SPIRITUALITY AND SPIRITUAL CARE IN NURSING PRACTICE: A CASE OF BACHELOR OF NURSING SCIENCE PREPARED NURSES IN BOTSWANA.

Janet Kuhlmann
University of Botswana
Faculty of Education
jkuhlmannk@gmail.com

Mmule Magama
Centre for Academic Development
mmule001@gmail.com

James Amanze

Department of Theology and Religious Studies
amanzejn@mopipi.ub.bw

Abstract

Historically, nursing care evolved as a vocation in the religious milieu for those who were freed from self – preoccupation by knowledge of God's love. The spiritual heritage of nursing origin, having been eroded by secularization, technology and materialism, is now gaining popularity as a component of holistic care. Without spiritual care, health care remains unbalanced and this makes holistic care a dream too far to reach. Spiritual care provides attention to the feelings of patients. The common feelings include, but not limited to, desire for love, faith, trust, and other inspiration that provides meaning and purpose for existence. According to literature, patients indicate desire to have their spiritual needs to be met during illness, nurses also acknowledge that patients as spiritual beings are in need of spiritual care. Researcher's view is that, nurses find it difficult to conduct spiritual assessment or to meet patients' spiritual needs and this may possibly be due to lack of knowledge. This report is a part of a larger mixed method study conducted to explore knowledge and attitudes of nurses about Spirituality and Spiritual care in one of the cities in Botswana.

A qualitative approach was used on a focus group of 15 baccalaureate nurses involved directly with patient care in 24 hour operating clinics in one of the cities in Botswana. A purposive sampling method was used to select the respondents while a semi structured interview was used to collect data.

Using Atlas ti software for qualitative analysis, themes that emerged from participants' direct codes revealed that nurses lacked education on spirituality and spiritual care. Asked if they experienced any challenges for offering spiritual care, nurses became more focused on other concerns such as environmental stressors which included lack of medical equipment and poor staffing. Patients' religious and cultural practices were cited as delaying attendance to modern health care. Personal barriers, burnout, stress and compassion fatigue were some of the issues raised by nurses.

Findings revealed that, disabling environment and compassionate fatigue was a major cause for failure to provide spiritual care. Provision of supervision, support and mentoring of staff are strategies essential for alleviation of stress and burnout that prevents nurses from offering spiritual care to patients. Health care

system policies and Stakeholders need to embrace the spiritual welfare of patients and health care providers.

Keywords: Spirituality, Spiritual care, Nurses, Patient.

Background and Introduction

Historically, nursing care evolved as a vocation in the religious milieu for those who were freed from self – preoccupation by knowledge of God's love and were enabled into fruitfulness for others as an instrument by which they lived (Bradshaw, 1994 p.334). This scenario is now lost as a result of secularization, materialism, technology and medical model where some of the Health Care Providers now identify patients by diseases and bed numbers, disregarding human and spiritual aspects (McSherry 2006).

Today, the unbalanced view of health is being challenged as conversations regarding holism are being revisited in society to consider spirituality as a component of holistic care. Though the concept of spiritual health is captured in definitions that explain meaning of health, a component of spirituality is missing and or not effectively addressed in health care delivery (Meier, St. James O' Connor & Van Katwyk, 2005). This missing component defeat the purpose of care as patients exhibit spiritual distress while health care professions find work meaningless due to failure to gratify the needs of their clients.

Puchalski (2009) defines spirituality as that aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred. Spiritual care involves how nurses should render care; it incorporates respect for patients' dignity, unconditional acceptance and love. It involves an honest health professional who encourage a positive nurse-patient relationship and foster hope and peace (Sawatzky & Pesut, 2005, p.23 Meyer, 2003, Baldacchino, 2008 & Lantz 2007).

Spiritual care addresses an affective domain in which a nurse demonstrates feelings that demonstrate existence of love, faith, trust, awe and inspiration. The need for spiritual care is more noticeable when an individual faces emotional and spiritual stress, due to physical illness. (Murray & Zentner 1989). Spiritually based activities such as prayer and meditation decrease the fear of death; increase comfort and support and add a positive perspective of death amongst gravely ill patients. Evidently, Nurses seem to have deficient skill on how to provide spiritual care during challenging and stressful times such as critical illness or end of life.

The Problem

Literature about spirituality and spiritual care is limited in Africa; most studies conducted were from the Western countries such as United States and United Kingdom; very few have been conducted locally and regionally. According to the researcher's views, nurses seem to experience difficulty in conducting spiritual assessment and meeting spiritual needs of patients. This could be due to lack of knowledge on the aspect of spirituality and the possibility that nursing curriculum does not cover this component. It is therefore possible that Nurses' limitation in

spiritual knowledge and skill could be one of the main barriers in achieving holistic care and a major cause for patients' grievances. Additionally, the Media, public and Policy makers have raised several issues against the nurses, lamenting poor nursing care, lack of commitment to work, negligence and failure to provide spiritual care which negates the very essence of human caring. According to Newell in Mmegi on line (July2011), a chief nursing officer in a workshop for Nursing and Midwifery council of Botswana, affirmed that complaints of pay by nurses could be blamed for lack of motivation, shoddy and unprofessional conduct amongst nurses in the country.

Purpose of the Study

The purpose_of this study was to investigate the extent to which nurses prepared at Bachelor's degree are knowledgeable about spirituality and spiritual care. Respondents were required to explain a) what they understand about and spiritual care, b) how they provide spiritual care in their settings and the c) challenges or barriers that prevent them from offering spiritual care focusing on factors such as environment, religion, personal and cultural.

Objective of the Study

The objectives of the study were to sensitize stake holders about the importance of spirituality in patient care and the need for inclusion of spirituality component into the curriculum for nursing education. Hence, the study is significant for a) educators responsible for nursing curriculum review and development, b) practicing nurses in the 21st century who are required to offer holistic care, c) researchers who seek to add more knowledge around the subject matter, d) the policy makers requiring development of policies that could improve patient experience, e) nurses and patients who seek gratification from offering or receiving quality nursing care.

This report is part of a larger mixed method study conducted to explore knowledge and attitudes of nurses about Spirituality and Spiritual care in one of the cities in Botswana. The report only covers a section that employed Focus group discussions to reveal deeper narrations that the quantitative part could not furnish. The following discussion provides details about methods, results, discussion and conclusions.

Methods

A Qualitative design approach was used as a suitable method for gaining insight into the nurses' conceptualization and experiences about the spirituality and spiritual care. Qualitative approach is highly versatile and offers a researcher opportunity to be flexible in selecting or combining data collection methods such as observations to note none verbal cues.

Sampling and Sample Size

Selected sample was conveniently drawn from nurses who had undergone Bachelor of nursing degree. This cadre was selected for its advanced level of preparation compared to nurses trained at a lower level. Bachelor prepared nurses are more skilled on issues of research, contemporary strategies that improve care, a better understanding of evidence based practice and holistic care. Respondents preferred to be interviewed at the place of work due to lack of time.

Sites Selection

Out of eight (8) clinics in Gaborone city, three were selected purposively based on the premise that these clinics are busy and operate for 24 hours.

Tools

A self-developed semi structured focus group discussion guide was used to direct discussions. Development of the tool was guided by a tool developed by McSherry, Draper and Kendrick (2002) in an exploration of knowledge and attitude on spirituality and spiritual care on ward based nurses in United Kingdom. The tool was used in 43 studies in 11 countries. Permission to use the tool was granted by the developer.

Data collection Process

A semi structured focus group guide was used to collect data; voice recorder was used to capture conversations and field notes were recorded by the research assistant while the researcher observed body language and non-verbal cues. The information was later compared and contrasted to make conclusions. Prior to data collection, Respondents were assigned identity numbers that ranged from one (1) to fifteen (15) in order to ensure confidentiality. A letter of permission to conduct research was read and a consent form was signed. At the end of the focus group discussions, respondents were educated on spirituality and spiritual care for 90 minutes.

Data Interpretation

The qualitative data were thematically analyzed and transcribed and imported into Atlas ti to produce codes and themes and conclusions were made.

Results

A homogenous group of 15 respondents with Bachelor's degree qualification recruited from clinics that operate for 24 hours were involved in the focus group discussion. Two (2) were male respondents while the rest were females. Twelve (12) respondents' ages ranged between 30 to 39 years while three (3) were above the age of 40 years. Eleven (11) respondents belonged to the rank of nursing officer 1; two (2) were in the rank of senior nursing positions and two (2) were principal nursing officer 2. All respondents worked in rotational shifts in the following Units: a) HIV and AIDS, b) Outpatient department, c) Gynecology, d) Maternity and e) General wards.

Understanding of Spirituality and Spiritual Care

In response to what respondents understand by the term spiritual care, respondents believed that spiritual care is when nurses treat patients as spiritual being, considering their religion and cultural beliefs. Calling a priest for the dying as well as praying and singing before work were also considered as spiritual care. The following statements were made by respondents to define spirituality and spiritual care:

a) *"a bio psycho social spiritual being*."

b) "*Caring for them within their religious beliefs, not imposing your beliefs on the patients*.
c) "*Leaving the patient religious beliefs intact*,"
d) "*Recognizing that not everybody is religious,"*
e) "*Calling a priest for the dying"*
f) "*Praying and singing before work*

All the above responses showed most nurses were unanimous in agreeing that a patient is a bio-psycho-social spiritual being, who requires care based on his/her belief system. For example, one respondent explained that: "*Maybe I would say, first we need to understand that man is made up of body mind and soul so when you give care, you need to do so within these three states."*

Chuckling, another respondent said… "*I believe spiritual care is when you first understand the religion of that person"* (Osa kgotlhele – the patient's religion (meaning – leaving the patient's religion intact) e.g. take Moslems, Baha'i faith- you must first understand them.'

Provision of Spiritual Care: Responding to a question that explored respondents' ability to provide spiritual care, most respondents felt it was not easy because of lack of educational preparation. Some respondents cited strategies for offering spiritual care as, involving patient and family in care of clients (client centered), reassuring and instilling hope to anxious patients, calling a pastor for the dying patient, singing and praying before work. According to one respondent,

> '*It is not easy- we health care professionals are not equipped to deal with many of the problems we meet in caring. The problems are diverse, but we try by usually starting the day by singing and praying in the mornings in the presence of the patients to gain strength and give patients some hope. Calling and allowing visitation of spiritual healers or priests in the ward is also constituting spiritual care.*

Challenges

Considering the challenges or barriers that prevent nurses from providing care, respondents cited barriers such as environmental factors, culture and religion as well as the personal factors of the nurse. Themes emerging from statements included *"lack of space for counseling patients", "lack of appreciation by patients, colleagues and nursing leaders," "high number of patients", "overworked nurses due to shortage", "religious practice that clash with contemporary medicine". "Harmful religious practices", "cultural beliefs that hinder timely management of conditions"* were some of the barriers mentioned. According to 1 respondent,

> *'There is no time to relax with patient and speak because of high patients' numbers waiting to be seen. Patients have to trust you first before they can trust you with deep concerns.*

Furthermore, respondent explained that, the patient whose real reason for inducing diarrhea and vomiting to get rid of too much gall/bile is not given chance to give detailed history. Due to time constraints, the nurse may order something else to get rid of the patient so that the chapter is quickly closed.

Religious Factors

In order to accommodate the patient's beliefs, respondents usually try to accommodate patient's religion. However, respondents expressed that most of the time patients' beliefs *"tend to slow*

down progress and can cause harm." According to respondent, a simple problem that could have been easily solved may be complicated because the patient was still treated at the church.

Cultural factors

Respondents cited that a cultural belief may also cause delay in administering therapy. One respondent explained a scenario where a woman from one of the villages brought a child with diarrhea and vomiting. Another patient pulled her from the crowd and took her to a traditional healer.

> Unfortunately, *"after few days the woman returned with the dying baby who had black marks all over the body. Despite all resuscitative attempts, the baby did not survive and the woman was sobbing uncontrollably but no one of us had any sympathy for her.*
> *How do nurses deal with some of these problems where patients come to the hospital with complications that could have been averted?"* According to respondent, this kind of a situation *"causes ethical dilemma which leaves us nurses emotionally drained and not even empathetic towards the patient."*

Personal factors:

One respondent felt Patients come to them with problems to solve, wondering if patients are aware of what nurses are sometimes going through or "*what I am going through in my life.*

May be I am emotionally abused by my spouse; I have no accommodation or undergoing divorce. Possibly, if I had been educated on how to handle patients or even how to handle my own stressors, burnout and fatigue at work, it would be better.''

Discussion

According to evidence, respondents were conversant with a man as a biopsycho-social spiritual being- a model that is referred to by most nursing text books. Respondents understanding of this concept may be emanating from nursing foundation courses that require understanding of the concept of human being and human needs. However, it was evident that respondents' understanding of spirituality and spiritual care was somehow deficient demonstrating that respondents may have not learnt the subject formally and systematically. Most respondents linked the subject with religion with more alignment to Christianity demonstrating that, respondents did not learn the subject in a formal and systematic approach. While there is a slim difference between the two terms, according to Puchalsky et al, (2009) spirituality is that aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred. Religion is a multidimensional construct that includes beliefs, behaviors, rituals, and ceremonies that may be held or practiced in private or public settings but are in some way derived from established traditions that developed over time within a community (Koenig 2001 et al, p. 288-487)

Evidence further revealed that in offering spiritual care, nurses tended to focus on general environmental issues. However, respondents finally acknowledged that it was not easy because of lack of education on spirituality and spiritual care. Singing and praying were some of the strategies for providing spiritual care. According to a survey by Monareng (2013:7) prayer and use of spiritual songs was the most common and simplest form of spiritual nursing care. Exploring the

meaning of religion and spirituality, it is clear that what nurses provide is more inclined to religious care.

Barriers that impede spiritual care were found to be environmental factors; as well as personal, culture and religion. Respondents raised issues such as shortage of staff and medical equipment as the main hindrance to achieving holistic care. There may be genuine reasons for such a response. However, there may be other factors to consider; lack of skill and knowledge in understanding the spiritual subject matter and some of the tactics that nurses may use to avoid responsibility of providing holistic care to clients may also exist. McSherry (2006) argued that some of the excuses given by nurses for failure to provide spiritual care may be a way of avoiding involvement with the patients. He further states that, spiritual care can be provided within the context of general care, for example, bathing a patient, dressing a wound, feeding, giving injection, and taking medical history. McSherry argues that, these activities can all be used as an opportunity to build trust and offer spiritual support.

According to evidence, respondents believe some religious beliefs held by patients slow down progress of healing and could even cause harm to the patient. This is congruent with, McSherry (2006) perspective that cautions against religious fanatics who will not see any other solution to the problem except their personal religious perspectives. Kealotswe (1994) has added that some of the churches have institutional homes of care where they pray and lay hands on people with chronic diseases such as HIV and AIDS and cancer to heal them. According to the researcher, health care professionals sometimes find themselves helpless to advice desperate families against institutionalization – even though they know the patient is better off in the hospital.

While culture has been identified as delaying medical attention in this study, it may be necessary to seek ways of integrating culture into the health care system. Introducing nurses to a subject on cultural sensitivity is an essential strategy because culture can never be divorced from human way of life. According to Olupona (2016) religion can never be separated from culture, society or environment of an African. It is a way of life. Culture informs everything in traditional African society including politics art, marriage, health, diet, dress, economics and death. The WHO Report of 2006 affirmed that 80% of Africans still seek help from traditional healers sometimes in secrecy, for fear of ridicule. Therefore, nurses need to find ways of dealing with cultural issues that affect health.

The impression created by respondents was that, they long passed the stage of stress and burn out; all that was left was to continue working in a stress filled environment to earn a living. This status quo has been highlighted by Oosthuizen (2012) analyzed the context of South African nurses as caring, compassionate and knowledgeable professionals, but these good findings were overshadowed by negative reporting articles that portray nurses as overworked, uncaring, lazy, ruthless, and incompetent and suffering from burnout.

Conclusions

In this study, disabling environment is a major hindrance for provision of spiritual care and a cause for compassion fatigue felt by health care workers. Spirituality and spiritual care needs an entrenched systematic inclusion of the course into the nursing curriculum. Provision of support and mentoring of nurses is essential, stress management forums are to be in place to allow nurses

debriefing and respite from spiritually distressing situations. Policy makers need to own health related issues by embracing the welfare of patients and nurses. More nursing research is required for clarity and understanding of spirituality and how it is operationalized through spiritual care.

References

Baldacchino, D.R. (2008) Teaching on the spiritual dimension of care to undergraduate students: The content and Method. *Nurse Education Today* 28(5), 3-14.

Bradshaw, A. (1994) *Lighting the lamp; the spiritual dimension of nursing care*. Harrow: Scutari Press.

Kealotswe, O.N. (1994) The nature and character of the African Independence Churches (AICs) in the 21st Century; their technological and social agenda. *Studia Hist. Ecc.* Vol 40 n. 2 Pretoria: PP. 122-124.

Kozier, B., Erb, G., Blais, K., & Wilkinson.J. (1995).*Fundamentals of nursing: concepts: Concept process and practice* (5th Ed.) Menlo Park, CA: Addison – Wesley.

Lantz, C.M. (2007) Teaching spiritual care in a public institution: legal implications, standards of practice, and ethical obligations. *Journal of Nursing Education* 46(1), 33-38.

Meier A & St James O' Connor & Van Katwyk (2005) Spirituality and health multidisciplinary exploration (Ed) Waterloo Ontario. [Online] Available from: https://doi.org/10.1002/S 320 (Assessed
17th September 2018]

McSherry, W. (2006) *Making sense of spirituality in nursing practice: an interactive approach.* Edinburg: Churchill Livingstone.

McSherry, W., Draper, P., & Kendrick, D. (2002). The construct validity of a rating scale designed to Assess spirituality and spiritual care. International Journal of Nursing Studies 39(7) 723-724.

McSherry, W., & Draper, P. (1998) 'The debates emerging from the literature surrounding the concept of spirituality as applied to nursing'. *Journal of Advanced Nursing 27, 683-69*

Olupona, J (2016). *The spirituality of Africa*. Harvard Gazette. Oxford University Press. UK.

Oosthuizen, M.J (2012). The portrayal of nursing in South African newspapers: A qualitative content
Analysis. *African Journal of Nursing and Midwifery* 14(1) pp. 49-62.

Puchalski C.M. (2009). Physician and Patients' Spirituality; Ethical Concerns and Boundaries in Spirituality and Health. AMA *Journal of Ethics*. Available from doi 10.1001/virtualmentor.2009.11.10oped1-0910

Ross, (1996). The nurse's role in assessing and responding to patients' spiritual needs. *International Journal of Palliative Nursing* 3 (1), 37-42.

Sawatzky, R., Pesut, B., (2005) Attributes of Spiritual Care Nursing Practice. *Journal of Holistic Nursing*, 23 (1), 19- 33.

The World Health Report (2006) Working together for health. Available https://www.who.int/whr/2006/whr06.e..pdf. [Accessed 02/10/2017]