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Factors related to spiritual well-being in patients hospitalised in intensive care unit

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Abstract

This study was planned as a descriptive study to determine the spiritual well-being of patients receiving treatment in intensive care unit and the factors affecting their spiritual well-being. This descriptive study was carried out with the participation of 156 patients who were receiving treatment in the intensive care unit of a university hospital, who were willing to participate in the study and who were able to communicate. In the study, the data were collected by using a 19-question survey form and the Spiritual Well-being Scale. In this study, it was found that the Spiritual Well-being scale scores of the patients treated in intensive care were above moderate. In line with the results found, it is recommended for intensive care unit nurses to consider the spiritual needs of patients and provide spiritually supportive care accordingly in the care and treatment processes of the patients.

Keywords: Care intensive care, nursing, spirituality, spiritual well-being.

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1. Introduction

Intensive care units are units in which the vital functions of patients with serious or life-threatening physical conditions are supported; the care of these patients is maintained; special treatment methods are applied with an interdisciplinary approach; and advanced biomedical devices are used [1]–[4]. The aim of intensive care units is to save lives; to support patients physically, psychologically and socially; and to ensure that patients are discharged with positive experiences. However, patients treated in intensive care units can also have some negative experiences due to treatment process and/or physical conditions of intensive care units [5], [6]. Having a serious illness that requires treatment in the intensive care unit may cause individuals to feel vulnerable and may increase their stress levels [7], [8]. The use of advanced biomedical tools in the treatment of patients and the monotonous sounds of these tools can be frightening for patients [7]. In addition to these, fear of death experienced by patients, disruption of body integrity, leaving the social environment, not seeing family and friends, not being used to the environment, the feeling of being dependent, repeated invasive interventions and pain and movement restriction due to these interventions, losing the distinction between day and night and sleep disturbance as a result of this, not getting enough information about the illness, treatment and practices can be listed among the factors that have a negative effect on patients [5], [9], [10]. Patients can make use of spirituality to be able to cope with such negative experiences and emotions resulting from the illness and the process of receiving treatment in the intensive care unit [4], [10]. Spirituality is a dynamic force that emerges especially in difficult situations when individuals experience an existential crisis, such as illness and death, which supports the individual positively against all threats and includes all elements that constitute the purpose of life, apart from seeking a relationship with a divine spirit [5], [6], [10], [11]. In other words, spirituality is also defined as the 'unifying force' that both affects the body and soul and also is affected by the body and soul [12]. It is reported in the literature that spirituality decreases patients' pain and anxiety; increases physiological, psychological and mental comfort; the wish to communicate and quality of life; affects the recovery process positively; helps in accepting the illness and making plans about the future; and is effective in protecting from some chronic illnesses [13]–[16]. For this reason, determining the spiritual well-being levels of patients treated in intensive care is extremely important in terms of providing holistic nursing care. In addition to this, evaluating the spiritual aspects of the patients treated in intensive care increases the quality of nursing care and contributes to the increase in patients' quality of life and satisfaction levels. This study was conducted to find out the spiritual well-being states of patients treated in the intensive care unit and the related factors.

1.1. Objective of the study

This study was planned to find out the factors associated with the spiritual well-being of patients treated in intensive care unit. Answers were sought to the following questions:

- What are the sociodemographic and clinical characteristics of patients treated in intensive care unit?
- How are the spiritual well-being levels of patients treated in intensive care unit?
- Is there a relationship between the sociodemographic and clinical characteristics of patients treated in intensive care unit and their spiritual well-being levels?

2. Methods

2.1. Place and time of the research

This descriptive study was conducted with the patients treated in the intensive care unit of a university hospital in the Central Black Sea region of Turkey.

2.2. Research population and sample

The study was carried out with the participation of 156 patients who were determined with improbable sampling method and who were receiving treatment in the intensive care unit where the study was conducted. Patients who did not have any psychological or mental problems, who were able to communicate verbally and who volunteered to participate were included in the study. The dependent variable of the study was spiritual well-being levels of the patients. The independent variables of the study were sociodemographic and clinical characteristics of the patients.

2.3. Tools of data collection

The data in the study were collected by using a questionnaire form introducing the patient and the Spiritual Well-being Scale. The questionnaire form consists of 19 questions introducing the sociodemographic (age, gender, marital status, educational status, employment status, profession, social insurance status, place of residence, family type, number of children, who the patient lives with, relationships with the family, relationships with the social environment and socio-economic status) and clinical characteristics (the state of having a chronic illness, what the chronic illnesses is if the answer is yes, the state of having received treatment in the intensive care unit before, how many times the answer is yes and the number of days of days treated in the intensive care unit currently).

2.3.1. Spiritual Well-Being Scale

The Spiritual Well-Being Scale was developed by Eksi and Kardas [17] to determine individuals' understanding life with personal, social, environmental and transcendental aspects and to determine their life processes. It has three sub-dimensions as transcendence, harmony with nature and anomie. The Spiritual Well-Being Scale is a 5-point Likert-type scale consisting of 29 items scored between '1 = Not applicable to me at all' and '5 = Completely applicable to me'. The range of score that can be taken from the scale is between 29 and 145 and the scale is interpreted with both the total score and the sub-dimension scores. The items in the anomie sub-dimension are reversely scored. High scores from each sub-dimension of the scale show that the individual has the characteristic evaluated by the related sub-dimension. A high total score on the Spiritual Well-Being Scale shows that individuals have high spiritual well-being levels [17].

In Eksi and Kardas's [17] validity and reliability study, Cronbach's alpha reliability coefficient of the scale was found as 0.89, while Cronbach's alpha reliability coefficients of the sub-dimensions were reported as 0.95, 0.86 and 0.85 for the sub-dimensions of transcendence, harmony with nature and anomie, respectively. In the present study, Cronbach's alpha reliability coefficient of the scale was found as 0.90, while Cronbach's alpha reliability coefficients of the sub-dimensions were found as 0.95, 0.81 and 0.80 for the sub-dimensions of transcendence, harmony with nature and anomie, respectively. Permission was obtained from Eksi and Kardas to use the Spiritual Well-Being Scale.

2.4. Data collection

The questionnaire form was tested with a pre-application in a group of eight individuals; incomprehensible or incomplete questions were identified and corrected and the draft was finalised as a result of the pilot study. The ethical standards of the Declaration of Helsinki were complied with in this study. The data were collected by the researchers through the face-to-face interview method with the patients. The questionnaire form was given to the patients after they were briefed about the study. The patients were told that the decision to participate in the study was entirely their decision, their names would not be written in the questionnaire forms and the data collected would be used only within the scope of the study. The data collection process was completed in about 8–10 minutes.

2.5. Data analysis

Statistical analysis of data of the patients included in the study was made by using SPSS 21.0 package programme in the computer environment. Normality distribution of the quantitative data was examined with Kolmogorov–Smirnov. Independent samples *t*-test was used in the analysis of normally distributed data. Kruskal–Wallis test and Mann–Whitney U test were used in the analysis of data that were not normally distributed. The results were presented as frequency, percentage, mean and standard deviation. The significance level was taken as $p<0.05$.

3. Results

It was found that 42.3% of the patients in the study were female, 57.7% were male, 53.2% were married, 24.4% were literate, 23.7% were primary school graduates, 53.2% were unemployed, 26.3% were housewives, 23.7% were workers, 20.5% were retired, 82.7% had social insurance, 57.7% had income equal to expense, 44.9% were living in city centre, 66% had a nuclear family, 78.2% had children, 34% lived with their spouses and children, 23.1% lived only with their children, 52.6% defined their relationship with their family as 'good', 55.1% defined their relationship with their social circle as 'good' and median age was found as 58.4±17.8 (Table 1).

Table 1. Distribution of the sociodemographic characteristics of the patients

		n	%
Age groups	17–25	6	3.8
	26–40	17	10.9
	41–55	48	30.8
	56–70	46	29.5
	71–85	27	17.3
	≥86	12	7.7
	Mean age	58.4 ± 17.8	
Gender	Female	66	42.3
	Male	90	57.7
Marital status	Single	21	13.5
	Married	83	53.2
	Divorced	21	13.5
	Widowed	31	19.9
Educational status	Illiterate	29	18.6
	Literate	38	24.4
	Primary	37	23.7
	Secondary	16	10.3
	High school	10	6.4
	University	26	16.7
Employment status	Yes	73	46.8
	No	83	53.2
Occupation	Housewife	41	26.3
	Worker	37	23.7
	Officer	24	15.4
	Self-employed	6	3.8
	Retired	32	20.5
	Student	2	1.3

	Not working	3	1.9
	Farmer	11	7.1
State of having social insurance	Yes	129	82.7
	No	27	17.3
Place of residence	City	70	44.9
	Town	40	25.6
	Village	46	29.5
Family type	Nuclear	103	66.0
	Extended	53	34.0
The state of having children	Yes	122	78.2
	No	34	21.8
People living with the patient	Alone	19	12.2
	Spouse	22	14.1
	Spouse and children	53	34.0
	Only children	36	23.1
	Daughter-in-law and grandchild	1	0.6
	Parents	14	9.0
	Spouse, children and parents	2	1.3
	Spouse and parents	2	1.3
	Parents and sibling	2	1.3
	children of a sibling	2	1.3
	Sibling	3	1.9
How the relationships with the family is defined	Very good	43	27.6
	Good	82	52.6
	Bad	27	17.3
	Very bad	4	2.6
How the relationships with the social circle is defined	Very good	34	21.8
	Good	86	55.1
	Bad	25	16.0
	Very bad	11	7.1
Income status	Income<expense	38	24.4
	Income=expense	90	57.7
	Income>expense	28	17.9

It was found that 92.9% of the patients had a chronic illness, 22.8% had heart disease, 22.1% had hypertension, 17.9% were diagnosed with diabetes, 68.6% had not been treated in intensive care before, 69.4% had been treated in intensive care once and 33.3% had currently been in intensive care for 1–5 days, while 18.6% had been for 11–15 days (Table 2).

Table 2. Distribution of the clinical characteristics of the patients

		n	**%**
The state of having a chronic illness	Yes	145	92.9
	No	11	7.1
[a]If the answer is 'yes', what are these	Diabetes	26	17.9

illnesses	Hypertension	32	22.1
	Cardiac disease	33	22.8
	Kidney disease	20	13.8
	COPD	24	16.6
	Lung cancer	5	3.4
	CVA	2	1.4
	Prostate cancer	3	2.1
The state of being in intensive care unit before	Yes	49	31.4
	No	107	68.6
If the answer is 'yes', how many times	Once	34	69.4
	Twice	15	30.6
The number of days in the intensive care unit currently	1–5 days	52	33.3
	6–10 days	26	16.7
	11–15 days	29	18.6
	16–20 days	17	10.9
	26–30 days	14	9.0
	31 days and longer	18	11.5

[a]Multiple answers were taken. COPD = Chronic obstructive pulmonary disease, CVA = Cerebrovascular accident.

While the Spiritual Well-Being Scale total score of the patients was found as 105.8±19.6, their mean transcendence, harmony with nature and anomie factor scores were found as 58 ± 13, 26.7 ± 5.3 and 21 ± 5.9, respectively (Table 3).

Table 3. Mean and median values of Spiritual Well-Being Scale and factors

Scales	Mean ± Standard deviation	Median (Min–Max)
Spiritual Well-Being Scale	105.8 ± 19.6	105.5 (48–141)
Transcendence	58 ± 13	59 (18–75)
Harmony with nature	26.7 ± 5.3	27 (13–35)
Anomie	21 ± 5.9	21 (7–35)

It was found that the Spiritual Well-Being Scale total median score of the patients differed in terms of their age (p = 0.002), marital status (p = 0.003), employment status (p = 0.001), the state of having social insurance (p = 0.002), place of residence (p < 0.001), the state of defining relationships with the family (p < 0.001), the state of defining relationships with the social circle (p < 0.001) and income status (p < 0.001); it was also found that the patients who were 26 years of age and older, those who were widowed, those who were not working, those who had social insurance, those who were living in village, those who defined their relationships with their family and social circle as very good and those whose income and expense were equal had higher total median scores. It was found that the Spiritual Well-Being Scale total median score of the patients differed in terms of gender, educational status, family type, the state of having children, the state of having a chronic illness, the state of being hospitalised in intensive care before and the number of days in intensive care unit currently (p > 0.05) (Tables 4 and 5).

Table 4. Comparison of spiritual well-being score and sociodemographic characteristics

		Med (Min–Max)	*p* value Test value
Age groups	17–25	73 (50–81) a	
	26–40	122 (71–136) b	
	41–55	104.5 (62–133) b	**p = 0.002**
	56–70	106.5 (79–141) b	**X^2 = 18.596**
	71–85	104 (48–135) b	
	≥86	116 (81–129) b	
Gender	Female	106 (62–137)	p = 0.137
	Male	103.5 (48–141)	U= 2,555.5
Marital status	Single	104 (50–137) a	
	Married	105 (48–141) b	**p = 0.003**
	Divorced	103 (86–122) a	**X^2 = 14.050**
	Widowed	122 (81–137) a	
Educational status	Illiterate	113 (81–141)	
	Literate	110.5 (48–137)	
	Primary	103 (73–137)	p = 0.05
	Secondary	103.5 (71–126)	X^2 = 14.824
	High school	101 (50–114)	
	University	105 (62–133)	
Employment status	Yes	103 (62–137)	**p = 0.001**
	No	109 (48–141)	**U = 2,075.5**
State of having social insurance	Yes	106 (50–141)	**p = 0.002**
	No	99 (48–136)	**U = 1,073**
Place of residence	City	104.5 (50–137) a	
	Town	100 (48–137) a	**p < 0.001**
	Village	120 (71–141) b	**X^2 = 19.968**
Family type	Nuclear	106 (50–141)	p = 0.373
	Extended	105 (48–137)	U = 2,491.5
The state of having children	Yes	105 (48–137)	p = 0.843
	No	106 (50–141)	U = 2,028
How the relationships with the family is defined	Very good	110 (79–137) a	
	Good	106 (76–141) a	**p < 0.001**
	Bad	86 (48–122) b	**X^2 = 35.715**
	Very bad	71 (50–88) b	
How the relationships with the social circle is defined	Very good	113.5 (76–136) a	
	Good	106 (62–141) a	**p < 0.001**
	Bad	81 (48–126) b	**X^2 = 32.499**
	Very bad	86 (50–106) b	

Income Status	Income<expense	98.5 (50–120) a	**$p < 0.001$** **$X^2 = 23.116$**
	Income=expense	109 (54–141) b	
	Income>expense	100 8–133) a	

x^2: Kruskal–Wallis test statistic, U: Mann–Whitney U test statistic, a-b: There are no differences between the groups with the same letters.

Table 5. Comparison of spiritual well-being score and clinical characteristics

		Med (Min–Max)	*p* value Test value
The state of having a chronic illness	Yes	106 (48–141)	$p = 0.092$ $U = 554$
	No	100 (50–122)	
The state of being in intensive care unit before	Yes	106 (62–137)	$p = 0.853$ $U = 2{,}573$
	No	105 (48–141)	
If the answer is 'yes', then how many times	Once	106.4 ± 18.6	$p = 0.799$ $t = -0.256$
	Twice	107.9 ± 20.2	
The number of days in the intensive care unit currently	1–5 days	106 (50–141)	
	6–10 days	101.5 (76–137)	
	11–15 days	103 (48–129)	$p = 0.055$ $X^2 = 10.842$
	16–20 days	109 (95–120)	
	26–30 days	98 (71–126)	
	31 days and longer	9 - 137)	

χ_2: Kruskal–Wallis test statistic, U: Mann–Whitney U test statistic, *t*: Independent samples *t*-test statistic, a-b: There are no differences between the groups with the same letters.

4. Discussion

In this study, which was conducted to find out the spiritual well-being of patients treated in the intensive care unit of a university hospital in the Central Black Sea region of Turkey and the factors associated, the results found are discussed in line with the related literature.

In this study, while the Spiritual Well-being Scale total score of the patients treated in intensive care unit was found as 105.8 ± 19.6, their mean transcendence, harmony with nature and anomie factor scores were found as 58 ± 13, 26.7 ± 5.3 and 21 ± 5.9, respectively. High Spiritual Well-being Scale score shows high spiritual well-being. When studies conducted were examined, the Spiritual Well-being Scale total score of the patients treated in intensive care unit was found as 115.9 ± 10.7 in Cicekli's study [18], while mean transcendence, harmony with nature and anomie factor scores were found as 56.32 ± 9.5, 32.3 ± 11.1 and 26.5 ± 8.8, respectively [18]. In a study conducted by Asiret and Okatan [15] on hypertension patients, the Spiritual Well-being Scale total score was found as 130.32 ± 8.25, whereas the Spiritual Well-being Scale total score was found as 108.06 ± 12.97 in Gursu and Ay's study [19]. Individuals with spiritual values can benefit from their values and beliefs while coping with their illnesses and/or other life stressors and during their recovery process. In other words, during the process of fighting with the illness, the individuals make use of the medical treatment opportunities and try to cope with the situation that threatens life with spirituality and belief [10], [20], [21].

In our study, it was found that the Spiritual Well-Being Scale total median score of the patients differed in terms of their age, marital status, employment status, the state of having social insurance, place of residence, the state of defining relationships with the family, the state of defining relationships with the social circle and income status; it was also found that patients who were 26

years of age and older, those who were widowed, those who were not working, those who had social insurance, those who were living in village, those who defined their relationships with their family and social circle as very good and those whose income and expense were equal had higher total median scores.

When the literature is reviewed, it can be seen that different results are found in studies in which sociodemographic characteristics and patients' spiritual well-beings were evaluated. In a study conducted by Asiret and Okatan [15] in which medication adherence and spiritual well-being levels of hypertension patients were examined, statistically significant difference was reported between patients' spiritual well-being in terms of age, marital status, educational status and the state of having another chronic illness [15]. In a study by Bezerra et al [22] in which the relationship between spiritual well-being and hope levels was examined in patients who underwent open heart surgery, no statistically significant difference was found between patients' spiritual well-being in terms of gender and educational status, but a significant difference was found between age and marital status. In a study by Pilger et al. [23] examining the relationship between hemodialysis patients' spiritual well-being and quality of life, no statistically significant difference was found between patients' spiritual well-being scores in terms of the patients' age, educational status and income status.

In a study conducted by Tasan [24] on the spirituality levels of cancer patients, similar to the results of our study, the spiritual orientation of patients who were not working was found to be higher. Work life and the stresses and difficulties caused by it have a negative effect on individuals' bodily and mental health and begin to harm the working environment and individuals. In addition, it is reported that individuals who are not working have higher spiritual well-being levels since working individuals cannot find the time for their inner world [25], [26].

In parallel with the results of our study, there are studies in literature which show that individuals who live with family members have higher spiritual well-being levels [27]. Spirituality is a dimension of well-being and it is positively affected by individuals' relationships with their families and social circles, their leisure activities and the feelings of loving and being loved. It is reported that individuals who are supported by their families and social circles have better physical and mental health, higher self-esteem and self-confidence and they can cope with negative situations, such as stress, more easily [16], [28], [29].

When other studies conducted were examined, it was reported that patients' spiritual well-being differed in terms of their length of hospital stay [4], the importance they placed on spirituality [30], the stage of chronic illnesses, symptoms of the illness [31], the state of receiving spiritual care [32]–[34], the state of using antidepressant [35], the state of piety [19], the state of perceiving health, who the individuals lived with at home and the state of using assistive device [36]. It is thought that the results of studies conducted on spiritual well-being and the related factors may be affected by the patients' sociodemographic, clinical, religious and cultural characteristics, their personal and social values perceptions and their perspectives on life.

As a result, while individuals are fighting an illness that requires them to stay in a private clinic, they can question the meaning and purpose of their life and spiritual needs may arise. Individuals with high spiritual well-being can cope with stress more easily and can adapt to their illness and maintain their hope levels. Therefore, it is extremely important for intensive care nurses to plan, implement and evaluate nursing care with a holistic and humanistic perspective [5], [10], [29].

5. Conclusion

In this study, the Spiritual Well-being Scale total score of the patients was found as 105.8 ± 19.6. The Spiritual Well-being scale total median scores were found to differ in terms of some sociodemographic characteristics of the patients ($p < 0.05$). It was found that the patients who were 26 years of age and older, those who were widowed, those who were not working, those who had social insurance, those who were living in village, those who defined their relationships with their

family and social circle as very good and those whose income and expense were equal had higher total median scores.

In line with the results obtained in the study, the following are recommended for intensive care nurses:

- to provide spiritual care by being aware of both their own and patients' spiritual needs;
- to identify the spiritual needs of patients with valid and reliable measurement tools;
- to plan the care of patients in a way that prevents and maintains their integrity;
- to implement non-pharmacological nursing interventions such as holding patients' hands, massage, music, relaxing and meditation therapies and to evaluate the results in order to decrease patients' spiritual distress; and
- for researchers to carry out both qualitative and quantitative studies since the number of studies on spiritual well-being levels of intensive care patients is limited.

Conflicts of interest

We have no conflicts interests to disclose.

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