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Examining the Relationship Between Patient's Spiritual Well-Being and the Nurse's Spiritual Care Competence, in Southern Philippines

Ashley A. Bangcola

College of Health Sciences, Marawi City, Mindanao State University 9700, Philippines

Corresponding Author's Email: ashley.bangcola@msumain.edu.ph

ABSTRACT

Background: Nurses and other healthcare providers must become culturally competent as well as culturally aware to meet the needs of culturally diverse patients. This descriptive inferential study investigated whether the patient's internal and external characteristics, as well as the nurse's spiritual care competency, influenced the patient's spiritual well-being. **Methods:** Descriptive correlation research design was utilized to capture information on the variables that were assumed to have an influence on the older persons' spiritual well-being and to test the hypotheses concerning the existence of significant relationships between the variables under investigation. Three sets of questionnaires were answered by three separate groups of respondents: 117 older persons aged 60 years and older admitted in Amai Pakpak Medical Center in Marawi City, 117 family members, and 117 nurses providing care to the patients. Linear regression and path analysis were used to analyze the data. **Results:** The results showed that the nurse's spiritual care competency was determined through the internal and external variables of the patient. Moreover, the patients' satisfaction in spiritual nursing care as a mediating variable of spiritual well-being was dependent on the patient's trust and the spiritual care competence of the nurse. Lastly, the spiritual well-being of the patient was significantly dependent on the spiritual care competence of the nurse and the patient's satisfaction. **Conclusion:** To attain optimal spiritual well-being, the patient, the family, and the nurse must work together in a harmonious triumvirate relationship.

Keywords: Spiritual Nursing Care; Spiritual Well-being; Care for Older Persons; Gerontology; Nursing; Philippines

INTRODUCTION

Spirituality is an important cultural factor for a large percentage of Filipinos of all ethnicities. According to the 2015 Global Attitudes survey, nearly 9 in 10 Filipinos (87%) consider religion/spirituality very important in their lives (Balboni *et al*., 2007). It is projected that by 2032, the Philippines will transition to an aging society. This means that by 2032, the older persons, or those aged 65 and older, would comprise at least 7% of the total population (Abrigo, 2019). This demographic shift will necessitate changes in healthcare to support the comprehensive needs of older persons including their spiritual needs. The aim of healthcare and the primary goal of the nurse is to satisfy patient's needs to mitigate distress and suffering when illness occurs. To reduce suffering and help patients attain meaningful well-being, nurses must be skilled not only in the physical aspects of caring but also in the spiritual aspect.

Conceptual Framework

There were five variables that this study explored: (1) the internal variables of the patient consisting of three domains: (a) the patient's educational attainment, (b) the patient's spiritual needs, and (c) the patient's trust in the spiritual nursing care; (2) the external variables of the patient consisting of two domains: (a) the family - focusing on the ethnic affiliation and trust in the spiritual nursing care, and (b) the nurse' ethnic affiliation; (3) the

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nurse's spiritual care competence; (4) the patient's satisfaction in the spiritual nursing care; and (5) the patient's spiritual well-being. The relationship between these variables is illustrated in Figure 1.

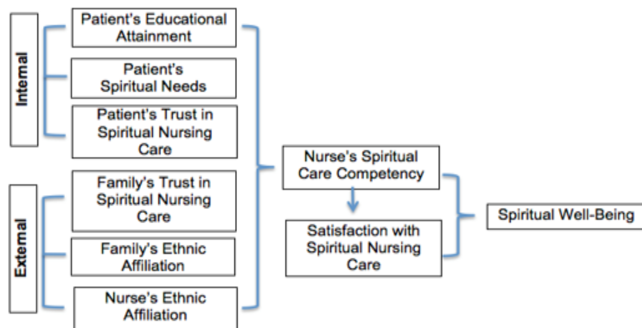

Figure 1: Conceptual Framework of the Relationship between the Variables

METHODOLOGY

Design

Descriptive correlation research design was utilized to capture information on the variables that were assumed to have an influence on the older persons' spiritual well-being and to test the hypotheses concerning the existence of significant relationships between the variables under investigation. There were three separate groups of samples: older persons, their family members, as well as the nurses providing care to them.

Sample and Setting

All admitted older persons aged 60 years or older in Amai Pakpak Medical Center (APMC) in Marawi City regardless of the duration of their hospital stay from March 1-31, 2019 were considered as potential respondents. With the help of gatekeepers (in this instance, somebody in the Admissions collaborating with the researcher), all older persons admitted in APMC meeting the inclusion criteria set forth for this study were contacted to determine their willingness to participate. Once a patient signified his/her intention to join in the research, his/her family member and attending nurse were also invited to participate in the study.

Data were obtained from self-administered questionnaires completed by 117 patients, 117 family members, and 117 nurses (n=117). A total of 172 questionnaires for each of the three groups of respondents were distributed and 141 questionnaires from each group were subsequently received, however, only 117 questionnaires from each group met the required inclusion criteria.

Instrument

There were three sets of questionnaires used in this study, one for each group of respondents. The questionnaire for the patients was a modified five-part questionnaire with 69 questions. The first part obtained the profile of the respondents and included measures of demographic characteristics. The second part of the instrument focused on the assessment of the patient's spiritual needs by asking a dichotomous question of whether the patient had experienced any spiritual need while in the hospital. The third part sought to measure the degree of trust placed by the patient in the spiritual care provided by the nurse. The fourth part was a 20-item section that gauged the patients' satisfaction in the six dimensions of spiritual nursing care as espoused by Van Leeuwen *et al.*, (2009). The Spiritual Care Competence Scale was used as a reference.

The questionnaire for the nurses was a modified two-part questionnaire with 33 items (see Appendix I). The first part was a demographic sheet that focused on the profile of the nurses and included measures of demographic characteristics. The second section focused on measuring the competencies of nurses in providing spiritual care using the Spiritual Care Competence Scale (Van Leeuwen *et al.*, 2009).

The questionnaire for the family members of the patients was a modified two-part questionnaire with eight items. The first part was a demographic sheet that focused on the profile of the family members and included measures of demographic characteristics. The second part of the questionnaire was a single-item question that sought to measure the degree of trust placed by the patient's family in the spiritual care provided by the nurse on a scale of 0 (no trust) to 4 (a great deal).

Data Collection

The researcher personally collected the questionnaires a day after it was administered to ensure the maximum response rate. Additionally, by collecting the questionnaires one day after being distributed, the researcher was able to administer another set of questionnaires for another batch of respondents who were admitted on that day. This cycle of administering-collecting-administering questionnaires was done every day for one month from March 1 to 31, 2019 irrespective of the number of respondents. After the end of one month, the statistical analysis of the collected data was conducted.

Data Analysis

The IBM-Statistical Package and Service Solution (IBM-SPSS) version 21 was used to perform all data computations in this study. For continuous data, descriptive statistics such as means and standard deviations were computed, while percentages and frequencies were computed for categorical variables. Pearson's product-moment correlation coefficient, or Pearson's r, was used to determine whether there was a correlation and whether there was a significant relationship between the research variables. In addition, semi-partial and partial correlation was employed in order to estimate the relationship between the predictor variables (the internal and external variables of the patient), mediating variables (nurse's spiritual care competence and patient satisfaction); and the outcome variable (the patient's spiritual well-being) after considering the influence of additional predictors in the equation. The hypothesized relationships between the study variables and the patient's spiritual well-being were analyzed using path analysis and mediation analysis.

Ethical Considerations

To ensure that this research study complied with ethics norms, an application for full ethical approval was made to Cebu Normal University Research Ethics Committee, which was subsequently approved on January 21, 2019 with record number 172/2018-12. The patients/participants provided their written informed consent to participate in this study.

Permission to use the Spiritual Care Competence Scale was obtained from the author through electronic mail sent from email address nr.vanleeuwen@viall.nl while permission to use the Spiritual Health and Life-Orientation Measure was obtained from the author through electronic mail sent from email address j.fisher@federation.edu.au.

The respondents in this validation study were provided with an information sheet that explained the purpose and nature of the study, the data collection methods, and the extent of the research. This information sheet, as well as the informed consent, was also comprehensively explained to the respondents in the language that is best understood by them. The respondents were asked to sign the informed consent. Older patients who may have none or little schooling were provided other means to express their consent, such as affixing their thumbprints or simply recording verbal consent.

RESULTS

Table 1: Patient's Spiritual Needs and Trust in Spiritual Nursing Care (n=117)

Patients' Spiritual Needs	%		M*	SD	Interpretation
	No	Yes			
At any time while you were in the hospital did you have a spiritual need that you felt must be satisfied for you to attain spiritual well-being?	4.3	95.7	2.31	1.054	Average Importance
Trust in the Spiritual Nursing Care Provided by the Nurse			**M**	**SD**	**Interpretation**
Patients' rating on the trust in the spiritual nursing care			1.71	1.059	Somewhat
Family members' rating on trust in the spiritual nursing care			1.59	0.984	Little Trust

Need: 0.00-0.80=Not Important; 0.81-1.60=Little Importance; 1.61-2.40=Average Importance; 2.41-3.20=Very Important; 3.21-4.00=Absolutely Essential

Trust: 0.00-0.80=No Trust; 0.81-1.60=Little Trust; 1.61-2.40=Somewhat; 2.41-3.20=Much; 3.21-4.00=Great Deal

*Note: *mean for the Yes responses*

The nurses as respondents generally agreed as to their perceived competence in providing spiritual nursing care to patients with a weighted mean of 3.62 (SD=0.54) for the nurses' spiritual care competence. In terms of spiritual nursing care specific dimensions, the nurses 'strongly agreed' that they were very competent in terms of professionalization and enhancing the quality of spiritual care as the highest level of their spiritual care competence based on ranking (M=4.60, SD=0.58). The nurses 'agreed' that they were competent in terms of personal support and patient counseling (M=3.84, SD=0.82), as well as in their spiritual care assessment and implementation (M=3.57, SD=0.85) and in their attitude towards patient spirituality (M=3.42, SD=0.92). However, the nurses were unsure of their competence in terms of making 'referral to professionals' (M=3.33, SD=0.82) and in the communication dimension of the spiritual care competence (M=3.96, SD=0.84).

The study showed that on the average, the patients who participated in the study were moderately satisfied in the spiritual care provided by the nurses with a mean score of 67.29. Based on ranking, the specific domains of spiritual care provided by the nurses showed that the patients were very satisfied in the context of the nurses' professionalization in enhancing the quality of spiritual care (MS=75.0) and in the personal support and counseling dimension (MS=72.2).

Meanwhile, the patients were moderately satisfied in the attitude of nurses' towards patient spirituality (MS=67.9), the nurses' communication with the patients

(MS=66.0), the nurses' assessment and implementation of spiritual care (MS=61.9), the nurses' system of referral to professionals (MS=61.6), with a moderate overall satisfaction (MS=66.4).

Table 2: Correlation of Internal and External Variables in the Path Analysis (n=117)

Variable	Spiritual Care Competence	Educational Attainment	Spiritual Needs	Patient's Trust	Family's Ethnicity	Family's Trust
Educational Attainment	-0.220**	---				
Spiritual Needs	-0.401***	0.171	---			
Patient's Trust	0 .367***	-0.078	-0.359***	---		
Family's Ethnicity	0 .231*	0.25**	0.164	0.211*	---	
Family's Trust	0 .180**	0.016	-0.068	0.017	0.099	---
Nurse's Ethnicity	0 .360	0.263**	-0.039	0.309**	0.804***	0.039

**p*<0.05. ***p*<0.01, ****p*<0.001

Multiple linear regression was employed to help determine which of the six internal and external variables could be used to predict the nurse's spiritual care competency. The prediction model which showed that path a to path f representing the internal and external variables of the patient were all statistically significant, F(6,110) = 22.048, p<0.001 with an R^2 of 0.546 accounting for 55% of the variation in nurses' spiritual care competence.

The patient's trust and family's trust had positive coefficients which could be interpreted to mean that an increase or decrease in either value will subsequently increase or decrease the nurse's spiritual care competence, respectively. Meanwhile, the patient's educational attainment and the patient's spiritual needs had negative coefficients, which could also be interpreted to mean that an increase in any of the two values will subsequently lower the nurse's spiritual care competence. Conversely, a decrease in any of the two values will subsequently raise the nurse's spiritual care competence.

A significant regression equation was also found that significantly predicted patient's satisfaction in the spiritual nursing care based on the patient's trust in the spiritual nursing care (path g) and nurse's spiritual care competence (path h), F(2,114) = 359.48, p<0.001 with an R^2 of 0.863 which accounted for 86% of the variation in patient's satisfaction in the spiritual nursing care.

The beta coefficients for the patient's trust in the spiritual nursing care (β=0.095, p=0.015) and the nurse's spiritual care competence (β=0.883, p<0.001) also indicate that they were significant predictors of the dependent variable, which substantiated the research hypothesis that the patient's satisfaction in the spiritual care provided by nurses was determined by the patient's trust in spiritual nursing care and the nurse's spiritual care competence. Both predictors had positive coefficients which meant that an increase or decrease of either value may subsequently raise or lower the level of patient's satisfaction in the spiritual nursing care, respectively.

As indicated in the diagram, all direct and mediating paths hypothesized within the model were statistically significant. In the path model, all of the independent variables had significant relationships with and were good predictors of nurse's spiritual care competence based on a high R^2=0.546. The model explained 54.6% of the variance in the nurse's spiritual care competence.

The beta coefficient for the direct effect of patient's trust on nurse's spiritual care competence shown as path c in the model was 0.37 significant at p<0.001 level while the beta coefficient for the direct effect of family's trust on nurse's spiritual care competence shown as path e in the model was 0.18 significant at p<0.01 level. Patient's and family's trust in the spiritual nursing care is the measure of the degree of trust placed by the patients and family members in the spiritual care provided by the nurse, therefore a high 'trust' score indicated that the patients and family members placed a high degree of trust in the spiritual care provided by the nurses. The positive significant relationships indicated that for any increase or decrease in the degree of patient's and family's trust in the spiritual care provided by the nurse, competence in the provision of spiritual care on the part of the nurse was either raised or lowered, respectively. This was the expected direction of the relationship and was significant within the model.

The beta coefficients for the direct effect of family's (path d) and nurse's ethnic affiliation (path f) on the nurse's spiritual care competence in the model were 0.23 for family's ethnic affiliation, significant at p<0.05 and 0.36 for nurse's ethnic affiliation, significant at p<0.001.

Meanwhile, the beta coefficient for the direct effect of the patient's educational attainment on the nurse's spiritual care competence shown in the model as path a was -0.22, significant at p<0.01 level. The negative relationship indicated that for any increase in the

patient's educational attainment, the degree of the nurse's spiritual care competency was lowered.

Similarly, the beta coefficient for the direct effect of the patient's spiritual needs on the nurse's spiritual care competence shown in the model as path b was -0.40, significant at $p<0.001$ level. The negative relationship indicated that with increasing scores on the predictor variable, spiritual needs, the likelihood of falling into a higher nurse's spiritual care competence was decreased.

Lastly, only the nurse's spiritual care competence and the patient's satisfaction in the spiritual nursing care had direct impact on the patient's spiritual well-being in the model. The beta coefficient for the direct effect of spiritual care competence on spiritual well-being indicated as path in the model was 0.52, significant at $p<0.05$ level while the beta coefficient for the direct effect of patient's satisfaction on spiritual well-being shown as path j in the model was 0.29, significant at $p<0.001$ level. These significant positive relationships fit the expected direction of the relationship in the model, with measures indicating higher nurse's spiritual care competency and patient's satisfaction relating to higher spiritual well-being scores. The model reaching significance meant that it successfully predicted spiritual well-being with an R^2 of 0.647.

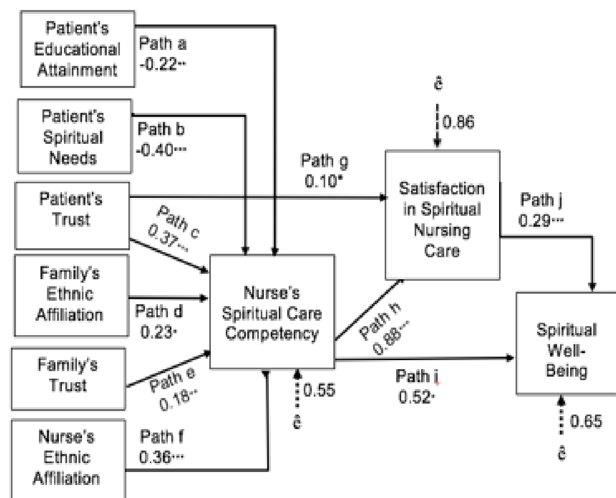

Figure 2: Path Model with Standardized-Coefficients Internal and External Variables, Nurses Spiritual Care Competency, Satisfaction in Spiritual Nursing Care, and Spiritual Well-Being

*Note: p<0.5, *p<0.001, f-Significant indirect effect, è - Un observed Exogenous Variable*

DISCUSSION

The results of the path analysis showed that all the internal and external variables were found to be significant predictors of the nurse's spiritual care competence. The more the patient and family trust the nurse's spiritual care, the more competent the nurse becomes in giving care.

In addition, the family member's and the patient's ethnic affiliation was proposed to be the same at the outset. Hence, if the nurse had the same ethnic affiliation as the patient, he or she was more likely to understand the nuances of the patient's spiritual needs having been raised the same way and thus, be able to better provide the appropriate spiritual care needed by the patient and the family. As most of the three groups of respondents in the study were affiliated in a single ethnic group, it was inferred that the more homogenous the three groups were, the higher the spiritual care competence was for the nurse. Thus, consistency in their ethnic groups (the patients and their family members with the nurses), the likelihood of falling in a higher spiritual care competency on the part of the nurse is increasing. Uniformity or consistency of cultural groups (of patients, family, nurses) promoted cultural knowledge and sensitivity subsequently influencing cultural care skills (Soriano, 2019) along with spiritual care competence. Consequently, diversity of ethnic affiliations in the groups increased the likelihood of falling in a lower spiritual care competency on the part of the nurse in that the presence of more ethnic affiliations in the patient/family group may negatively affect the competence of the nurse in providing spiritual care adequate for all of them.

The negative relationship between the patient's spiritual needs and the nurse's spiritual care competence may also be attributable to how a surge in the patient's spiritual needs can relatively outweigh the level of spiritual care, which may affect the nurse's competency in handling all of them. Utriainen & Kyngäs (2009) indicate that nurses' highest priority was their patients and that they wanted above all to fulfill their patients' care needs, but that an excessive workload made them feel inadequate and frustrated.

Moreover, it is important that nurses develop competencies. Nevertheless, there are a myriad of factors, both internal and external that might prevent the nurses from acquiring competencies. The development of nurse's competencies is influenced to a large extent by the environment (Tabari-Khomeiran *et al.*, 2007) which may include the patient.

Implications on Nursing Practice

The findings of the study imply that it is not enough that the nurse must be competent in providing spiritual care, but that it must also match with the trust the patient has in the nurse and the spiritual care received for the patient to feel the effect of the competency of the nurse in providing spiritual care. In other words, the spiritual care from the nurse and the trust from the patient must match to fill in the competencies needed.

CONCLUSION

The determining factors as whether the patient attained a positive or high spiritual well-being depended on how competent the nurse was in providing spiritual nursing care and how satisfied the patient was in the spiritual nursing care received. If the nurse was more aware and sensitive of the spiritual needs of the patient, the more competent he or she was in providing spiritual care. When there was an increase in the competence on the part of the nurse, this influenced the patient's trust as well causing there to be an increase in the level of patient satisfaction. Thus, sensitivity, congruence, and trust are crucial in order to satisfy the patients' spiritual needs for them to attain spiritual well-being.

The potential modifiability of the nurse's spiritual care competence have a hopeful message for both nurses and older adults who are dependent on the competence of nurses in order to satisfy their spiritual needs which may contribute to their overall well-being. The results of this study may have implications for nurses internationally when providing spiritual nursing care to their patients regardless of cultural or religious differences.

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Conflict of Interest

The author declares no conflict of interest in preparing this research.

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