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RESEARCH / ARAŞTIRMA

Examination of Spiritual Care Needs of Oncology Patients and Spiritual Care Competencies of Oncology Nurses

Onkoloji Hastalarının Manevi Bakım Gereksinimleri ile Onkoloji Hemşirelerinin Manevi Bakım Yeterliliklerinin İncelenmesi

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Abstract

Objective: The study aimed to investigate the spiritual needs of oncology patients and spiritual care competencies of oncology nurses caring for the oncology patients.

Material and Method: The study has a descriptive and cross-sectional design. The study was carried out with oncology patients (n=324) and oncology nurses (n=17) who were caring for them in oncology unit of a hospital in the city of İzmir, Turkey. The study data were collected using the Spiritual Needs Scale for the patients and the Spiritual Care Competency Scale-T for the nurses. In statistical analysis, number, percentile, mean score, and standard deviation were used. In the calculations, the level of statistical significance was taken as $p<0.05$.

Results: The mean age of the oncology patients was 57.60±11.41 years. More than half of the patients (61%) indicated at least rarely a need for spiritual care. The mean age of the oncology nurses was 37.11±1.13 years. The nurses' item mean score on the Spiritual Care Competency Scale-T was 3.77±0.45. The nurses' item mean scores on the SSCS-T subscales were 3.34±0.58, 3.44±0.66 and 4.52±0.60 for Assessment and Implementation of Spiritual Care, Professionalization and Patient Counselling in Spiritual Care, and Attitude toward the Patient's Spirituality and Communication, respectively.

Conclusion: More than half of the oncology patients need spiritual care. The spiritual care competencies of the oncology nurses providing care to those patients was at a moderate level.

Keywords: Spirituality, spiritual care, oncology nursing.

Öz

Amaç: Bu araştırma onkoloji hastaların manevi bakım gereksinimlerini ve onkoloji hemşirelerinin manevi bakım yeterliliklerini incelemeyi amaçladı.

Gereç ve Yöntem: Araştırma tanımlayıcı ve kesitsel bir tasarımdadır. Bu araştırma ülkemizin İzmir ilinde bir hastanenin onkoloji biriminde tedavi alan onkoloji hastaları (n=324) ve hastalara bakım veren onkoloji hemşireleri (n=17) ile yapıldı. Araştırmanın verileri hastalar için Manevi Gereksinimler Ölçeği ve hemşireler için Manevi Bakım Yeterlilik Ölçeği kullanılarak toplandı. İstatistiksel analizde, sayı, yüzdelik, puan ortalaması ve standart sapma kullanıldı. İstatistiksel anlamlılık düzeylerini hesaplamada $p<0.05$ alınmıştır.

Bulgular: Onkoloji hastalarının yaş ortalaması 57,60±11,41 yıldır. Hastaların yarısından fazlası (%61), en azından nadiren de olsa manevi bakıma gereksinimi duyduğunu belirtti. Onkoloji hemşirelerinin yaş ortalaması 37,11±1,13 yıldır. Hemşirelerin Manevi Bakım Yeterlilik Ölçeği madde puan ortalaması 3,77±0,45 (min=3,26, maks=4,73)'dir. Hemşirelerin Manevi Bakım Yeterlilik Ölçeğin alt boyutlarının madde puan ortalamaları sırasıyla Manevi Bakımın Değerlendirilmesi ve Uygulanması için 3,34±0,58, Manevi Bakımda Profesyonellik ve Hasta Danışmanlığı alt boyutu için 3,44±0,66 ve Hastanın Maneviyatına Karşı Tutumu ve İletişimi alt boyutu için 4,52±0,60'dır.

Sonuç: Onkoloji hastalarının yarıdan fazlasının manevi bakım gereksinimi vardır. Onkoloji hastalarına bakım veren onkoloji hemşirelerinin manevi bakım yeterlilikleri orta düzeydedir.

Anahtar Kelimeler: Maneviyat, manevi bakım, onkoloji hemşireliği.

1. Introduction

Patients diagnosed with cancer experience a significant amount of stress from the moment they are told about their illness, and sometimes they can be confused and have negative feelings against God, which can further increase their stress (1). Along with their awareness towards cancer diagnosis, patients' spiritual needs increase significantly, and their religious beliefs and self-esteem may change (2). Therefore, it is necessary to use a holistic approach when providing patient care (3). Spirituality is a crucial dimension to consider when treating patients towards the end of life, according to new guidelines on the quality of palliative care (4). The spiritual dimension comes to the fore especially, in crisis where the individual experiences illness, stress, fear of death, questioning the meaning of life and exhausting hope (5). In particular, life-threatening diseases lead to the emergence of spiritual needs (6). Meeting patients' spiritual needs reduces worry, stress, and suffering and it strengthens coping abilities and improves prognoses (7).

Starting from patients' needs, the aim of spiritual care, which is among the basic principles of nursing, is to provide multi-directional care to meet the spiritual needs of patients and their relatives (3). It is expected that nurses are competent to provide the spiritual care needed by patients. Nurses determine a patient's spiritual needs during the care process and perform proper interventions (3,8). However, nurses are not well trained to identify or address spiritual issues, and nursing programs do not adequately equip nurses (9). Research suggests that nurses have an inadequate perception of the meaning of spirituality and how patients benefit from spiritual care, and that their spiritual care training is weak (10).

Literature suggests that oncology patients are one of the patients who most need spiritual care (11,12-14). In the literature, oncology patients' spiritual care needs were caring satisfaction, better quality of life, optimal existential well-being, more palliative care practices rather than aggressive care, and it is stated as the necessity of low cost of end-of-life treatments (12). Oncology patients lose their connection with themselves and their environment due to their diseases, experience uncertainty about the present and the future, meaning and purpose of life are threatened. They need spiritual practices to cope with fears, have a positive perspective, feel love and establish a relationship with God or a great/supreme power (13). Therefore, nurses should have spiritual care competence in meeting the spiritual needs of these patients (4,7-9). However, the studies have shown that nurses are inadequate in meeting the spiritual care needs of patients (4,8,10). In the process until this study is planned, among the studies conducted in Turkey, researchers found very few studies which determined the spiritual care needs of oncology patients (11) and no studies which examined the spiritual care competencies of the nurses caring for these patients were found. In light of this information, the aim of this study was to determine the spiritual care needs of oncology patients, and to assess the spiritual care competencies of the oncology nurses caring for those patients.

2. Materials And Methods

2.1. Design

The type of the study was descriptive and cross-sectional. The study was carried out with oncology patients and oncology nurses who were caring for them, between January and November 2018 in the oncology unit of a hospital in the city of İzmir, Turkey.

2.2. Participants

In date between January and November 2018, the population of the study consisted of the oncology patients (N=600) who were hospitalized or receiving outpatient treatment and the oncology nurses (N=20) who were providing care to the oncology patients in the same hospital. The sample of the patients was selected randomly by the multi-clustered stratified sampling method. The following formula "$n=N.t^2.p.q/d.(N-1)+t^2.p.q$" was used to determine the size of the sample (15). The minimum sample size was determined as 235. The study inclusion criteria for patients were (a) being at 18 years or older, and having a mini-mental score of 24 or higher in patients aged 65 years or over; (b) having a cancer diagnosis; (c) having begun cancer treatment; (d) having cognitive competence; (e) being able to speak Turkish; (f) being of the Muslim religion, and (g) being willing to participate. The study exclusion criteria for patients were having cognitive impairment, being closed to verbal and nonverbal communication, and refusing to participate. The sample of the study consisted of 324 from 600 oncology patients. It was aimed to recruit the entire population of the nurses. The study inclusion criteria for nurses were (a) working in the oncology unit during the study period and (b) being willing to participate in the study. The study exclusion criteria for nurses were being healthcare staff except for nurses and refusing to participate. One nurse was transferred to another unit during the study, and two nurses refused to participate. Thus, 17 of 20 nurses were included in this study.

2.3. Data Collection

Four tools were used: a patient sociodemographic form, a nurse sociodemographic form, Turkish version of the Patients Spiritual Needs Assessment Scale (PSNAS-T) to determine the patients' spiritual needs, and Turkish version of the Spiritual Care Competency Scale (SCCS-T) to determine the nurses' spiritual care competencies.

2.3.1. Patient Sociodemographic Form: This form prepared by the researchers considering the literature consisted of five questions on the patient's age, gender, marital status, educational level, and type of cancer diagnosed (11,12-14).

2.3.2. The PSNAS-T: Flannelly et al. (2006) developed the PSNAS. The PSNAS' factor loadings of the 24 items ranged from 0.34 to 0.74 (11). In this study, Turkish version of the PSNAS was used. Dedeli et al. (2015) tested the validity and reliability of Turkish version of the scale in Turkey (11). The scale is composed of 23 items and six subscales: (a) divine, (b) appreciation of art and beauty, (c) meaning and purpose, (d) love and belonging, (e) death/resolution, and (f) positivity/gratitude/hope/peace. The response categories were a four-point scale ranging from "never,"

to "very often." Spiritual needs were evaluated according to identifying statistical analysis that represented number and percentage. The PSNAS-T demonstrated satisfactory validity and reliability, and the Cronbach's alpha coefficient was .89 (11). For this study, the Cronbach's alpha coefficient was found as .92.

The two instruments were applied by a researcher who was nurse and also master of science student by asking the questions with a face to face interview with the patients in a quiet environment before treatment. These instruments took approximately 15-17 minutes to complete.

2.3.3. Nurse Sociodemographic Form: This form prepared by the researchers considering the literature consisted of five questions on the nurse's age, gender, educational level, years working in the profession and in the oncology unit (7,8,16).

2.3.4. The SCCS-T: The SCCS was developed by van Leeuwen et al. (2009) in the Netherlands (16). The Cronbach's alpha coefficients of six-factor SCCS were between .56 and .82 (16). The validity and reliability of Turkish version of this scale was carried out by Dağhan et al. (2019) (16). The SCCS-T was found reliable and valid for assessing spiritual care competencies of Turkish nursing students and nurses in delivering spiritual care. There are 27 items on a five-point scale ranging from "completely disagree" to "completely agree". The cut-off point was set at a mean item score of 3.5 or higher, indicating the perception of spiritual care competence. A high score indicates a high level of recognized spiritual care competency. There are three subscales that measure assessment and implementation of spiritual care, professionalization and patient counselling in spiritual care, and attitudes about the patient's spirituality and communication. The Cronbach's alpha coefficient for Turkish scale was 0.97 (16). Cronbach's alpha coefficient for the scale was determined to be 0.91 in this study.

The forms for the nurses were collected by the researcher when the nurse was available, without affecting the nurse's working plan and outside the hours of treatment and patient visiting. It took approximately 15 minutes to complete these instruments.

2.4. Statistical Analysis

The data of the study were analysed using SPSS for Windows 23.0. The statistics such as number, percentage, mean, and standard deviation were used to describe participants' sociodemographic characteristics, the patients' spiritual needs assessment, and the nurses' spiritual care competency. In the calculations, the level of statistical significance was taken as $p<0.05$.

2.5. Ethical Considerations

Informed consent was obtained orally and in written from the oncology patients and from the participating nurses. The information included the purpose and procedures of the study, the voluntary nature of their participation and the option to withdraw at any time. For this study, ethical consent was obtained from the management of the hospital and the University's Ethics Committee of Faculty of Medicine (Approval Number: 20478486-050.04.04-E.97427). This study was conducted in accordance with the principles of the Declaration of Helsinki.

3. Results

3.1. Patients' Sociodemographic Characteristics and Spiritual Needs

The oncology patients' (n=324) age ranged within 28-84 years, with a mean age of 57.60±11.41 years. Of the patients, 69.4% were female, most of them (73.5%) were married, and more than half of them (62.7%) were primary school graduates. The patients' three most frequent cancer types were breast cancer (36.1%), colorectal cancer (17.3%), and lung cancer (8.6%).

As shown in the Table 1, in the "Divine" subscale, cancer patients had a need "to participate in religious or spiritual services" (68.8%), and they did have a need "to spiritual or religious material" (70.1%). In the "Appreciation of Beauty" subscale, the needs "to experience or appreciate beauty" (64.8%) were stated. In the subscale of "Meaning and Purpose", there was a need "to find meaning and purpose in life" (67.9%), but the need "to make sense of why this happened to you" (34.3%) was not felt. In the subscale of "Love and Belonging", the need "to give or receive love" (71.3%) were felt. In the subscale of "Death and Resolution", it was found that there was no need "to address issues before death and dying" (33.3%). In the subscale of "Positivity/Gratitude/Hope/Peace", there was a need "to keep a positive outlook" (59.9%).

3.2. Nurses' Sociodemographic Characteristics and the Spiritual Care Competencies

The mean age of the oncology nurses participating in the study was 37.11±1.13 years; all of the nurses were female, and 55% had graduate degrees. The nurses' mean years of working in the profession was 16.27±8.87. The nurses' mean working years in the oncology service was 4.41±3.10.

The nurses' item mean score on the SSCS-T was 3.77±0.45. The nurses' item mean scores on the SSCS-T subscales were as follows: Assessment and Implementation of Spiritual Care: 3.34±0.58, Professionalization and Patient Counselling in Spiritual Care: 3.44±0.66, and Attitude toward the Patient's Spirituality and Communication: 4.52±0.60 (Table 2).

A statistically significant difference was not found between the nurses' mean scores of SSCS-T and SSCS-T subscales and their age, educational level, year of working in the profession, year of working in the oncology service ($p>0.05$, data not shown in the table).

4. Discussion

In the event of physical illness, emotional stress or death, the need for a power that can feel important and purposeful in one's life, namely spiritual well-being, may increase (17).

4.1. Patients' Spiritual Needs

As a result of the study, more than half of the patients (61%) indicated at least rarely a need for spiritual care. Spiritual values differ in every geography, every culture, and every religion. Therefore, the patients differ in their need for religious practices.

Patients often interact with God during periods of illness and tend to religious practices. This helps them adapt to

their treatment and improve their quality of life (17). When patients' spiritual needs were examined in this study, it was found that on the Divine subscale, more than half of the patients had need "to be able to participate in religious or spiritual services", and they needed "to read spiritual or religious material". Contrarily, in a study by Dedeli et al. (2015), researchers found that all of oncology patients had needs "to participate in religious or spiritual services" and "to read spiritual or religious material" (11). One of the spiritual needs that patients needed most was "not being able to participate in the religious practices/ceremonies" (12).

In the subscale of Appreciation of Art and Beauty, more than half of the patients were found to need "to experience or appreciate beauty", and "to experience or appreciate nature". Similar results were obtained in the study by Dedeli et al (2015) (11), Otuzoglu and Talasoglu (2019) (18). The search for meaning and purpose in life is a spiritual need that should be recognized, especially in times of crisis and life-threatening events. The patient's positive meaning to the illness reduces anxiety and depression levels and increases their quality of life (17). In this study, in the subscale of Meaning and Purpose, many patients expressed the need "to find the meaning and purpose of life", but one-third of patients did not feel a need "to make sense of why this happened to you". Similarly, in studies by Dedeli et al. (2015) (11), Hatamipour et al. (2015) (19) and Devi and Fong (2019) (20), many patients had a need "to find the meaning and purpose of life".

Table 1. Spiritual Needs of Patients with Cancer (n=324)

	How Often Do You Experience Each of These Needs, During You Are Hospitalized?								
Subscales		**Never**		**Rarely**		**Fairly Often**		**Very Often**	
	Items	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Divine	To participate in religious or spiritual services	101	31.2	75	23.1	80	24.7	68	21.0
	To read spiritual or religious material	97	29.9	75	23.1	79	24.4	73	22.5
	To have someone pray with or for you	86	26.5	54	16.7	74	22.8	110	34.0
	For guidance from a higher power	117	36.1	52	16.0	79	24.4	76	23.5
Appreciation of art and beauty	To experience or appreciate beauty	63	19.4	51	15.7	131	40.4	79	24.4
	To experience or appreciate nature	68	21.0	51	15.7	121	37.3	84	25.9
	To experience or appreciate music	103	31.8	60	18.5	97	29.9	64	19.8
Meaning and purpose	To find meaning and purpose in life	118	36.4	102	31.5	95	29.3	9	2.8
	To find meaning in the suffering	107	33.0	110	34.0	92	28.4	15	4.6
	To make sense of why this happened to you	111	34.3	71	21.9	97	29.9	45	13.9
Love and belonging	To give or receive love	62	19.1	31	9.6	115	35.5	116	35.8
	To be accepted as a person	66	20.4	49	15.1	95	29.3	114	35.2
	For companionship	63	19.4	67	20.7	94	29.0	100	30.9
	For compassion and kindness	64	19.8	48	14.8	100	30.9	112	34.6
	To feel a sense of connection with the world	85	26.2	59	18.2	91	28.1	89	27.5
Death and resolution	To address issues before death and dying	108	33.3	116	35.8	84	25.9	16	4.9
	To address concerns about life after death	112	34.6	96	29.6	85	26.2	31	9.6
	To review your life	118	36.4	79	24.4	83	25.6	44	13.6
	To forgive yourself and others	126	38.9	92	28.4	74	22.8	32	9.9
Positivity/gratitude/ hope/peace	To be thankful or grateful	76	23.5	93	28.7	101	31.2	54	16.7
	To feel hopeful	51	15.7	77	23.8	126	38.9	70	21.6
	To keep a positive outlook	63	19.4	67	20.7	111	34.3	83	25.6
	To feel a sense of peace and contentment	62	19.1	87	26.9	102	31.5	73	22.5

Table 2. Mean scores of SCCS-T of oncology nurses (n=17)

SCCS-T and subscales of SCCS-T	Mean ± SD	Minimum	Maximum
SCCS-T	3.77±0.45	3.26	4.73
Assessment and implementation of spiritual care	3.34±0.58	2.33	4.50
Professionalization and patient counselling in spiritual care	3.44±0.66	2.47	4.87
Attitude toward the patient's spirituality and communication	4.52±0.60	3.33	5.00

Examining patients' needs in the subscale of Love and Belonging, researchers found that many of them felt the need "to give or receive love" and the need "for compassion and kindness". The same result was obtained in the study by Dedeli et al. (2015) (11), and in addition, all of patients in that population experienced each of these needs; "to be accepted as a person" and "for companionship. In the study by Otuzoglu and Talasoglu (2019), the love and support of relatives sub-dimension of spiritual care needs scale was 3.12±0.854 (18).

People often expect to know about death and the experience of dying. Patients often want to stay active and involved as much as possible in decisions and choices about their lives. Therefore, they feel the need to learn about drug treatment, medical treatment, etc. (17). Examining patients' needs in the subscale of Death and Resolution, it was concluded that one-third of patients did not have a need "to address issues before death and dying" and "to forgive yourself and others". However, in the study by Dedeli et al. (2015) (11), and Haußmann et al. (2017) (21) the opposite was found, that many patients had a need "to address issues before death and dying". The reason for dissimilarities in the results may be different cultural experiences and differences in belief/value/judgment.

The search for a connection with God can be a way to find peace (18). Examining patients' needs on the subscale of Positivity/Gratitude/Hope/Peace, more than half had a need "to keep a positive outlook" and "to feel a sense of peace and contentment". In studies by Dedeli et al. (2015) (11), Hatamipour et al. (2015) (18) and Hsiao et al. (2011) (22), it was found that many patients had the same needs.

In the research results of other countries, it was found in a study in Singapore with 28 oncology patients of different ethnicities that they chose to turn to God/Allah to gain more hope or to recover by being closer to God/Allah. Patients said that their spirituality practices included praying to God/Allah, reading religious materials, or meditating, and that the spiritual side influenced their perception of the meaning and purpose of life as well as their acceptance of their condition (19). In study of Balboni et al. (2015) (23), the spiritual needs of nearly half of patients (47%) by a religious community and the spiritual needs of most of patients (72%) by the medical system were met at a minimum level or not at all. In a study by Hsiao et al. (2011) (22), advanced oncology patients needed "to experience more reciprocated human love" (100%), nearly all needed "to nurture the hope of remaining alive and to have peace of mind" (88%), "to be able to give meaning to life and preserve their dignity" (88%), and "to receive help for a dignified death" (85%).

In the literature, researchers found that when patients thought their life was coming to an end, many reviewed their beliefs and wanted to re-confirm them. In the hope of having a peaceful death, they prioritized their own spirituality or spiritual wellbeing (19,22,24). Spirituality is connected to oneself, others, nature, and love. It is thought that strengthening these connections will help reduce anxiety and fear in terminally ill patients (25).

4.2. Nurses' Spiritual Care Competencies

In this study, the nurses' SCCS-T item mean score of 3.77±0.45 showed a medium level of competency in spiritual care. The other study in Turkey, psychiatric nurses' competency in spiritual caregiving was at a medium level (3.54±0.63) (26). Similar to the study herein, studies conducted in other countries with nurses (14,27,28) showed nurses' spiritual care adequacy at a medium level. In a study conducted in the Netherlands, nurses' competency and practice in spiritual caregiving was at a high level. In this study, among subscale item mean score, Assessment and Implementation of Spiritual Care was 3.34±0.58, lower than the overall item mean score; Professionalization and Patient Counselling in Spiritual Care was 3.44±0.66, lower than the overall item mean score, and Attitude toward the Patient's Spirituality and Communication was 4.52±0.60, higher than the overall item score. Since the basis of spiritual care is to be able to communicate effectively with the patient, this competency in Attitude toward the Patient's Spirituality and Communication of the nurse was higher than others. Examining other studies in the literature, it was seen that in some nurses, competencies in Attitude toward the Patient's Spirituality and Communication were better than in the other subscales (26,30), but in others (27,28), they were lower. Spiritual care competency, consisting of the knowledge, skills and attitudes required to provide spiritual care, is a competency expected from nurse (31). In Turkey, the topic of spiritual care has been debated in the field of nursing for over 10 years, but there is still a lack of understanding, making nurses feel inadequate in practicing and developing the quality of spiritual care.

5. Conclusion

In conclusion, more than half of oncology patients had at least rarely a need for spiritual care. It was concluded that the spiritual care competencies of the nurses providing care to these patients was at a moderate level. Therefore, it was concluded from this study that the fact that nurses' spiritual care competency was at a moderate level meant that patients' spiritual needs were not being adequately met.

6. Contribution to the Field

These results suggest that a guidance system to explain spirituality and the spiritual care of patients diagnosed with a critical illness such as cancer would be a positive step towards a correct determination of the spiritual needs of these patients. From another aspect, the topic of spiritual

care may be added to the training curriculum in order to increase the spiritual care competency of nurses meeting the spiritual care needs of oncology patients, in-service training may be arranged for nurses in the professional field, and encouragement of nurses on that topic may be increased. Also, surroundings and opportunities are recommended in which spiritual care may be carried out to meet the spiritual care needs of patients. The future studies may be conducted in a descriptive or experimental research type with larger sample size on the spiritual care competency of nurses and the spiritual care needs of patients in Turkey.

Limitations

Since the research population is from a single institution, research results could not be generalized. Due to the pain and suffering of the patients, their feeling of fatigue, anxiety and tension, they did not want to answer the research questions from time to time, and the nurses were reluctant to answer the questions due to the workplace environment and workload, and difficulties experienced during the collection of the research data. In addition, due to the insufficient number of samples of nurses, analysis could not be made on variables that affect their competence in spiritual care.

Ethical Aspect of the Research

Informed consent was obtained orally and in written from the oncology patients and from the participating nurses. The information included the purpose and procedures of the study, the voluntary nature of their participation and the option to withdraw at any time. For this study, ethical consent was obtained from the management of the hospital and the University's Ethics Committee of Faculty of Medicine (Approval Number: 20478486-050.04.04-E.97427). This study was conducted in accordance with the principles of the Declaration of Helsinki.

Conflict of Interest

There is no conflict of interest regarding any person and/or institution.

Authorship Contribution

Concept: GA, TSM; **Design:** TSM, GA; **Supervision:** GA, TSM; **Funding:** GA, TSM; **Materials:** GA, TSM; **Data Collection/Processing:** GA; **Analysis/Interpretation:** GA, TSM; **Literature Review:** GA, TSM; **Manuscript Writing:** GA, TSM; **Critical Review:** TSM, GA.

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