were conducted at the unit's pantry or quarters. The patients answered the

tools during their hospitalization. The researcher stayed with the respondents when they were answering the tools to provide clarification and to verify responses.

Statistical analysis

The mean of the SSCSR and the total scores of the SAS and per category was taken to assess the perception of spirituality, spiritual care and spiritual well-being of the nurses and patients. Data from both groups was compared with each other to determine who has higher perception of spirituality, spiritual care and spiritual well-being.

III. Result

Spirituality and Spiritual Care Rating Scale (SSCRS)

Results shows that nurses ($\bar{x}$=4.76) and Patients ($\bar{x}$=4.87) "Strongly Agree" that spirituality is concerned with a need to forgive and be forgiven. Similarly, both groups "Strongly Agree" ($\bar{x}$=4.41); ($\bar{x}$=4.87) that spirituality is about having a sense of hope. Both groups "Strongly Agree" ($\bar{x}$=4.41); ($\bar{x}$=4.43) that spirituality is a unifying force which enables one to be at peace with the oneself and the world. Further, they "Strongly Agree" ($\bar{x}$=4.34); ($\bar{x}$=4.77) also that spirituality has to do with the way one conducts one's life and spirituality includes people's morals ($\bar{x}$=4.57); ($\bar{x}$=4.83).

Furthermore, both groups "Strongly Agree" ($\bar{x}$=4.53); ($\bar{x}$ =4.63) that spirituality involves personal friendships or relationships and about finding meaning in the good and bad events of life ($\bar{x}$=4.40); ($\bar{x}$=4.60). Considering relationships as an integral part of spirituality, participants "Strongly Agree" ($\bar{x}$=4.76); ($\bar{x}$=4.87) that spirituality is also concerned with a need to forgive and be forgiven. On the other hand, both groups are "Uncertain" ($\bar{x}$=2.33); ($\bar{x}$=2.97) if spirituality applies to Atheists or Agnostics. Similarly, nurse respondents are "Uncertain" ($\bar{x}$=2.60) while patients "Disagree" ($\bar{x}$= 1.93) that spirituality is not concerned with a belief and faith in a Supreme Being.

Both groups "Disagree" ($\bar{x}$=1.83); ($\bar{x}$=1.63) that spirituality involves only going to church or place of worship and that nurses also "Disagree" ($\bar{x}$=2.03) while patients are "Uncertain" ($\bar{x}$=2.40) if spirituality does not include art, creativity and self - expression.

Table no 1 shows the mean ratings of nurse and patient respondents' perception on spirituality. The nurse respondents demonstrated a "Good" ($\bar{x}$=3.66) level of perception regarding spirituality. Similarly, patient respondents' overall mean rating of 3.81 also signifies "Good" perception of spirituality.

Table no 1: Mean ratings of nurse and patient respondents' perception on spirituality.

ITEMS: SPIRITUALITY	NURSES		PATIENTS	
	Mean	**DR**	**Mean**	**DR**
I believe spirituality is concerned with a need to forgive and a need to be forgiven.	4.76	SA	4.87	SA
I believe spirituality involves only going to Church/Place of Worship. **	1.83	D	1.63	D
I believe spirituality is not concerned with a belief and faith in a God or Supreme Being. **	2.60	U	1.93	D
I believe spirituality is about finding meaning in the good and bad events of life.	4.40	SA	4.60	SA
I believe spirituality is about having a sense of hope in life	4.41	SA	4.87	SA
I believe spirituality is to do with the way one conducts one's life here and now.	4.34	SA	4.77	SA
I believe spirituality is a unifying force which enables one to be at peace with oneself and the world.	4.41	SA	4.43	SA
I believe spirituality does not include areas such as art, creativity and self-expression. **	2.03	D	2.40	U
I believe spirituality involves personal friendships, relationships.	4.53	SA	4.63	SA
I believe spirituality does not apply to Atheists or Agnostics. **	2.33	U	2.97	U
I believe spirituality includes peoples' morals.	4.57	SA	4.83	SA
Overall	**3.66**	**G**	**3.81**	**G**

**Reverse scoring was used for four items in the scale

Weighted Mean	**Item DR**	**Overall DR**
4.10-5.00	Strongly Agree (SA)	Very Good (VG)
3.10-4.00	Agree (A)	Good (G)
2.10-3.00	Uncertain (U)	Fair (F)
1.10-2.00	Disagree (D)	Poor (P)
1.00	Strongly Disagree (SD)	Very Poor (VP)

Table 2 shows that the nurse and patient respondents both have a "Very Good" perception of spiritual care (4.54 and 4.68 respectively).The findings suggest congruence. Nurses "Strongly Agree" ($\bar{x}$=4.79) and patient respondents "Strongly Agree" ($\bar{x}$=4.93) that nurses can provide spiritual care through kindness, concern and cheerfulness when giving care. Both groups "Strongly Agree" ($\bar{x}$=4.38) ($\bar{x}$=4.70) respectively, that nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties and troubles. Further, both groups "Strongly Agree" ($\bar{x}$=4.63) ($\bar{x}$=4.53), that nurses can provide spiritual care by arranging pastoral visits if requested by the patient and the also "Strongly Agree" ($\bar{x}$=4.38) ($\bar{x}$=4.63) that spiritual care includes spending time with a patient, giving support and reassurance especially in time of need. Similarly, both groups "Strongly Agree" ($\bar{x}$=4.77) ($\bar{x}$=4.83) respectively, that spiritual care can be provided by having respect for privacy, dignity and religious and cultural beliefs. Lastly, both groups "Strongly Agree" ($\bar{x}$=4.28) ($\bar{x}$=4.47) that, nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness.

Table no2: Mean ratings of nurse and patient respondents' perception on spiritual care.

ITEMS: SPIRITUAL CARE	NURSES		PATIENTS	
	Mean	DR	Mean	DR
I believe nurses can provide spiritual care by arranging a visit by the hospital Chaplain or the patient's own religious leader if requested.	4.63	SA	4.53	SA
I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care.	4.79	SA	4.93	SA
I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need.	4.38	SA	4.63	SA
I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness	4.28	SA	4.47	SA
I believe nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties and troubles	4.38	SA	4.70	SA
I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient	4.77	SA	4.83	SA
Overall	**4.54**	**VG**	**4.68**	**VG**

Spiritual Assessment Scale (SAS)

The personal faith, religious practice and spiritual contentment are the essential components of the SAS survey tool by O'Brien (2011)[2]. In this study, the tool was similarly used to reflect the same components. The personal faith of patient respondents had higher subscale score of 34.50 out of 35 compared to nurse respondent's 33.47. Similarly, religious practice of patient respondents is higher (33.07 out of 35 possible score) compared to nurse respondents (31.00 out of 35 possible score). patient respondents had a higher spiritual contentment (30.43 out of 35 possible score) compared to nurse respondents (27.20 out of 35 possible score)

Table no3: Comparison of overall scores of nurse and patient respondents' spiritual well-being**.**

TOOL	Nurses	DR	Patients	DR
Personal Faith	33.47	High	34.50	High
Religious Practice	31.00	High	33.07	High
Spiritual Contentment	27.20	High	30.43	High
SAS	91.57	High	97.83	High

Total Score:	Subscale Score:	Overall DR	
85 - 105	26 – 35		High
65 – 84	15 – 25		Moderate
64 and below	14 and below		Low

IV. Discussion

A person who experiences spiritual distress expresses feelings of guilt and therefore requires the opportunity for forgiveness. Some people seek forgiveness through prayers[14]. Forgiveness may bring a feeling of joy, peace and elation, and a sense of renewed self- worth[15]. Confession of sin is one way in which some people achieve forgiveness from God. A study of forgiveness by Macaskill (2002) suggests that those who forgive also derive positive effects in terms of healing[15]. Forgiveness and reconciliation can be important steps allowing strength and peace to cope with the serious nature of terminal illness[16]. Such practice brings a way through and beyond the problems that psychology uncovers.

Hope is closely related to the need for a source of strength. A source of hope provides the spiritual and psychological strength that the person may need[14]. The strength that comes from one's sense of hope provides courage to an ill person facing the different challenges of the disease process. Hope has been found to be so essential to patients that it has been described as almost equal to life itself[16]. Hence, both groups strongly agree that spirituality is a unifying force which enables one to be at peace with the oneself and the world. Further, they strongly agree also that spirituality has to do with the way one conducts one's life and spirituality includes people's morals. From this standpoint, spirituality is more than religion, it encompasses deep feelings, the search for answers and a feeling of being at one with self. According to Coyle (2002), spirituality 'motivates, enables, empowers, and provides hope'[17]. For many people a sense of hope can be a powerful motivator in enabling an open attitude towards new ways of coping[18].

Baldacchino (2005) defined spirituality as involving interpersonal relationships and those about the meaning of life, particularly at times of crisis and illness[19]. A study conducted by Bush and Bruni (2008) stated that both nurse and non – nurse participants described how they cultivated their own sense of spirituality in order to relate to others[20]. The participants cultivated their sense of spirituality by developing interpersonal relationships with those around them, usually family, friends, colleagues and patients. These relationships were viewed by all participants as integral to their personal and professional lives and have been posited as being central to the spiritual dimension of health[21] and helped a person adapt to the stresses of the illness environment[22]. Considering relationships as an integral part of spirituality, respondents stronglyagree that spirituality is also concerned with a need to forgive and be forgiven. Forgiveness and reconciliation can be important steps allowing strength and peace to cope with the serious nature of terminal illness[16]. Such practice brings a way through and beyond the problems that psychology uncovers.

On the other hand, both groups are uncertain if spirituality applies to Atheists or Agnostics. Similarly, nurse respondents are uncertain while patients disagree that spirituality is not concerned with a belief and faith in a Supreme Being. McSherry and Ross (2002) recognized the association of spirituality with philosophical or religious traditions[23]. However, they stated that for some people, e.g. atheists and agnostics, 'the word spirituality may take on a humanistic or existential meaning'. They went on to say that the term was meaningless and irrelevant for secular humanists because 'they do not believe in the existence of any spiritual dimension'. Based on the findings, the participants are uncertain if Atheists or Agnostics believe in the existence of spiritual dimension.

Many definitions of spirituality are currently being employed in the by different authors with most making a distinction between religion and spirituality. Religion or religiosity is part of spirituality but as Wright (2005) remark: 'Everybody is spiritual but not everybody is religious'[24]. He elaborates further by recognizing that spirituality is the solid center in our lives that allows us to cope with life's difficulties and express ourselves. This supports the notion that both nurse and patient respondents agrees that being spiritual is not measured by simply going to church or place of worship. Being spiritual goes beyond by what the eye can see. Spirituality may be expressed in different ways of mediation of Yoga. It is just as important to acknowledge these practices and assist who requires support to fulfill their needs[25].

There has been an ongoing debate regarding the nature of spirituality in nursing and some even questions if nurses should be concerned regarding matters of spiritual and religious aspects of their patients[26,27]. Some nurses would say that it is part and parcel of their task to provide spiritual care to patients. However, due to some factors, it is quite difficult to do so. Furthermore, patients, sees the importance of spirituality in their lives particularly that it provides them hope and helps them in recovery. A similar study done by Bolmsjo (2000), focused on existential issues for dying people and concluded that these people regard these issues as important and wishes to discuss them[28]. While patients have developed identifiable spiritual coping mechanisms, nurses may also have a role in supporting these mechanisms[29]. Wright (2005) has also proposed that spirituality is what gives people balance when finding meaning in the existential challenges of life[24]. When a person is sick, it is human nature to seek the help of a higher force. A particular example are the Filipino people. They tend to draw closer to their faith in a Supreme Being when they are sick. Moreover, being ill increases the spirituality of one person because it helps them feel better and gives them hope. The notions of hope and will to live are indeed included in one's spirituality. Hope appears to be an essential element for human life and has been linked to positive health outcomes[25].

Culliford (2002) reported evidence that spiritual care has a positive effect on physical and psychological health of patients[30]. Spiritual care was defined as the care that nurses provide to meet the spiritual needs and/or problems of the patients[31]. Scholars have also identified that spiritual care is a central element of holistic and multidisciplinary care that is unfortunately not included in practice[32,33]. This supports the findings that both nurse and patient respondents know the importance of spiritual care, however, they do not know how to apply due to its complexities.

Spiritual care can be provided in a number of ways like listening, laughing, use of therapeutic touch and spending time with the patient[34]. Spiritual care is given in a one-on-one relationship and makes no

assumptions about personal conviction or life orientation[35]. It can be given by anybody, to anyone, regardless of belief, faith or organization. Spiritual care needs to tap into patient's inner resources, and resilience; their sense of identity, meaning and purpose – their spirituality – so as to combine effectiveness, humanity, dignity and cost effectiveness[36]. In this manner, achieving spiritual well-being will be easier for patients because of the guidance of the nurse.

Having a very good perception of spiritual care indicates that the respondents are aware of the importance of spiritual care in the delivery of quality and efficient nursing care. During the earlier discussion, it states that having a good spirituality will dictate how the nurse relates to the spirituality of the patient. Assessing the spiritual needs of the patient will therefore increase the likelihood of providing the specific intervention needed by the patient when it comes to spirituality. Sensitivity to the spiritual need of the patient will facilitate respect for others' needs. Taking into consideration the respondents' perception regarding spiritual care, it is essentially vital in promoting a good nurse – patient relationship; the nurse must understand the point of view of a patient who needs care. Putting a little extra effort to get to know the patient will do wonders for a nurse because knowing the ill person means knowing what he needs. As Carter (2009), specifically stated that when a nurse pays attention to the needs or struggles of the patients, it also heightens the confidence a patient gives to the nurse[37]. Hence, a good nurse – patient relationship grows. The growth process becomes both beneficial in the spirituality and spiritual care dynamics of the nurse and the patient. Spiritual care is therefore vital in supporting both those expressing spiritual wellness and those experiencing spiritual distress during their period of illness[38].

V. Conclusion

The spirituality and spiritual care are vital components of the healing process of a patient that in turn promotes spiritual well-being among nurses and patients. The implication of having a good perception regarding spirituality is having a better understanding between nurses and patient when it comes to dealing with spiritual needs. Having been able to identify factors that may affect spirituality that are stated in the tool will guide nurses in their assessment of the spirituality of their patients. Nurses, as the biggest members of healthcare team, who spend more time with their patients than do other healthcare providers, must recognize the spiritual needs of patients as a domain of nursing care[39]. The importance of nurses' abilities to understand their own perception of spirituality before assessing others' spiritual needs must be emphasized. Having a good perception of one's spirituality is important because it will dictate how you will provide spiritual care.

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