Original Article

The Inter-professional Dimensions of Spiritual Care for Chronically Ill Patients: A Qualitative Study

Maryam Moghimian[1,2], Alireza Irajpour[3], Habibreza Arzani[4]

[1]Department of Mental Health Nursing, Nursing and Midwifery Student Research Committee, School of Nursing and Midwifery, Isfahan University of Medical Sciences, [3]Department of Critical Care Nursing, Social Determinants of Health Research Center, School of Nursing and Midwifery, Isfahan University of Medical Sciences, Isfahan, [2]Nursing and Midwifery Sciences Development Research Center, Islamic Azad University, Najafabad Branch, Najafabad, [4]Department of Religion, Islamic Studies Center, Islamic Sciences and Culture Academy, Qom, Iran

ORCID:

Maryam Moghimian: https://orcid.org/0000-0001-8589-2279;

Alireza Irajpour: https://orcid.org/0000-0002-0091-7180;

Habibreza Arzani: https://orcid.org/0000-0002-3825-145X

Abstract

Background: Spiritual care is an integral part of holistic care. Its delivery should be based on patients' spiritual needs. **Objectives:** This study aimed to explore the interprofessional dimensions of spiritual care for chronically ill patients. **Methods:** This exploratory qualitative study was done in Isfahan, Iran, on a purposive sample of 25 participants including patients, family caregivers, nurses, physicians, psychologists, social workers, and religious counselors. Data were collected through semi-structured interviews and analyzed through conventional content analysis. **Results:** The interprofessional dimensions of spiritual care for chronically ill patients fell into four main themes. The first theme was religious care with the three subthemes of assistance in doing religious rituals, assistance in referring to religious values, and assistance in doing religious activities. The second theme, that is, pastoral care, consisted of three subthemes, namely, assistance in finding the meaning of life/death/illness, assistance in achieving spiritual transcendence, and encouragement to communicate with self and to do spiritual exercises. The third theme was psychological care, the four subthemes of which included assistance in acquiring peace of mind, assistance in accepting and coping with illness, assistance in creating a source of hope, and empathizing with patients. Finally, the fourth theme was supportive care and included the four subthemes of support and assistance to meet basic needs, continuity of care after hospital discharge, providing patient and family education, and respecting patients. **Conclusion:** Spiritual care has different dimensions. Its delivery necessitates adequate knowledge and expertise, close interprofessional collaboration, effective teamwork, and efficient patient referral system.

Keywords: *Chronic illness, Interprofessional collaboration, Iran, Qualitative study, Spiritual care*

Introduction

Health is a holistic concept and includes all existential dimensions of human beings, including physical, mental, social, and spiritual. The spiritual dimension is supposed to affect all other dimensions.[1] Spirituality gives chronically ill patients a feeling of significance.[2] These patients usually suffer from alterations in their relations and experiences,[3] and therefore, they need comprehensive care services which specially focus on their spiritual needs.[4] Yet, there are many uncertainties about spiritual care delivery, particularly about the most competent persons to deliver it, the degree to which they can enter patient privacy and affect his/her beliefs, and how they can fulfill patient needs.[5]

A potentially appropriate approach to spiritual care delivery is interprofessional collaboration. In other words, interprofessional collaboration among different members of the health-care team is essential for effective

Address for correspondence: Dr. Alireza Irajpour, Department of Critical Care Nursing, Social Determinants of Health Research Center, Faculty of Nursing and Midwifery, Isfahan University of Medical Sciences, Hezarjerib Street, Isfahan, Iran.
E-mail: irajpour@nm.mui.ac.ir

Access this article online

Quick Response Code:

Website: www.nmsjournal.com

DOI: 10.4103/nms.nms_83_17

How to cite this article: Moghimian M, Irajpour A, Arzani H. The inter-professional dimensions of spiritual care for chronically ill patients: A qualitative study. Nurs Midwifery Stud 2019;8:34-9.

spiritual care delivery.[6-8] Interprofessional collaboration can improve the quality, availability, and efficiency of care.[9-11] Therefore, further clarification of spiritual care and the roles of different members of the health-care team can facilitate effective spiritual care delivery.[12]

Islam is the dominant religion in Iran. It introduces spirituality as the basis of human evolution.[13] The most critical aspect of spirituality among Muslims pertains to the understanding of the meaning of human entity and human relationship with God.[14] On the other hand, Quran, the holy book of Muslims, recommends Muslims to cooperate.[15] Moreover, Islam makes Muslims accountable to their parents and requires them to treat them respectfully. Given the great emphasis of Islam on close interpersonal relationships in families, the needs of chronically ill patients in Islamic societies can be properly fulfilled.[16] Muslims, in turn, consider close intrafamily relationships as a source of peace and hope and a reliable means for need fulfillment.[17]

Objectives

This study was part of a larger study which aimed to develop a clinical guideline for spiritual care delivery to chronically ill patients. This study dealt with the interprofessional dimensions of spiritual care for chronically ill patients. The main study question was, "What are the expectations of chronically-ill patients from their families and healthcare team?"

Methods

Design and setting

This was an exploratory qualitative study. Qualitative exploration is used to understand and discuss people's views.[18] Study setting consisted of clinics, nursing homes, patients' private homes, and medical hospital wards (including cardiology, endocrinology, cancer, and respiratory care wards) in four teaching and nonteaching hospitals in Isfahan, Iran. Around 99% of people in Isfahan are Muslims and 1% is Christians, Jews, and Zoroastrians.

Sampling was performed purposively with maximum variation to recruit 25 participants including patients, family caregivers, nurses, physicians, psychologists, social workers, and religious counselors. Inclusion criteria for patients were an age of 20 or more and affliction by chronic health conditions (such as diabetes mellitus, cancer, cardiovascular or pulmonary diseases, or disability). Moreover, inclusion criteria for family caregivers were an age of over twenty and companionship with patients during hospitalization. For health-care professionals, the only inclusion criterion was a work experience of >3 years.

Data collection was done in May–November 2016 through semi-structured interviews. Interviews with patients, health-care providers, and family caregivers were opened using, respectively, the following statements: "Please speak about your nonphysical problems and your current needs and expectations;" "Please speak about your experiences of chronically ill patients' needs and expectations and providing spiritual care to them;" and "Please speak about your patient's nonphysical problems and his/her current needs and expectations." Following participants' answers to these statements, pointed questions were asked for further clarification. Examples of pointed questions were "How does the patient deal with this problem?" and "What makes the patient calm?" One participant was interviewed twice and the others once. Interviews ranged in duration from 40 to 60 min. All interviews were recorded using an MP3 recorder.

Ethical considerations

Before each interview, the intended interviewee was asked to read and sign the informed consent form of the study. Interviews were anonymized using numerical codes. Participants were assured of their right to voluntarily withdraw from the study. Moreover, they were ensured that they would have access to psychological support if they experienced any negative consequence as a result of participation in the study. Of course, the study had no negative consequence for participants, and none of them requested psychological support.

Data analysis

Data analysis was done using the conventional qualitative content analysis approach proposed by Graneheim and Lundman.[19] Immediately after conducting each interview, the first author listened to it twice and made a word-by-word transcript of it. Then, the interview transcript was divided into meaning units, and the units were coded, compared with each other, and grouped into primary subthemes. After that, the first and the second authors independently read and compared subthemes and categorized them into main themes according to their similarities and differences. Finally, they compared their generated themes and developed a shared set of subthemes and themes. After 26 interviews with 25 participants, the data became saturated, that is, no new data were obtained from the interviews. Yet, two more interviews were done with a patient and a nurse to ensure saturation. These two interviews yielded no new data.

Different techniques were used to ensure trustworthiness. For instance, member checking was done by asking two patients, one nurse, and one religious counselor

to review and confirm our interpretations of the raw data. Moreover, during peer checking, the results of our analyses were reviewed and confirmed by ten experts in the areas of spirituality, qualitative research, and chronic diseases. The experts were external to this study. Transferability was ensured through sampling from different age groups, educational levels, and fields of study. Moreover, two nurses and two physicians who were external to the study but had the same experiences as study participants were invited to review and confirm the similarity of our findings to their own experiences. External audit was also performed by an experienced qualitative researcher.

Results

Study participants were 14 patients, nine health-care professionals, and two family caregivers – 25 in total. Half of the participating patients were male. Moreover, two were single, and 12 were married. Patients were ten Muslims, two Christians, one Jew, and one Zoroastrian. On the other hand, all health-care professionals were Muslims and had a work experience of 15 years, on average. Seventeen interviews were conducted with patients and family caregivers and nine with health-care professionals.

In total, 14 subthemes were generated and grouped into the four main themes of religious care, pastoral care, psychological care, and supportive care. Together with their subthemes, these main themes are explained in what follows.

Religious care

All participating patients expected God to help them and expected health-care professionals to be attentive to their religious needs. The three subthemes of this theme are as follows.

Assistance in doing religious rituals

Patients desired to do religious rituals such as lying facing toward kiblah and observing purity. They expected health-care professionals to help them do their religious rituals. A nurse mentioned: *The patient said*, "*How can I say prayers in hospital. How can I expect God to help me, while I cannot carry out His commands*." *We*, *the nurses*, *need to take care of these issues* (*EP2*).

Assistance in referring to religious values

Participating patients' religious values were repentance, request for forgiveness, and compensation for previous wrongdoings. They needed health-care professionals' help and support to preserve these values. A religious counselor said: "*The patient is worried. He constantly reviews his past actions and seeks forgiveness from God. He needs help*" (*EP4*).

Assistance in doing religious activities

Reciting Quran, reading prayer books, appealing to holy Imams, and performing good deeds were among patients' religious needs. The fulfillment of these needs necessitates necessary facilities and the help of health-care professionals. A nurse highlighted: "*We put prayer books in the ward. Religious rituals are also held in the hospital. All facilities for worshiping are available to patients. Nonetheless, we occasionally ask patients about any other religious needs*" (*EP1*).

In Iran, there are religious counselors in hospital settings and when needed, patients are referred to them by physicians and nurses. Yet, effective religious care necessitates closer collaboration among nurses, physicians, and religious counselors.

Pastoral care

Chronically ill patients face considerable challenges in understanding the meaning of life and hence, they need counseling.

Assistance in finding the meaning of death/life/illness

Patients always find it difficult to understand the meaning of life/death/illness. Assisting them in finding the meaning of these phenomena is the responsibility of healthcare professionals. A patient with respiratory failure noted: "*I keep thinking 'Why me?' I didn't deserve it. Those who are so cruel are healthy. Is God really fair*?" (*PP8*).

Assistance in achieving spiritual transcendence

Spiritual growth and transcendence were among the needs of chronically ill patients. The fulfillment of these needs necessitates recommendations by health-care providers to patients about relying on God, appealing to holy Imams, and maintaining dignity and self-esteem. A religious counselor said: "*The patient thought he should have been very bad that this problem happened to him. He needed to change his attitude towards illness*" (*EP3*).

Encouragement to communicate with self and to do spiritual exercises

Participating health-care professionals recommended some spiritual exercises for patients to do privately to solve their perceptual challenges and problems. A psychologist said: "*It is our duty to encourage them for positive self-talk and also to direct their thoughts and perceptions towards positive things. These strategies are needed to prevent their thoughts from turning into negative ones*" (*EP8*).

Offices in Iranian health-care settings have been established to provide pastoral care to patients. Yet, effective pastoral care delivery necessitates closer

collaboration between health-care professionals and religious counselors.

Psychological care

Patients need psychological care to achieve peace of mind, feel hopeful, and accept and cope with the status quo. This main theme included four main subthemes which are as follows.

Assistance in acquiring peace of mind

To gain peace, patients used different strategies such as entertainment, emotional release, positive thinking, and creating a peaceful environment. A diabetic patient stated "*I just want to talk about everything with someone in a quiet place. I want him to listen and to tell me what I should do to get rid of intrusive thoughts*" (*PP1*).

Assistance in accepting and coping with illness

Chronically ill patients need to have the abilities to cope with their illnesses and changes in their roles as well as to adopt new lifestyles. The caregiver of a cancer patient said: *My sister told*, "*I don't want to receive chemotherapy because it causes me hair loss and makes my daughter feel ashamed. Tell me how I should manage such a situation*" (*CP1*).

Assistance in creating a source of hope

Sometimes, patients seek or create sources of hope. Health-care professionals can create a happy environment for patients and help them find sources of hope and happiness. A patient with heart failure said: "*When I become seriously ill, my children immediately take me to hospital and my wife continuously takes my pulse throughout our way to hospital. Their concern over my health gives me hope and tells me that I should stay alive and become healthy. These things make me happy*" (*PP2*).

Empathizing with patients

Participating patients expected their families to treat them kindly, their relatives to visit them regularly, and health-care providers to talk to them positively. A psychologist expressed: "*The only thing we can do for the peace of patients is to empathize with them, listen to them, help them, and show them that they are not alone*" (*EP8*).

Specialized psychological care services in Iranian health-care settings are provided by psychologists. However, as patients express their psychological needs primarily to nurses, physicians, and family caregivers, all people who are in direct contact with them need to assess their needs and if indicated, refer them to psychologists.

Supportive care

Patients with chronic illnesses suffer from different problems, and hence, they need supportive care.

Support and assistance to meet basic needs

Medical support from different sources (such as the community, workplace, insurers, charities, and associations) is of paramount importance to the health of chronically ill patients. The wife of a cancer patient said: "*He has a constant fear over drug prescriptions which are not covered by insurance. Again, I thank the charity for its help*" (*CP2*).

Continuity of care after hospital discharge

To achieve desired treatment outcomes, effective measures are needed to alleviate patients' concerns respecting postdischarge care continuity and care delivery at homes. A patient with diabetic foot said: "*I'm always preoccupied with what will happen to me after hospital discharge. I don't have anybody to care for me at home*" (*PP5*).

Patient and family education

Chronically ill patients and their family caregivers need educations about end-of-life care, doing daily activities, and adhering to treatments. One of the participants said: "*I always fear death. I don't know what will happen to me after discharge. I need an expert to visit me at home or at least train me about self-care*" (*PP9*).

Respecting patients

Patients appreciate others' respect for their privacy, beliefs, and values. A cancer patient stated: "*I'm the head of the family. All of my relatives respect me. However, here in hospital, they do not respect my privacy. It's very annoying*" (*PP6*).

Supportive care delivery in Iranian health-care settings necessitates greater collaboration among doctors, nurses, and social workers.

Discussion

The delivery of religious care, as a dimension of spiritual care, necessitates special attention to patients' religious rituals and values because they may have no hope for recovery. Health-care providers need to avoid inquisition but have to find evidence of religiosity in their patients. Together with religious counselors, they should plan for religious care delivery.[20] Religious counselors also need to teach health-care providers about religious care delivery and attempt to fulfill patients' religious needs.[21] Pastoral care is also important for patient health, particularly in stressful conditions.[22] Religious counselors[23] and psychologists[24] can play significant roles in helping patients resolve their meaning-related conflicts and challenges.

When there is a need to help patients achieve peace, accept the status quo, or regain hope, then psychological care is strongly linked to spiritual care.[25] In fact,

psychological care complements spiritual care.[26] On the other hand, supportive care helps patients manage their concerns and learn about their underlying conditions and problems. Charities, non-governmental organizations, community-based organizations, insurers, and social workers can help and support chronically-ill patients to afford health-care costs.[27]

Health-care providers in the present study believed that interprofessional collaboration is essential for achieving the expected outcomes of spiritual care. An earlier study also reported that interprofessional collaboration needs to be taken into account in assessing patients' needs and developing care plans and policies.[28] Given the crucial role of spiritual care in care quality and patient satisfaction, health-care providers should be trained and supported to provide quality spiritual care.[29]

One study limitation was that the study sample was consisted mainly of Muslims, and therefore, the results may not reflect the spiritual needs of other religious groups and minorities.

Conclusion

The study findings highlight that due to the life-threatening complications and the debilitating effects of chronic conditions, spiritual care is of great importance to chronically-ill patients' health and well-being. Spiritual care is a multidimensional care, the different dimensions of which complement each other. Moreover, spiritual care delivery necessitates adequate knowledge and expertise, close interprofessional collaboration, effective teamwork, and efficient patient referral system. Further studies are needed to determine the spiritual needs of other religious groups in Iran and to specify the requirements of effective spiritual care delivery to chronically ill patients.

Acknowledgments

The authors are thankful of all people who participated in this study.

Financial support and sponsorship

This study was supported by the research deputy of Isfahan University of Medical Sciences (IUMS, Research Project Number: 395255).

Conflicts of interest

There are no conflicts of interest.

References

1. Adib-Hajbaghery M, Zehtabchi S, Fini IA. Iranian nurses' professional competence in spiritual care in 2014. Nurs Ethics 2017;24:462-73.
2. Vallurupalli M, Lauderdale K, Balboni MJ, Phelps AC, Block SD, Ng AK, *et al*. The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. J Support Oncol 2012;10:81-7.
3. Bekelman DB, Hutt E, Masoudi FA, Kutner JS, Rumsfeld JS. Defining the role of palliative care in older adults with heart failure. Int J Cardiol 2008;125:183-90.
4. Koenig HG. Research on religion, spirituality, and mental health: A review. Can J Psychiatry 2009;54:283-91.
5. Yardley SJ, Walshe CE, Parr A. Improving training in spiritual care: A qualitative study exploring patient perceptions of professional educational requirements. Palliat Med 2009;23:601-7.
6. Hospice & Palliative Nursing Association. HPNA position statement spiritual care 2013. Available from: http://hpna.advancingexpertcare.org/wp-content/ uploads/2014/ 09/Spiritual-Care-Position-Statement-FINAL-1010.pdf. [Last accessed on 2015].
7. Kalish N. Evidence-based spiritual care: A literature review. Curr Opin Support Palliat Care 2012;6:242-6.
8. Maxson PM, Dozois EJ, Holubar SD, Wrobleski DM, Dube JA, Klipfel JM, *et al*. Enhancing nurse and physician collaboration in clinical decision making through high-fidelity interdisciplinary simulation training. Mayo Clin Proc 2011;86:31-6.
9. So WS, Shin HS. From burden to spritual growth: Korean students' experience in a spiritual care practicum. J Christ Nurs 2011;28:228-34.
10. Olson JK. Knowledge required to use the power of spirituality in health care. Acta Paul Enferm 2015;28:3-4.
11. Pedrão Rde B, Beresin R. Nursing and spirituality. Einstein (Sao Paulo) 2010;8:86-91.
12. Edwards A, Pang N, Shiu V, Chan C. The understanding of spirituality and the potential role of spiritual care in end-of-life and palliative care: A meta-study of qualitative research. Palliat Med 2010;24:753-70.
13. Isgandarova N. The evolution of islamic spiritual care and counseling in ontario in the context of the college of registered psychotherapists and registered mental health therapists of ontario. J Psychol Psychother 2014;4:1.
14. Ghobary Bonab B, Miner, M, Proctor MT. Attachment to god in islamic spirituality. J Muslim Ment Health 2013;7:77-104.
15. Irajpour A, Ghaljaei F, Alavi M. Concept of collaboration from the islamic perspective: The view points for health providers. J Relig Health 2015;54:1800-9.
16. Quran Holy. Translated by Makarem Shirazi AA. Qom: Imam Ali Ebne Abi Taleb (Ýa); 2010.
17. Arzani H. [Ethical responsibility of children to wards their parents in the Quran and the Bible]. Ethics 2014;3:E.
18. Grove SK, Burns N, Gray JR. Understanding Nursing Research: Building an Evidence-Based Practice. US: Elsevier Health Sciences; 2014.
19. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today 2004;24:105-12.
20. Koenig HG, Zaben FA, Khalifa DA. Religion, spirituality and mental health in the West and the Middle East. Asian J Psychiatr 2012;5:180-2.
21. Lucchetti G, Braguetta CC, Vallada C, Vallada H. Exploring the acceptance of religious assistance among patients of a psychiatric hospital. Int J Soc Psychiatry 2013;59:311-7.
22. Khodayar D, Ghaemi M. The quran view to educational functions and its role in spiritual health and mental health. J Med Ethics 2016;7:55-91.
23. Carey LB, Cohen J. Religion, spirituality and health care

treatment decisions: The role of chaplains in the Australian clinical context. J Health Care Chaplain 2008;15:25-39.
24. Clinebell HJ, Mckeever BC. Basic Types of Pastoral Care and Counseling: Resources for the Ministry of Healing and Growth. Nashville: Abingdon Press; 2011.
25. Shields M, Kestenbaum A, Dunn LB. Spiritual AIM and the work of the chaplain: A model for assessing spiritual needs and outcomes in relationship. Palliat Support Care 2015;13:75-89.
26. Debellis R, Marcus E, Kutscher AH, Torres CS, Barrett V, Siegel ME. Suffering: Psychological and Social Aspects in Loss, Grief, and Care. Abingdon, UK: Routledge; 2014.
27. Herber OR, Johnston BM. The role of healthcare support workers in providing palliative and end-of-life care in the community: A systematic literature review. Health Soc Care Community 2013;21:225-35.
28. Irajpour A, Alavi M. Health professionals' experiences and perceptions of challenges of inter-professional collaboration: Socio-cultural infl uences of IPC. Iran J Nurs Midwifery Res 2015;20:99-104.
29. Adib-Hajbaghery M, Zehtabchi S, Fini IA. Iranian nurses' professional competence in spiritual care in 2014. Nurs Ethics 2017;24:462-73.