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Spiritual wellbeing of Iranian patients with acute coronary syndromes: a cross-sectional descriptive study

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Abstract

Spiritual wellbeing harmonises several dimensions of human life and is essential for coping with diseases. Acute coronary syndromes (ACS) cause crisis in physical, psychological aspects and spiritual dimensions of patients' lives. The purpose of this study was to determine the level of spiritual wellbeing and its dimensions in patients with ACS. For this, a cross-sectional descriptive study was conducted. For data collection, Paloutzian and Ellison's Spiritual Wellbeing Self-report Questionnaire was filled in by 364 patients with ACS. Patients referred to the cardiac wards of five teaching hospitals in Tehran between August 2011 and April 2012 were recruited using the convenience sampling method. The data were analysed using descriptive and inferential statistics.

[†]It is with great sadness that we inform of the death of our dear colleague and co-author, Prof. Melanie Jasper, during preparation and development of this paper. We acknowledge her kind efforts, expertise and help. Her absence from the team is deeply regretted by all of us.

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The findings revealed that the majority of patients (97.9%) benefited from moderate spiritual wellbeing, although religious wellbeing was higher than existential wellbeing in the patients. It is concluded that nurses are required to improve their cultural and contextual knowledge of patients' spiritual wellbeing to meet patients' needs in nursing care. Spiritual beliefs can influence coping with diseases, help patients to find meaning and purpose in life to deal with problems resulting from physical and mental illnesses. These findings can be used to suggest the incorporation of religious aspects of spirituality into care programmes designed to improve the quality of life of patients with ACS.

Keywords

acute coronary syndrome, existential wellbeing, heart disease, religious wellbeing, spiritual wellbeing, spirituality

Introduction

Acute coronary syndrome (ACS) is the most prevalent type of cardiovascular disease (CVD) in adults and the single largest cause of death of people in developed countries. ACS refers to a group of symptoms attributed to obstruction of the coronary arteries (Yun and Alpert, 1997). It is predicted that by 2030, almost 23.6 million people will die from CVD, and over 80% of death related to CVD will take place in low- and middle-income countries. According to Gaziano et al. (2010), about 35% of all incidences of death in the Middle East and North Africa (MENA) and East Asia and Pacific (EAP) regions can be attributed to CVD.

ACS has an unpredictable course with long-term dysfunctions and frequent waxing and waning of symptoms (Bekelman et al., 2007). ACS as a critical life event compels people to confront any change in their lifestyles and try to achieve a way to promote their quality of life. Some ways have been suggested for dealing with issues caused by the disease (Brunner and Suddarth, 2010). While patients may suffer in mind, body and spirit due to confrontation with emotional stress, physical diseases or death (McEwan, 2005), it is known that they try to keep their faith towards their values and beliefs in coping with diseases (Potter and Perry, 2005).

Spirituality is a necessary component of life (Lin et al., 2011). Spiritual wellbeing (SWB) has been defined as the affirmation of life in a relationship with God, self, community and environment that nurtures and celebrates wholeness (Arnold et al., 2007). Humans obtain spiritual wellbeing by finding balance between values, goals, beliefs and relationships with self and others (McSherry et al., 2004; Potter and Perry, 2005; Wu et al., 2012).

Spirituality including religious faith as well as inner personal strength allows patients to think positively and focus on the goodness of life, while admitting limitations imposed by their illness. Spirituality touches the deepest human level, the world of being, which is beyond words (Santavirta, 2004) and emphasises two religious and existential dimensions. Religious wellbeing (RWB) is the result of being satisfied with having a relationship with a superior power, while the existential wellbeing (EWB) is interpreted as trying to understand the meaning and purpose of life (Brunner and Suddarth, 2010). SWB has been shown to assist in coping with stressful life events (Bekelman et al., 2009). Previous studies conducted on spirituality in patients with chronic diseases such as multiple sclerosis (MS) (McNulty et al., 2004) and AIDS (Litwinczuk and Groh, 2007) show that it has a significant relationship with health and is useful in adjusting with the disease. Higher concentration on patients' physical needs during illness crisis may lead to less attention being paid to patients' psychological and spiritual needs (Timmins, 2008). It is evident that spirituality

can be a protective factor against CVDs (Morris, 2001). Bekelman (2007) declares that spirituality is emphasised in palliative care and has been advocated in patients with CVD to relieve their suffering and distress. It plays a major role in patients' health status as it helps with adjustment with illness. According to most studies focusing on spirituality and CVDs, those patients who are more spiritual have healthier hearts and are less likely to die from heart diseases (Blumenthal, 2007; Morris, 2001; Jahani et al., 2012). This effect can be attributed to the influence of religion and spirituality on physical health through psychosocial and behavioural pathways, and the strong influence that psychosocial and behavioural factors have on risk of developing CVDs (Coyle, 2002; George et al., 2000).

Nurses can help patients with a holistic approach to acquire and maintain health and physical, mental and spiritual recovery (Delaney and Barrere, 2008). Therefore, assessment of SWB in hospitalised patients can accelerate recovery and promote patients' quality of life (Moeini, 2012).

Background in Iran

According to Persian people's culture and religious doctrine, the human being, as the God's creature, possesses physical, mental, emotional, cultural, social, spiritual and environmental dimensions (Farahaninia, 2005; Omidvari, 2008). Praying is considered by Iranian Muslims to be one of the main ways of communication with God, through which they seek justice, submit petition and compliance, and strengthen their compatibility for dealing with stressful incidents. Iranian people practise their religious rituals to achieve a higher level of spirituality. Avowing, almsgiving, attending spiritual events, respecting other religions such as Christianity and Judaism, practising religious activities such as repeating a word or a phrase in prayer, and attendance to holy shrines especially mosques are tools used by people to reach satisfaction with life, promote their spiritual health, create better relaxation and achieve compatibility with diseases and life issues (Akhbardeh, 2011).

Although the nursing profession has already begun to view prayer and meditation practices as emergent forms of the field of patient care, only a few studies have been conducted on spirituality in patients with diseases such as MS (Allahbakhshian et al., 2011), breast cancer (Olver and Dutney, 2012), diabetes (Akhbardeh, 2011), rheumatoid arthritis (Lin et al., 2011) and war disaster (Ebadi et al., 2009). However, no study has explored this phenomenon in patients with ACS. Therefore, the aim of this study was to determine the level of spiritual wellbeing and its dimensions in Iranian patients with ACS.

Methods

Design

This study used a cross-sectional descriptive design. Cross-sectional designs as collection of data at one point in time involve the description of characteristics that exist in a population. They are non-causal in nature and are used to suggest and initiate further research (Polit and Beck, 2010).

Sample and setting

The sample included 367 patients referred to the cardiac wards of five teaching hospitals in Tehran, Iran between August 2011 and April 2012 who were recruited using the convenience

sampling method. Of these, three patients refused to participate in this study. Therefore, 364 patients with the following inclusion criteria agreed to participate in this study:

- Having been diagnosed with ACS;
- Aged 18 years or older;
- Being a resident of Tehran city;
- Being aware of the disease;
- Having willingness to participate in this study.

They were excluded from the study if they were diagnosed with myocardial infarction, cancer, renal failure (RF), cerebrovascular accident (CVA) and any sort of psychiatric diseases.

Measurements and data collection

The Paloutzian and Ellison's Spiritual WellBeing Questionnaire (1982) was filled in by the patients at their bedsides. It was a self-report questionnaire; however, if a patient was illiterate and unable to complete it, the primary investigator as an independent person read the questions to the patient and wrote his/her responses into the answer sheets.

The questionnaire consisted of two parts: the first part included demographic characteristics such as age, gender, educational level, marital status, history of CVD; the second part included Paloutzian and Ellison's spiritual wellbeing questions. It is noted that this questionnaire was designed in 1982 by Paloutzian and Ellison to assess the existence and religious dimensions of SWB using the 6-degree Likert scale, from completely disagree to completely agree. In this 20-item questionnaire of spiritual wellbeing, 10 questions were related to RWB and 10 questions were related to EWB. The range of scores for each of the religious and existential subgroups was between 10 and 60. A higher score indicated higher religious and existential health. Inverse scoring was used in negative questions (Kor et al., 2013). The SWB score was the summation of the two subgroups with a range between 20 and 120. The SWB score was classified into three levels as low (20–40), medium (41–99) and high (100–120).

In a previous study, the questionnaire's content validity was assessed after translating it to the Persian language. It showed that the Paloutzian and Ellison's spiritual wellbeing questionnaire was a valid and reliable instrument. Its Cronbach's alpha coefficient was reported to be 0.82 (Seyedfatemi, 2006).

Data analysis

The data were analysed via the SPSS software for Windows version 16 (SPSS, Chicago, IL, USA). Descriptive and inferential statistics were used to analyse the collected data.

Ethical considerations

This study was approved by the Ethics Committee of Shahed University. All participants signed a written consent form and were assured regarding the confidentiality of their data.

The first researcher gave information about the topic of the research and invited the patients to fill in the spiritual wellbeing questionnaire. They were assured that participation in the study was voluntary and they could withdraw from it at any time without any impact on their care. Finally, the written informed consent was signed by the participants.

Results

Characteristics of the sample

The participants' mean age was 58.95 years ($SD=1.23$ years). The majority of the participants were men (54.40%). The duration of ACS in the patients was 21.6 years ($SD=1.08$ years). They were mainly (89.60%) married. Regarding the educational level, 28.80% of them studied high school, and 16.20% of them were illiterate. About 87.90% of the patients suffered from other chronic diseases at the same time. A summary of the participants' demographic data is presented in Table 1.

Spiritual wellbeing

Among the expressions related to religious health, the following items obtained the highest mean scores: 'I believe that God loves me and cares about me' (mean = 5.59, $SD=0.76$) and 'My relationship with God helps me not to feel lonely' (mean = 4.21, $SD=1.82$). With regard to existential health, the item 'I believe there is some real purpose for my life' (mean = 4.20, $SD=1.81$) obtained the highest mean score. Spiritual wellbeing mean score was 82.11 ($SD=2.90$) out of a total score of 120 related to existential and RWB scores. Therefore, based on the three levels of SWB, 53.3% of the patients were in moderate level and 44.2% were in the group of high SWB level.

It also was found that RWB (mean = 41.67, $SD=14.90$) was higher than EWB (mean = 40.61, $SD=15.19$, $p=0.002$) in the patients. A summary of the participants' scores in both acceptable and captured ranges of spiritual wellbeing data are presented in Table 2.

Women's mean scores for SWB (mean = 83.99, $SD=29.25$), RWB (mean = 42.36, $SD=14.59$) and EWB (mean = 41.62, $SD=15.17$) were higher than the men's mean scores for SWB (mean = 80.54, $SD=28.78$), RWB (mean = 41.08, $SD=15.17$) and EWB

Table 1. The demographic characteristics of the patients ($n=364$).

Characteristics		<i>n</i>	%
Gender	Male	198	54.40
	Female	166	45.60
Marital status	Widow and divorced	16	4.3
	Single	22	6.70
	Married	326	89.60
Occupation	Employed	190	52.19
	Unemployed	174	47.81
Economic status	Favourable	62	17.00
	Unfavourable	302	83.00

Table 2. Spiritual wellbeing of the study patients ($n = 364$).

Spiritual wellbeing	Mean (\pm SD)	Acceptable range	Capture range
Existential wellbeing	40.61 (SD = 15.19)	10–60	10–53
Religious wellbeing	41.67 (SD = 14.90)	10–60	15–60
Total	82.11 (SD = 2.90)	20–120	41–120

(mean = 39.76, SD = 15.20). It was also shown that there was no statistically significant relationship between total SWB and its related dimensions, and the gender of patients ($p = 0.25$).

The mean score of SWB in the age range of the group >60 years old (mean = 83.12, SD = 1.18) was higher than the other age groups. Moreover, there was no statistically significant relationship between SWB and the patients' age ($r = 0.014$, $p = 0.78$).

It was shown that there was no statistically significant relationship between SWB and marital status ($p = 0.39$). However, the SWB mean score for divorced and widowed patients (mean = 86.21, SD = 2.18) was higher than the other groups.

In addition, no statistically significant relationships were found between patients' employment condition, economic status and education status, and SWP and its aspects ($p = 0.41$). Nevertheless, the mean score of SWB (87.18) was higher in the patients who studied up to high school diploma.

Discussion

According to the findings, a moderate level of SWB in the participants was reported. Additionally, the score of RWB was higher in comparison with EWB. These parallel the findings of Allahbakhshian et al. (2011) in Iran, in which patients suffering from MS showed a moderate level of SWB. The results of Dalmida et al.'s (2011) study in the United States with patients with HIV/AIDS were the same as our study's findings stating that spirituality is a factor in patients' wellbeing in different religions. While the results of the study by Bussing et al. (2007) in Germany showed low spirituality scores in patients with cancer, Rezaei et al.'s (2006) study in Iran reported high scores of SWB in patients with cancer. This difference can be attributed to participants' cultural and contextual backgrounds in different societies.

In this study, the score of RWB was higher than the score of EWB that is similar to the findings of Rezaei et al.'s study (2006) on patients with cancer and Dalmida et al.'s study (2011) on patients with HIV due to the nature of chronic diseases. On the other hand, the authors of this study believe that creating spiritual meaning in life plays an important role in coping with stressful situations caused by diseases, which appears to justify such findings. Livneh et al. (2004) in the United States stated that religious belief has an important role in coping with stressful situations induced by diseases.

Although there was no statistically significant difference between genders in the SWB, mean scores in both religious and existential aspects were shown to be higher in women. Similarly, Allahbakhshian et al.'s (2011) study on patients with MS, Bekelman et al.'s (2007) study on patients with heart failure in the United States, and Rezaei et al.'s (2006) study on

patients with cancer did not find a significant relationship between SWB and gender. Similar to our findings, Bussing et al. (2007) in Germany and Sawatzky et al. (2005) in the United States reported that EBW and RBW were higher in women with cancer than men, respectively.

It was found that the tendency to spirituality increased with age, contrary to findings of Allahbakhshian et al.'s (2011) study that the SWB mean score in middle-age patients was higher than the other age groups. Rowe and Allen (2004) in the United States indicated that spirituality helped adjust to losses. This might be that ageing was accompanied with losing some abilities and functions in life such as health and facilitated facing and adapting with the reality of death.

Schwarzer et al. (2004) declared that older widowed, divorced or single patients with cancer received less emotional support than their younger counterparts. It is possible that the same pattern is present in our study's patients as they received less emotional support. Karren (2006) believes that divorced people and those who are unhappy with their life lose the source of social support besides to the stress of the disease imposed on them. Thus, the tendency to higher levels of spirituality can be an effective adjustment for this difficult condition.

The results showed that there was no significant relationship between SWB and marital status. However, a significant relationship was observed between EWB and being divorced and widowed rather than being married and single. Similarly, Riley et al. (1998) in the United States showed that EWB in married people was higher than in single people.

No statistically significant relationship was found between spiritual wellbeing and educational level. Momeni et al. (2012) in Iran reported that the mean score of SWB was higher in patients with breast cancer who studied up to middle school, although Rezaei et al. (2006) and Musgrave and McFarlane (2003) declared that a significant relationship was present between SWB and the education level in patients with cancer. The older group had a stronger connection between prayer and the importance of religion, and this variable plus higher education predicted the role of prayer on wellbeing in the older group patients.

Conclusions

Both existential and religious aspects of spirituality were found to be significant contributors to wellbeing in patients with ACS. It is believed that religious and existential wellbeing are central to coping and living with ACS. Spiritual beliefs can influence coping with diseases, and help patients to find meaning and purpose in life to deal with problems resulting from physical and mental illnesses. These findings can be used to suggest the incorporation of religious aspects of spirituality into care plans designed to improve the quality of life of patients with ACS.

Limitations and suggestions for future studies

This study only used a descriptive approach and did not explore the perspectives of nurses and the mechanism by which spirituality could enhance patients' wellbeing. Therefore, future studies with a qualitative design are suggested to improve nurses' understanding on how spirituality interventions can be incorporated into nurses' care planning from both nurses' and patients' perspectives.

Key points for policy, practice and/or research

- Tendency to spirituality increases with age.
- Creating spiritual meaning in life plays an important role in coping with stressful situations caused by diseases.
- It is required to incorporate religion and spirituality into nursing education curricula to prepare nurses to develop care plans designed to improve the quality of life of patients.
- Future studies with a qualitative design are suggested to improve our understanding on how spirituality interventions can be incorporated into nurses' care planning from both nurses' and patients' perspectives.

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The researchers would like to thank the patients for their participation in this study. It is with great sadness that we were informed of the death of our dear colleague and co-author, Prof. Melanie Jasper, during preparation and development of this article. We acknowledge her kind efforts, expertise and help. Her absence from the team is deeply regretted by all of us.

Declaration of conflicting interest

None declared.

Ethical approval

The Shahed University approved the study.

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The late **Melanie Jasper** (PhD MSc BNurs BA RN RM RHV PGCEA) became Professor of Nursing in 2004, moved to Swansea as Head of School in 2007, and merged two schools to form the College in 2009. She had an extensive international career including keynotes at conferences, doctoral and post-doctoral work. She served on the local Health Board as an Independent Member for 5 years. In 2012, she was seconded to the Office of the Chief Nurse for Wales to explore professionalism in nursing in Wales. She authored eight books and numerous high-quality journal articles. She presented keynote lectures at conferences, particularly relating to reflective practice, reflective writing, portfolio and professional development, and on leadership. In 2002, she also became Editor-in-chief of the *Journal of Nursing Management*.