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Nurses' spiritual well-being and their perspectives on barriers to providing spiritual care

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ABSTRACT

Aims: Spiritual well-being has been recently considered as one of the main aspects of human life. Nurses' competence in providing spiritual care is directly related to their spiritual well-being and their awareness of spirituality. This study sought "to assess coronary care nurses' spiritual well-being and their perspectives on barriers to providing spiritual care".

Methods: This descriptive-correlational study was conducted in 2013. The study setting was all hospitals with coronary care units affiliated to Isfahan University of Medical Sciences, Isfahan, Iran. All 88 nurses practicing in the study setting were recruited through the census method. Participants were invited to complete the Paloutzian and Ellison's standardized Spiritual Well-being Scale and the researcher-made valid and reliable Barriers to Spiritual Care Delivery Questionnaire. The study data were analyzed by conducting the Chi-square, the Pearson and the Spearman correlation, and the independent-samples t tests as well as regression analysis in $SPSS_{18}$.

Results: Most of the study participants were female (87.5%) and worked in rotational shifts (86.4%). The mean of participants' age was 38.76±5.92 years. Participants' mean score of spiritual well-being was 90.06±14.88. This finding denotes that the level of nurses' spiritual well-being was higher than moderate. Moreover, nurses' spiritual well-being was negatively correlated with barriers to spiritual care delivery (r=0.35 and p=0.001).

Conclusions: The most important barriers to spiritual care delivery are nurses' greater involvement in alleviating patients' physical problems, their own preoccupations and personal problems, and lack of educational programs and workshops in the area of spiritual care. Healthcare authorities need to adopt strategies for improving nurses' spiritual well-being and lowering barriers to spiritual care delivery.

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1. Introduction

As the most magnificent creature of God, human has different aspects such as cognition, emotion, sociality, and spirituality which should be studied separately [1 and 2]. Neglecting each of these aspects means neglecting an important part of human's existence [2].

The idea of including spirituality in the definition of the health concept highlighted the importance of the spiritual aspect of humans' personal and group life [3].

In fact, spiritual well-being is the newest aspect of health [4].

By definition, spiritual well-being is having a sense of acceptance, positive feelings, and mutual positive relationship with a higher divine power which is acquired in a dynamic and consistent cognitive, emotional, and action-reaction process [5]. In fact, spiritual well-being is humans' spiritual experiences in two areas of religious well-being (which focuses on perceptions of health in spiritual life when communicating with a higher power) and existential well-being (which focuses on individuals' psychosocial concerns). Existential well-being deals with how people cope with themselves, society, and environment while religious well-being concentrates on feeling satisfied with having relationship with higher power [6].

For instance, Assarroudi et al. (2012) reported that spiritual well-being was significantly correlated with life satisfaction and different aspects of quality of life [7]. Duggleby et al. (2009) also found that spiritual well-being significantly affects job satisfaction [8]. Besides affecting nurses' life satisfaction, Fatemi et al. (2011) reported that spiritual well-being can also affect patients' satisfaction with nursing care services [9].

Spirituality is the key component of psychological health. In the recent decade, some healthcare professionals, psychologists, nurses, and sociologists have found that spirituality can dramatically affect different aspects of medical care [10].

Currently, paying attention to patients' spiritual needs is considered as an inseparable part of nursing care.

Consequently, spiritual care is a key element of nursing practice, the unique aspect of care, and a main attribute of care givers.

Studies have highlighted the importance of holistic care which included caring for patients' body, mind, and soul.

Accordingly, a nurse who is providing holistic care needs to fulfill all needs of a patient including the spiritual ones [11].

Besides physical needs, patients also have spiritual needs whose fulfillment can facilitate their recovery [12].

Accordingly, nurses should consider patients' spiritual aspect and respect their values and beliefs while providing care to them.

Spiritual interventions in addition to other types of nursing interventions can create a balance among body, mind, and spirituality and thereby, facilitate regaining full and holistic health [13].

Spiritual nursing care includes nurses' supportive presence for answering patients' questions [14], attending and listening to them, implementing procedures for them, sharing information with them, establishing a close relationship with them and their families, helping them perform their religious rituals [15], and referring them to spiritual and religious specialists and counselors [3].

Vonce (2001) reported that nurses' spiritual care practice is significantly correlated with their own spiritual well-being [16]. Nonetheless, despite nurses' interest in fulfilling patients' spiritual needs; there are ambiguities about the nature of spiritual care. For instance, Lundmark (2006) noted that many factors such as individualized spirituality, belief systems, spiritual care educations, life experiences, and personal characteristics can affect nurses' attitudes towards spiritual care [17].

Mazaheri et al. (2009) noted that nurses have positive attitude towards spirituality and spiritual care [18]. Shahrabadi et al. (2012) also found that 56% of nursing students and 51.8%

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of last-year medical students participating in their study held positive attitude toward spiritual care [19].

Hubbel et al. (2006) found that although nurses considered spiritual care as a principal part of nursing care, 73% of them did not routinely provide spiritual care to patients [20]. Moreover, the results of a study conducted by Chan et al. (2006) to investigate Hong Kong nurses' perceptions of spiritual care revealed that nurses rarely integrated spiritual care into their daily care practice.

Moreover, they reported that some nurses were barely aware of spiritual care [21].

Despite the known effectiveness of spiritual interventions on patients' recovery and health as well as patients' requests for receiving it, many nurses are reluctant to provide it. Many nursing scholars have noted that nurses' ability to provide spiritual care is improved as their awareness of spiritual care and their spiritual well-being is enhanced [1].

Accordingly, fulfilling patients' spiritual needs is of paramount importance to facilitating their recovery, enhancing their health, and improving their quality of life [9], particularly in critical care units where patients are hopeless, vulnerable, and isolated.

Patients who are hospitalized in critical care units suffer from poor intra- and inter-personal communication as well as low awareness of the surrounding environment [3].

Another issue in the area of spiritual care is spiritual outlook which is sometimes equated with religiosity.

Stranhan (2001) found a positive correlation between nurses' outlook on their own religious beliefs and their attitudes towards providing spiritual care [22]. According to Abedi et al. (2005), the first step to understanding spiritual care is to assess nurses' attitudes towards spirituality.

Accordingly, given the importance of holistic and spiritual care to enhancing patients' health, it is necessary for nurses to identify and eliminate barriers to spiritual care delivery and fulfill patients' spiritual needs in addition to physical needs [9]. The results of a qualitative study conducted by Yousefi (2009) showed that the main barriers to providing spiritual care to hospitalized patients were nurses' intense involvement in fulfilling patients' physical needs, their heavy workload, their unawareness of spiritual care, nursing staff shortage, and lack of spiritual care guidelines [23].

Despite the importance of spiritual care delivery and patients' request for receiving spiritual care during their hospitalization [13], our literature review yielded no result regarding barriers to providing spiritual care to patients hospitalized in critical care units.

Similarly, greater importance of fulfilling critically-ill patients' physical needs has resulted in having limited knowledge about barriers to fulfilling spiritual needs of patients in critical care units [24].

According to McSherry et al. (2004), nurses cannot adopt a holistic approach to care and help patients regain and maintain physical and mental health and spiritual well-being [25].

We have also personally observed that patients' spiritual needs are not properly fulfilled in critical care units. This study sought to assess coronary care nurses' spiritual well-being and their perspectives on the barriers to providing spiritual care.

2. Methods

This descriptive-correlational study was conducted in 2013. The study setting was all hospitals with coronary care units (CCU) affiliated to Isfahan University of Medical Sciences, Isfahan, Iran, which included Al-Zahra, Chamran, Feyz, Isa Ibn Marayam, Noor, and Amin Hospitals.

All 88 nurses practicing nursing in these hospitals were recruited through the census method.

Nurses were considered as eligible if they had an associate, bachelor's, or master's degree in nursing, had a minimum work experience of two years in CCU, and had not received psychoactive drugs (as noted in their medical

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record). The exclusion criterion was filling out the study questionnaire incompletely.

After obtaining necessary permission from Isfahan Faculty of Nursing and midwifery, Nursing and Midwifery Research Center of Isfahan University of Medical Sciences, and administrators of the study setting, we referred to the study setting and started sampling. Eligible nurses were invited to sign the informed consent form and participate in the study.

Three instruments were used for data collection which included a demographic questionnaire, the Paloutzian and Ellison's Spiritual Well-being Scale, and the researcher-made Barriers to Spiritual Care Delivery Questionnaire.

The items of the demographic questionnaire were age, gender, marriage, educational status, work experience, and working shift.

The 20-item Paloutzian and Ellison's Spiritual Well-being Scale (SWB) contains ten items on religious well-being (items 1, 3, 5, 7, 9, 11, 13, 15, 17, and 19) and ten items on existential well-being (items 2, 4, 6, 8, 10, 12, 14, 16, 18, and 20) [26].

These items are scored on a six-point Likert scale from 'Completely disagree' to 'Completely agree' [17].

Therefore, the total score of the religious and the existential well-being subscales and the total SWB score are 10–60 and 20–120, respectively. The SWB is a standardized scale and has been used widely in previous studies. Seyyed Fatemi et al. (2006) used SWB and reported a Cronbach's alpha of 0.82 for it [4].

The researcher-made Barriers to Spiritual Care Delivery Questionnaire (BSCDQ) contained 32 items on patient-related barriers (eighteen items) and nurse-related barriers (fourteen items). The items of the BSCDQ are scored on a five-point scale from 'Never' (scored 1) to 'Always' (scored 5). Consequently, the total scores of the patient- and the nurse-related subscales are 18–90 and 14–70, respectively. The BSCDQ was developed through conducting a literature review.

The content validity of the questionnaire was assessed by an expert panel.

A two-week test-retest technique was used for assessing the reliability of the questionnaire which yielded test-retest correlation coefficients of 0.71 and 0.78 for its two subscales.

The Cronbach's alpha values for these two subscales were 0.85 and 0.89, respectively. The study data were analyzed by conducting the Chi-square, the Pearson correlation, and the independent-samples t tests as well as regression analysis in $SPSS_{18}$.

3. Results

In total, 88 coronary care nurses participated in this study. Most of the participating nurses were married (63.6%) and worked in rotational shifts (86.4%). The mean of nurses' age was 38.76±5.92 years.

The means of SWB and its religious and existential well-being subscales were 90.06±14.88 (range: 25–118), 47.44±8.09 (range 23–60), and 42.62±7.94 (range: 25–58), respectively.

On the other hand, the means of nurse- and patient-related barriers to spiritual care delivery were respectively equal to 49.4±9.4 (range: 28–70) and 56.8±10.9 (range: 24–90).

The three most important patient-related barriers to spiritual care delivery were the diversity of patients' religious and cultural beliefs (47.7%), lack of pre-allocated time for spiritual care delivery (46.6%), and individualized nature of spiritual care (43.2%). On the other hand, the three major nurse-related barriers to spiritual care delivery were nursing staff shortage and nurses' heavy workload (60.2%), their poor work motivation due to receiving limited support from hospital administrators and managers (43.3%), and lack of educational programs and workshops in the area of spiritual care (30.7%).

Table 1 shows that nurses' spiritual well-being was only correlated with their age (p=0.02). On the other hand, there was a significant correlation between the barriers to spiritual care

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delivery and nurses' age, marital status, and affiliated hospital ($p<0.05$; table 2).

In addition, the score of nurse- and patient-related barriers to spiritual care delivery was negatively correlated with the scores of total SWB and its subscales ($p<0.05$; Table 3).

In other words, nurses with higher levels of spiritual well-being encountered fewer barriers to spiritual care delivery.

4. Discussion

This study was done to assess coronary care nurses' spiritual well-being and their perspectives on the barriers to providing spiritual care. Study findings revealed that the level of nurses' spiritual well-being was higher than moderate.

Moreover, the levels of nurses' religious and existential well-being were moderate. Assarroudi et al. (2012) reported that the means of total spiritual well-being as well as religious and existential well-being scores were respectively 94±16, 49.9±7.6, and 44.3±9.6, denoting moderate levels of spiritual well-being. The only difference between our study and the study conducted by Assarroudi et al. (2012) was that our study was conducted on nurses working in CCUs.

Hsiao and Chien (2010) also reported that nursing students' spiritual well-being was at moderate level [27].

Our findings showed that among nurses' demographic characteristics, spiritual well-being was only correlated with their age

Table 1: The correlation of nurses' demographic characteristics with their spiritual well-being

	r	p	Statistical test
Age	– 0.33	0.02	Pearson
Educational status	0.08	0.45	Pearson
Official position	0.012	0.9	Pearson
	t	p	
Type of hospital	1.25	0.19	Independent-samples t
Marital status	0.42	0.67	Independent-samples t
Gender	0.39	0.69	Independent-samples t
Working shift	1.23	0.23	Independent-samples t

Table 2: The correlation of nurses' demographic characteristics with barriers to spiritual care delivery

	r	p	Statistical test
Age	– 0.002	0.02	Pearson
Educational status	0.095	0.38	Spearman
	t	p	
Type of hospital	2.11	0.003	Independent-samples t
Marital status	2.3	0.024	Independent-samples t
Gender	1.21	0.23	Independent-samples t
Working shift	1.55	0.09	Independent-samples t

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($p<0.05$).

Assarroudi et al. (2012) also reported no significant correlation between gender and spiritual well-being [28] while in a study conducted by Jafari et al. (2010), the level of female students' spiritual well-being was higher than male studens [29].

We also found that the most important patient-related barriers to spiritual care delivery were the diversity of patients' religious and cultural beliefs, lack of pre-allocated time for spiritual care delivery, and individualized nature of spiritual care.

On the other hand, the most important nurse-related barriers to spiritual care delivery were nursing staff shortage and nurses' heavy workload, their poor work motivation due to receiving limited support from hospital administrators and managers, and lack of educational programs and workshops in the area of spiritual care.

This is in line with the results of a qualitative study conducted by Abadei et al. (2005) which showed passivity of the cultural affairs departments of hospitals, lack of spiritual care educational programs, and lack of a comfortable environment as the main barriers to spiritual care delivery [9].

Most of our participating nurses noted that lack of educational programs and workshops in the area of spiritual care and lesser importance of spiritual care compared with physical care were among the main barriers to spiritual care delivery.

Shahrabadi et al. (2012) noted that including spirituality and spiritual care in the academic curriculum of health-related fields seems crucial [19].

Study findings also revealed that the total score of nurses' spiritual well-being was negatively correlated with both nurse- and patient-related barriers to spiritual care delivery ($p<0.05$), i.e. nurses with higher levels of spiritual well-being encountered fewer barriers to spiritual care delivery.

Farahaninia et al. (2006) also found that nursing students had a positive attitude towards spirituality and spiritual care. Moreover, they reported that the level of first- and fourth-year nursing students' spiritual well-being was moderate [1].

Hsiao and Chien (2010) also noted that Taiwanese nursing students' level of spiritual well-being was moderate [27].

According to Mazaheri et al. (2009), religious affinity and the general atmosphere of household are the most important predictors of nursing students' spiritual well-being [18].

5. Conclusions

The most important barriers to spiritual care delivery are nurses' greater involvement in alleviating patients' physical problems, their own preoccupations and personal problems, and

Table 3: The correlation of nurses' spiritual well-being with nurse- and patient-related barriers to spiritual care delivery

	r	p	Statistical test
Correlation of total SWB score with nurse-related barriers	–0.29	0.006	Pearson
Correlation of religious well-being score with nurse-related barriers	–0.35	0.001	Pearson
Correlation of existential well-being score with nurse-related barriers	–.035	0.001	Pearson
Correlation of total SWB score with patient-related barriers	–0.28	0.009	Pearson
Correlation of religious well-being score with patient-related barriers	–0.195	0.007	Pearson

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lack of educational programs and workshops in the area of spiritual care.

Healthcare authorities need to adopt strategies for improving nurses' spiritual well-being and lowering barriers to spiritual care delivery.

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