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Assessing spiritual well-being of Palestinian Cardiac Patients: A reflection for a new spiritual care policy

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Abstract

Religious and spiritual beliefs are important factors that influence quality of life outcome of patients diagnosed with chronic diseases such as heart disease. Spirituality is an important component of overall well-being as it helps in reducing the levels of stress, depression and anxiety. The purpose of this study was to assess spiritual well-being of Palestinian cardiac patients admitted to coronary care units in Gaza Strip. A cross-sectional design was used in this study using the Spiritual Well-Being Scale (SWBS). A total of 275 patients who were diagnosed with a heart disease and admitted to coronary care units at Gaza Strip's hospitals participated in this study. Results revealed high scores of SWBS. Scores for the total SWBS was 101.58 (±9.49) while was 57.25 (±1.18) for Religious Well-Being (RWB) and 44.32 (±6.20) for Existential Well-Being EWB subscales subsequently. Results of this study revealed high scores of SWBS which should be considered by health care providers and health policy makers to adopt new spiritual care policy for cardiac patients and other patients diagnosed with other chronic diseases.

Keywords:
Cardiac Disease,
Spiritual Care,
Spiritual Well-Being,
Spirituality.

1. Introduction:

Heart disease is very common in Palestine. According to the health annual report, it was the leading cause of death among Palestinians and accounted for 27.5% of death cases occurred in 2015 (Ministry of Health, PHIC, 2016) . The number of deaths due to cardiovascular diseases increased from 23.5% in 2010 (Ministry of Health, PHIC, 2011) to 27.5% in 2015 (Ministry of Health, PHIC, 2016). Diagnosis with a chronic disease, such a heart disease, markedly alters the lives of patients and their family members physically and psychologically (Clay, Talley, & Young, 2010)

Patients diagnosed with cardiac diseases, especially those admitted to coronary care units (CCUs), are exposed to various types of anxiety, depression, uncertainty, and psychological distress (McBride, Clipp, Peterson, Lipkus, & Demark-Wahnefried, 2000; Rufener, 2011). Depression is common among cardiac patients (Rutledge, Reis, Linke, Greenberg, & Mills, 2006) and it worsens their general health status (Rumsfeld et al., 2003). Moreover, it

negatively impacts quality of life (Sullivan, Newton, Hecht, Russo, & Spertus, 2004) and social and physical functioning (Vaccarino, Kasl, Abramson, & Krumholz, 2001). Cardiac diseases were also associated with repeated hospitalizations and higher mortality rates (Jiang et al., 2001; Vaccarino et al., 2001). Repeated hospitalizations of cardiac patients increase utilization and total cost of health care services (Grant et al., 2004; Sullivan et al., 2004). Furthermore, repeated hospitalizations expose patients to higher levels of anxiety and stress (Rieck, 2000). On the other hand, experiencing pain and discomfort, uncertainty, invasion of privacy, dealing with strangers and unknown care givers, and dependence on others during hospitalization leads to spiritual pain and isolation from their old routine lives and the world around them (Noguchi et al., 2006).

To cope with their feelings during this time, many patients rely on spirituality and religious beliefs to alleviate their stress, maintain hope and sense of meaning and purpose in life, and to retain a sense of control (Koenig, Larson, & Larson, 2001). At the same time, other patients may lose faith in their religious beliefs, therefore; they will seek for alternative methods to alleviate their feelings (Büssing, Ostermann, & Matthiessen, 2005). Spirituality is believed to be an important component of overall well-being and it is especially significant in relation to how patients cope with their morbidity (Levine & Targ, 2002).

As a result, prevention and relief of stress and suffering and improving spiritual well-being should be a major goal in treatment (Oates, 2004). Therefore, providing cardiac patients with spiritual support becomes necessary since they are subject for an increasing number of stressors and spiritual distress. Several studies conducted in Gaza strip revealed inadequate provision of spiritual care despite the recognition and belief of health care providers and cardiac patients regarding the importance of providing spiritual care (Abu-El-Noor, 2012; Abu-El-Noor & Abu-El-Noor, 2013; Abu-El-Noor, 2016). Health care providers reported several barriers for such inadequacy (Abu-El-Noor & Abu-El-Noor, 2016). The purpose of this study was to explore spiritual well-being of patients living in Gaza Strip, Palestine who were diagnosed with cardiac diseases and admitted to coronary care units.

2. Methodology

A cross-sectional, descriptive design was used in this study. The study targeted all patients diagnosed with a cardiac disease who were admitted to coronary care units (CCUs) in the Gaza Strip hospitals. A convenient sample of 275 adult patients who were admitted to all CCUs in Gaza Strip was used in this study. Patients were privately interviewed at the medical centers where they receive treatment. Patients who were passing through critical conditions were not interviewed until their condition was stabilized so that the interview will not affect their health conditions. After explaining the purpose of the study to each participant, each participant was asked to sign a consent paper reflecting his/her agreement to participate in the study. Prior to conducting the study, permission from the research review board at the ministry of health was obtained to conduct the study.

The instrument used in this study consisted of two parts. The first part included demographic data such as age, gender, marital status, and level of education of participants. The second part of the instrument was the Spiritual Well-being Scale (SWBS). The original SWBS was developed by (Paloutzian & Ellison, 1982). SWBS consists of 20 items that are divided into two main subscales: religious well-being (RWB) and existential well-being (EWB). Each domain includes ten items. The RWS provides an assessment on one's relationship with God and the sense of comfort derived from this relationship, while the EWB assess one's sense of purpose, infer peace, hopefulness and overall satisfaction (Edmondson, Park, Blank, Fenster, & Mills, 2008; Musa & Pevalin, 2012).

The SWBS is a self-reported scale that is scored on a six-point Likert-Scale that ranged from one (strongly disagree) to six (strongly agree). The highest possible score for each subdomain is 60 while the highest level of SWB scale is 120. Higher scores reflect a higher perception of one's spiritual well-being. Classification of SWB scores is as follows: participants score from 100-120 have high spiritual well-being, while those score between 41-99 have moderate spiritual well-being, and those who score less than 40 are considered to have low spiritual well-being (Abbasi, Farahani-Nia, & Mehrdad, 2014).

SWBS was translated into the Arabic language and validated by Musa and Pevalin (2012) with a Cronbach's alpha of .83 for the entire SWS and .90 and .75 for the RWB and EWB subscales respectively.

Statistical Package of Social Science (SPSS) version 20 was used to analyze data. Negatively worded items were inversed before running data analysis. Data were analyzed using descriptive statistics (mean, standard deviation, frequency, and percentage). Independent *t*-test was used to compare the means in relation to different variables and Pearson correlation was used to detect correlation among some variables of the study.

3. Results

3. 1 Characteristics of the sample

A total of 275 patients diagnosed with cardiac disease participated in the study; 151 males (54.9%) and 124 females (45.1%). Age of participants ranged between 24 and 100 years with a mean of 58.7 (ST = ±12.8) years. Table **1** represents the characteristics of the participants. The majority of patients (75.9%) are over the age of 50 years and most of them (75.9%) had no school or just finished primary school. Only 37.8% of participants needed surgical intervention, but most of them (70.9%) have a history of at least another chronic disease.

The great majority of participants (n=264, 94.9%) pray five times a day while only two participants reported that they don't pray at all. Moreover, 21.8% of participants listen to the Holy Quran several times a day (Table 2).

3. 2 Spiritual Well-Being

The results of the Spiritual Well-Being Scale for our participants and its subscales are presented in Table **3**. The score for the total SWBS was 101.58 (±9.49) while was 57.25 (1.18±) for RWB subscale and 44.32 (±6.20) for EWB subscales. When the mean of scores of RWB was compared with the mean of scores for EWB, the differences between them were found to be statistically significant with a p value of < 0.0001.

Scores of RSW subscales ranged between 5.08 for "I feel a sense of well-being about the direction my life is headed in" and 5.92 for "I feel most fulfilled when I'm in close communion with God." Scores of EWB subscale ranged between 1.95 for "I don't enjoy much about life" and 5.58 for "My relationship with God helps me not to feel lonely."

3. 3 Factors that affect spiritual well-being

Pearson's correlation test revealed that age was not correlated with SWS or its two subscales; while it revealed that it was positively correlated with frequency of prayer (p value is less than .0001) and negatively correlated with length of hospitalization. On the other hand, one way ANOVA test showed that there were no statistically differences among the scores of SWB scale and its subscales among participants in relation to their level of education. Similarly, t test revealed that there were no statistically significant differences between the scores of SWS or its subscales in relations to participants' gender (male or female), marital status (married or not), work status (working or not) or between those who had only heart disease and those who had another chronic health disorder. There are statistically significant differences in the means of the religious and total wellbeing among those who had surgical interventions and those who did not (p < .0001). Those who did not need any surgical interventions had higher means (religious wellbeing = 55.65, total wellbeing = 98.17) than those who did not (religious wellbeing = 58.22, total wellbeing = 103.66).

Table 1 *Characteristics of participants*

Variable		Frequency	Percentage
Gender	Male	151	54.9
	Female	124	45.1
Age Category	≤ 40 Years	15	5.5
	41-50 Years	51	18.6
	51-60 Years	81	29.6
	61-70 Years	78	28.5
	71-80 Years	36	13.1
	>80 Years	13	4.7

Level of education	Primary school and below	219	79.7
	Finished secondary School	2	.7
	Finished High school	53	19.3
	Higher Education	1	.4
Marital status	Single	23	8.4
	Married	168	61.1
	Divorced	36	13.1
	Widowed	48	17.5
Work status	Working	68	24.8
	Not working	206	75.2
Surgery	Needed surgical intervention	104	37.8
	Did not Need surgical intervention	171	62.2
Health issues	Have a history of other chronic diseases	195	70.9
	Have no history of other chronic diseases	80	29.1

Table 2 *Frequency of listening to the Holy Quran*

Variable		Frequency	Percentage
Listening to Quran	Absolutely not	4	1.5
	once monthly	12	4.4
	2 or more a week	25	9.1
	2-6 times a week	67	24.4
	once daily	107	38.9
	several times a day	60	21.8

Table 3 *Results of the Spiritual Well-Being Scale.*

	Item	Mean	Std. Dev
Religious well-being	**Religious Wellbeing (maximum score is 60)**	**57.25**	**1.18**
	*I don't find much satisfaction in private prayer with God.	5.85	.55
	I believe that God loves me and cares about me.	5.85	.46
	*I believe that God is impersonal and not interested in my daily situations	5.69	.66
	I have a personally meaningful relationship with God.	5.88	.45

	*I don't get much personal strength and support from my God.	5.61	.93
	I feel a sense of well-being about the direction my life is headed in.	5.08	1.38
	I believe that God is concerned about my problems.	5.81	.54
	*I don't have a personally satisfying relationship with God.	5.65	.87
	I feel most fulfilled when I'm in close communion with God.	5.92	.53
	My relation with God contributes to my sense of Well-being.	5.90	.43
	Existential Wellbeing (maximum score is 60)	**44.32**	**6.20**
Existential well-being	*I don't know who I am, where I came from, or where I'm going.	5.53	.83
	*I don't enjoy much about life.	1.95	1.16
	I feel that life is a positive experience.	4.95	1.26
	*I feel unsettled about my future.	3.9	1.76
	My relationship with God helps me not to feel lonely.	5.58	1.07
	*I feel that life is full of conflict and unhappiness.	3.25	1.71
	I feel very fulfilled and satisfied with life.	5.33	1.01
	*Life doesn't have much meaning.	4.09	1.76
	I feel good about my future.	4.62	1.39
	I believe there is some real purpose for my life.	5.10	1.18
	Spiritual Wellbeing (maximum score is 120)	101.58	9.49

* items that were reversed

4. Discussion

Recently, there is more interest and emphasis on the relationship between spirituality and physical and psychological health, reflecting the importance of the influence of spiritual well-being on health (Clay et al., 2010; Huitt & Robbins, 2003). Previous studies showed that spiritual well-being is positively connected to social support, purpose of life, lower depression rates and lower stress levels (Yi et al., 2006) and has a positive impact on health (Bredle, Salsman, Debb, Arnold, & Cella, 2011; Koenig, 2013). Therefore; the current study was conducted to explore spiritual well-being of cardiac patients admitted to CCUs at the Gaza Strip, Palestine. Mean scores of SWBS, RWB, and EWB of this study were 101.58, 57.25, and 44.32 respectively. Our participants have a high level of spiritual well-being. According to Abbasi et al. (2014), scores of more 100 of SWBS are considered high. These findings go on line with other studies (Abu-El-Noor & Radwan, 2015; Bai, Lazenby, Jeon, Dixon, & McCorkle, 2015; Bufford, Paloutzian, & Ellison, 1991; Ellison & Smith, 1991; Genia, 2001; Hendricks-Ferguson, 2008; Jafari et al., 2013; Miller, Fleming, & Brown-Anderson, 1998; Morgan, Gaston-Johansson, & Mock, 2006; Musa & Pevalin, 2012; Peterman, Fitchett, Brady, Hernandez, & Cella, 2002; Rippentrop, Altmaier, & Burns, 2006; Tate & Forchheimer, 2002), who found that the mean scores of spiritual well-being were high among participants of various religious beliefs. Moreover, the mean score levels of SWB, RWB, and EWB in this study are similar to scores reported in other studies using participants diagnosed with various diseases. For example, the mean scores of SWB, RWB, and EWB were high in patients diagnosed with breast cancer (Mickley, Soeken, & Belcher, 1992); patients diagnosed with prostate cancer (Abu-El-Noor & Radwan, 2015), patients following a coronary artery bypass graft (CABG) surgery (Musa & Pevalin, 2012), patients received kidney transplant (Martin & Sachse, 2002); and adult primary care patients who seek treatment of acute and/or chronic complaints (Skye, 1998).

The high level of spiritual well-being reported by the participants of this study could be attributed to the fact that the majority of the participants were older than 50 years old (mean age=58.7 years), and being married (61.1% of participants). These factors have been associated with higher levels of spiritual well-being in previous different studies (Abu-El-Noor & Radwan, 2015; Clay et al., 2010; Meraviglia, 2003; Mystakidou et al., 2008; Peterman et al., 2002). Moreover, literature revealed that at critical times, such as being diagnosed with cardiac diseases, people get closer to the divine (Salman & Zoucha, 2010) and praying becomes useful in facilitating the process of health and promoting the sense of hope during such critical times (Doucet & Rovers, 2010).

The mean score for RWB (57.25) was higher than the mean score for EWB (44.32). This difference was found to be statistically significant. Such a difference can be related to the deep beliefs of Muslim participants in Allah and their beliefs in fate and destiny (Abu-El-Noor & Radwan, 2015). This also emphasizes the importance of the vertical aspects of spirituality, which involves aspects of relationships between the individuals and their God. Through this vertical aspect, Muslim patients become closer to Allah to increase their spirituality by adhering to religious practices, such as prayer, paying Zakat, fasting, and reciting the Holy Quran (Musa & Pevalin, 2012).

Similar results were reported by another two studies that were conducted in Muslim communities. Musa and Pevalin (2012) assessed spiritual well-being among Jordanian patients following a CABG surgery. Participants reported a mean score of RWB of 58.2 and a mean score of EWB of 45.7 respectively. In the second study, Abu-El-Noor and Radwan (2015) assessed spiritual well-being among Palestinian Muslim patients who were diagnosed with prostate cancer. Their participants reported a mean score of RWB of 58.91 and a mean score of EWB of 42.25 respectively. On the other hand, another study conducted by Martin and Sachse (2002) reported inversed values. Their participants reported lower mean scores for RWB (48.6) than the mean scores for EWB (53.4) among kidney transplant recipients. However, other studies reported close values with marginal differences between RWB and EWB (Mickley et al., 1992; Skye, 1998).

The results of this study revealed that the scores of SWBS and its subscales were not affected by level of education, age, gender, marital status, job status (working or not) and having another chronic health disorder besides heart disease. These findings are consistent with other previous studies which

reported that socio-demographic data did not correlate significantly with SWBS and its subscales' scores (Abu-El-Noor & Radwan, 2015; A Büssing, Balzat, & Heusser, 2010; Darvyri et al., 2014). On the other hand, another study revealed that some socio-demographic factors such as age, gender, marital status, ethnicity, and type of disease had an impact on spiritual well-being of participants (Peterman et al., 2002).

5. Conclusions and recommendations

The results of this study revealed high scores of Spiritual Well-Being Scale and its subscales. Scores of RWB were higher than scores of EWB which requires further investigation to explore the reasons behind such a difference. Scores of levels of well-beings were not influenced by several socio-demographic factors such as level of education, age, gender, marital status, job status, or having other chronic health conditions.

Results of this study provide a preliminary insight into spiritual well-being of Palestinian Muslim patients diagnosed with a heart disease. These findings are supported by similar results from other studies in breast cancer survivors (Ferrell, Grant, Funk, Otis-Green, & Garcia, 1998), prostate cancer (Abu-El-Noor & Radwan, 2015) and colorectal and lung cancers (Clay et al., 2010). Therefore, health care professionals, especially those working in coronary care units, must be aware of spiritual needs and concerns of their clients and integrate spirituality into the care of their clients.

The importance of spirituality in health care and the impact of spiritual care were eminent in the literature. For example, one study revealed that provided spiritual care acts as a protector against depressive symptoms and improves coping and adjustments of patients to their health conditions (Gonzalez et al., 2014). Other studies revealed that providing spiritual care improves the sense of purpose, meaning in life, peace, and relationship (Edwards, Pang, Shiu, & Chan, 2010) and serves as a buffer against stress and maladaptive coping (Gonzalez et al., 2014).

Moreover, literature showed that spirituality is positively connected to purpose of life, social support, lower stress, and lower depression and anxiety levels (Mueller, Plevak, & Rummans, 2001; Wachholtz, Pearce, & Koenig, 2007; Yi et al., 2006). Furthermore, spirituality has a positive impact on physical and mental health as well as health-related quality of life (Balboni et al., 2007; Campbell, Yoon, & Johnstone, 2010; Finkelstein, West, Gobin, Finkelstein, & Wuerth, 2007; Krupski et al., 2006; Nelson, 2009; Park et al., 2013; Vallurupalli et al., 2012), lowers levels of discomfort and anxiety (Krupski et al., 2006; Leak, Hu, & King, 2008), has an impact on better health (Bredle et al., 2011; Koenig, 2013), and will help patients to cope more effectively with the process of terminal illness and find meaning in the experience (Lin & Bauer-Wu, 2003). Therefore, assessment of spiritual well-being of patients is an essential component of the holistic approach to screen for spiritual suffering and to identify those who need spiritual care (Selman, Harding, Gysels, Speck, & Higginson, 2011; Sulmasy, 2002).

Other studies claimed that involvement of religious aspects in health care has positive impact on physical and mental health, therefore, reducing mortality rate (Hamilton, Powe, Pollard III, Lee, & Felton, 2007; Hummer, Ellison, Rogers, Moulton, & Romero, 2004; Morgan et al., 2006; Schnall et al., 2010). Similarly, spirituality played significant protective and mediating roles in coping with health-related problems for participants (Hamilton et al., 2007; Newlin, Knafl, & Melkus, 2002).

Therefore; the researcher recommends that health care policy makers at the top levels to pay more attention to this undervalued domain of care. Health policy makers need to tailor and adopt new health policies to assess spiritual needs and to provide spiritual care and promote spiritual well-being of cardiac patients and other groups of patients with different diagnoses. Adopting such policies will improve quality of life (Gonzalez et al., 2014), reduce level of stress, anxiety and depression (Mueller et al., 2001; Wachholtz et al., 2007; Yi et al., 2006) which will lead to decreasing the chance for re-hospitalization, and therefore, reducing the cost incurred by the ministry of health spent on treatment of heart disease and other diseases (Grant et al., 2004; Jiang et al., 2001; Sullivan et al., 2004; Vaccarino et al., 2001).

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