JKKI
SCIENTIA EST BASIC VITAE

Jurnal Kedokteran dan Kesehatan Indonesia

Indonesian Journal of Medicine and Health

Journal homepage : https://journal.uii.ac.id/JKKI

An exploratory study on the dimensions of spiritual care

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Original Article

ABSTRACT

ARTICLE INFO

Keywords:
dimensions,
spiritual care,
qualitative research

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DOI: 10.20885/JKKI.Vol10.Iss2.art5

History:
Received:
Accepted:
Online:

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Background: Spiritual care is one of the important services. The dimensions of spiritual care have not been fully identified clearly. Therefore it is necessary to explore the dimensions of spiritual care.
Objective: The aim of this study is to explore spiritual care.
Methods: Qualitative research methods were used in order to obtain data through observation techniques, in-depth interviews, and focus group discussions (FGD). The research was conducted within several number of hospitals in Central Java, Indonesia. The samples of this research were 57 nurses with given criteria as following: has a minimum education of associate's degree in the nursery and a work experience minimum of 2 years in a hospital. Obtained data were, was analyzed with constant comparative and content analysis.
Result: The exploration of spiritual care is depicted by hospital nurses as personal belief towards spirituality that can be experienced through spiritual comfort, which is manifested through routine worships, prayers, and intense presence as spiritual implementations and support.
Conclusion: This explorative study concludes that there are dimensions in the spiritual care of hospital nurses: personal belief, spiritual knowledge, spiritual comfort, spiritual implementation, and spiritual support. The implications may be able to bring benefit in its application toward the government, hospitals, nurses, patients, and their families, as well as the society.

Latar Belakang: *Perawatan spiritual merupakan salah satu layanan penting. Dimensi perawatan spiritual belum sepenuhnya teridentifikasi dengan jelas. Oleh karena itu perlu menggali dimensi perawatan spiritual..*
Tujuan Penelitian: *Mengeksplorasi dimensi perawatan spiritual.*
Metode: *Penelitian kualitatif dengan pengambilan data menggunakan teknik observasi, indept interview, dan Focus Group Discussion (FGD). Lokasi penelitian pada beberapa rumah sakit di Jawa Tengah, Indonesia, Sampel penelitian adalah 57 perawat dengan kriteria, yaitu pendidikan D3 Keperawatan dan bekerja minimal dua tahun di rumah sakit. Data yang telah dikumpulkan dianalisis dengan constant comparative dan content analysis.*
Hasil: *Eksplorasi perawatan spiritual digambarkan oleh perawat rumah sakit sebagai keyakinan pribadi terhadap kerohanian yang dapat dialami melalui kenyamanan spiritual, yang dimanifestasikan melalui pemujaan rutin, doa, dan kehadiran yang intens sebagai implementasi dan dukungan spiritual.*
Kesimpulan: *Dimensi-dimensi yang ditemukan antara lain, keyakinan personal (personal belief), pengetahuan spiritual (knowledge of spirituality), kenyamanan (comfort of spirituality), implementasi spiritual (implementation of spirituality), dan dukungan spiritual (support for spirituality). Implikasinya*

bermanfaat aplikatif bagi pemerintah, rumah sakit, perawat, pasien, keluarga pasien, dan masyarakat.

INTRODUCTION

Holistic health is defined as an achievement of a whole healthy condition in biological, psychological, social, and spiritual terms. Spirituality becomes the basis of biopsychosocial studies and gives a significantlarge contribution to the quality of human life. Good health qualities in a hospital are some meaning of good life qualities.[1] The challenge is to increase the quality of health, which is the professional capabilities in providing biological, psychological, social, and spiritual nursery care. One of the health staffs, which has the most substantiallargest role in providing care for hospital patients is a nurse.[2]

Spiritual care, as one of the most criticalimportant services by nurses, has begun to be explored. There are a few limitations in the skill of spiritual care, such as the lack of preparation in nursing by nurses, especially the tendency to avoid spiritual matters in providing service toward the hospital patients.[3]

Spiritual care becomes a service that is needed in a hospital. Spiritual care is defined as a part of providing care to spiritual needs toward patients.[4] An explorative spiritual study toward patients mentions that spiritual care is marked by the proximity of physicality and internationally. There is an action of co-creating, which is the spiritual care between nurses, patients, and family members of patients. This action begins by offering support to the patient's life experience until the end of their lifeline, focusing toward the preservation of patients' humanity.[5] Explorative research of spiritual care in Australia tends to provide for people who undergo court cases emotionally, and it is done by priests.[6] In a descriptive study with a qualitative approach, which is carried out through semi-structured interviews toward six nurses working in a hospital, it is found that nurses do not prioritize spiritual care in their work. Even though so, they still consider that spiritual care is an important service in nursery care.[7]

In 2012, the National Conference on Creating More Compassionate System of Care was upheld in the U.S. The consensus' result of the national conference recommended the spiritual integration approaches within the healthcare structure. Within the following year in 2013, the International Conference on Improving the Spiritual Dimension of Whole Person Care: The Transformational Role of Compassion, Love, and Forgiveness in Health Care was organized in Geneva, Switzerland. The result of the international conference regarding the development of quality of spiritual care in a model of interprofessional contains standard strategies which mention that there needs to support from many parties to delve the quality of spiritual care in health, especially in the multidisciplinary of nursery and psychology.[8] Based on the notion, this research focuses on the exploration of spiritual care by hospital nurses. This is a multidisciplinary research that involves psychology, nursery, health, and religion.

In a few hospitals in Central Java, the nurses have not yet implemented spiritual care, as mostly it is done by religious careers. The data which depicts spiritual care services by nurses toward patients is not much as it is yet to be researched, thus hoping that it gives benefit in increasing the quality of health in hospitals. This study aims to explore the spiritual care of hospital nurses and dimensions representing spiritual care by nurses.

METHODS

This research equips qualitative methods. The samples of this research are hospital nurses with inclusive criteria as following: 1) nurses who have a minimum of associate's degree in the nursery, 2) nurses who have a minimum work experience of 2 years.

The data is gathered through observation techniques, in-depth interviews, and focus group discussions (FGD). Descriptive, as well as explorative qualitative methods, are done to describe spiritual care by hospital nurses. Multimedia equipment, i.e. voice recorder, as well as a video recorder, are used for documentation

purposes of the in-depth interviews and FGD. Documentation also takes the form of supporting data regarding manual of spiritual care in hospitals.

Central questions of the in-depth interview as following What are the personal beliefs in your life? What is your understanding of spirituality? What makes someone feel comfortable particularly in spiritual matters? What spiritual application do you do in everyday life? What kind of spiritual support is given to patients? Data gathering via interviews and forms are done in alternates toward subjects. Data gathering via FGD are carried out within 60 minutes and each FGD groups are comprised of 5 subjects at maximum. The location of the interviews and FGDs is at the hospital hall, the duration of the interviews is carried out 30-60 minutes per subject.

Analysis based on verbatim information is categorized into correctly coded concepts to reflect data. Data analysis is done qualitatively through constant comparative and classical content analysis.[9]

The steps carried out in data processing are: a) Preparation of data which have been obtained via interviews, FGD, and observation b) Identification and interpretation of meaning by creating descriptions, coding, and simplifying data into smaller units c) Categorization by grouping themes as well as looking for differences and similarities among categories until it can no longer be elaborated d) Data integration by making correlations between categories. Credibility or legitimacy of qualitative research data is how far the research results' validity can be taken into responsibility. The way to maintain credibility is participating throughout the research carried out with diligence, as well as holding out discussions with competent people and looking out for sufficient references.[10]

The research procedures are: a) The researcher will carry out data collection related to filling the subject's identity and in-depth interview to find out whether the subject meets the criteria of the research subject b) Researcher provides a list of questions to find information and help illustrating things which are in line with the circumstances of the research subject c) Research subjects get benefit about illustration of spiritual care d) Confidentiality is maintained. Published research results do not mention the identity of the research subject e) Research subjects are voluntary, meaning that they have free participation in research. If the participation is fulfilled, the subjects still receive service as they should.

The data is comprised of primary and secondary data. Primary data is obtained from in-depth interviews and FGD. Secondary data is obtained through the hospital management, which are standard operational procedures (SPO) on spiritual service, spiritual help on terminal patients, terminal patients' service, value identification of patients' trust, and fulfilment of patients' trust value; patients' rights and duties in the hospital, hospital profiles, and other supporting data.

Measurable indicators in research are: a) researcher makes a guide for questions from the research results with measurable assessment from linguists and professional judgment b) The researcher collects the subjects' answers on the checklist sheets and measured psychometric sheets c) The total responses from the research subjects are recapitulated and made percentage to have them measured d) Measured indicators in the research are listed in the assessment form of the subject including the contents of the answer, the idea of the subject's mind (cognitive), the subject's feelings (affection), the willingness of the subject (conation), and social interaction.

Ethical review was carried out by the Medical and Health Research Ethics Committee (MHREC) Faculty of Medicine Universitas Gadjah Mada with ethical number KE/FK/1125/EC/2017.

RESULTS

The total number of samples in this research is 57 nurses. In the beginning, this research includes 70 paramedic staffs comprised of midwives and nurses, but after identifying samples in by inclusion criteria, only 57 nurses are eventually involved. These nurses

participate in in-depth interviews and FGD. The interviews and FGD are performed based on a guide in gathering data that has been composed beforehand.

Exploration Through Interview

According to the results acquired through the interviews with the nurses, several behaviours emerge self-assurance, possessing self-identity and knowledge, carrying out help, creating peace, doing good deeds, and having self-potential. Spiritual care behaviour is also exhibited through praying, presenting self in the patient's room, listening to murottal, having conservations of spirituality and illness in a healthy discussion, and providing help by giving a chance to pray. Other behaviors which appear including understanding towards SOPs of spiritual care; acknowledging policies of spiritual care; understanding the standards and orientations of spiritual care and the service of the procedure.

The nurses' behaviours which have similarities are aligned within a category which becomes an indicator. Indicators or subthemes are grouped into a large theme (dimension). Based on such categories, themes or dimensions which emerge from interviews with nurses are a personal belief, spiritual knowledge, spiritual comfort, spiritual implementation, and spiritual support. Research data shows more toward implementation of the spiritual dimension, emphasising the indicator of capabilities to implement prayers routinely, to pray, to be present as a nurse, to practice spiritual fulfilment, to listen to murottal, and to give a chance to pray.

Exploration Through Focus Group Discussions

The nurses' behaviours which reflect knowledge of spirituality including possessing insights, experience, concepts, ideas, and knowledge of spirituality. The behaviours which reflect the nurses' self-assurance involve awareness, self-identity, spiritual belief, pre-eminence, and potentials related to one's own. The comfort in praying is shown by helping, keeping one safe, creating pace, and doing good insincerity.

Themes which appear from FGD are almost similar to the ones which appear from the interviews, which are of personal belief, spiritual knowledge, spiritual comfort, spiritual implementation, and spiritual support. Personal belief often pertains about the nurses' beliefs in self-principle, spiritual comfort tends to allude on helping others, and spiritual knowledge generates spiritual ideas to provide spiritual care towards the patients. Subthemes that often appear in spiritual implementation and spiritual support are prayer routine and the nurses' capability in giving motivation to the patients.

Exploration Through Observation

Observations are done in hospitals since the focus of the research is toward nurses who work in hospitals. Observations are carried out between one to three sessions, each for as long as 30-60 minutes. They're focused on spiritual care behaviour that is categorized as spiritual service by the nurses.

Some of the spiritual care behaviour which appears in these observations include listening to murottal, praying, giving a chance to ray, and providing facilities to pray in the hospital. When there is a patient that undergoes a crisis or facing death, nurses offer more chances for family members to pray and to give moral or spiritual support. It is sufficed for the nurses to understand the ethics, procedure, sequence, and standards of spiritual service. Despite being unable to profoundly comprehend SOP and policies regarding spiritual care, the nurses understand caring techniques before and after facing death.

Spiritual support more often appears in observation. These behaviours are exhibited in actions that are carried out through warm interactions, such as connecting with patients and their families as well as friends from interdisciplinary studies, being attentive and caring, and giving out spirit and motivation to the patients.

According to the five dimensions that are found in this research, the indicators and behaviours of spiritual care are summarized as a whole in Table 1.

Table 1. Dimensions and indicators in spiritual care

Dimensions (Themes)	Indicators (Sub themes)	Emerging behaviour
Personal belief	The nurses' beliefs regarding self principle, pre-eminence, and self potential that relates to personal and spiritual matters	Certain of one's pre-eminence; possesses self awareness, self identity, and self assurance spiritually
Spiritual knowledge	The nurses' understanding towards concepts, ideas, insights, spiritual experiences, procedures, and policies of spiritual care	Understands spiritual care, ethics, procedures, sequences, service standards, orientations, standard operational procedures, and policies regarding spiritual care
Spiritual comfort	The capability to create comfort for other people, to help out, to create peace, to do good and to be sincere	Carries out prayers comfortably, takes care of surroundings at ease, gives help and does good deeds toward patients in need as well as their family members
Spiritual implementation	The capability to implement prayers routinely, praying, and being present in providing care service	Carries out spiritual fulfilment practices, gives out motivation to pray, listens to murottal, conducts talk regarding spiritual matters, gives a chance to pray
Spiritual support	The capability to provide motivation, spirit, and help toward other people	Initiates warm interactions or connects with patients and their family members; coordinates with people of interdisciplinary backgrounds; be attentive and caring, and provides spirit and motivation to the patients

The sociodemographic characteristic of research subjects consists of age, sex, education level, religion, work experience, and working status. In Table 2, we can conclude that more than half of the total participants are 21-40 years old (56,1%) while the latter half is 41-60 years old (43,9%). A majority of them are female (66,7%), and they have varying levels of education: from associate's degree (29,9%), profession (43,9%), and bachelor's degree (26,3%). Nearly half of the total subjects have 0-5 years of work experience (45,6%), while some of them have 6-10 years (29,8%) to 11-15 years (24,6%) of work experience. The hospital sector of their work is less likely to be at a private hospital (36,9%) rather than in a government hospital (63,1%). A large number of the nurses profess Islam (75,4%), while there is a few of them who are Catholic (15,7%) or Protestant (8,7%).

Table 2. Sociodemographic characteristics of the subjects

Data	Information	Frequency (N=57)	Percentage (%)
Age (year)	21-40 years	32	56,1
	41-60 years	25	43,9
Sex	Male	19	33,3
	Female	38	66,7
Education level	Associate's Degree	17	29,9
	Profession	25	43,9
	Bachelor's Degree	15	26,3
Work experience in hospital (year)	0-5 years	26	45,6
	6-10 years	17	29,8
	11-15 years	14	24,6
Working status in hospital (private/government)	Private	21	36,9
	Government	36	63,1
Religion	Islam	43	75,4
	Catholic	9	15,7
	Protestant	5	8,7

Inter-Dimensional Dynamics of Spiritual Care

The theory of quality spiritual nursing care discloses spiritual comfort and spiritual wellbeing, which is a link between rational development and a strong relationship with God.[11] It is expounded further with four dimensions; receptivity, positivity, competency, and humanity. Each dimension develops as they complete one another. A personal belief of spirituality is deemed the most important to possess in foremost by a nurse. The results show that spiritual implementation and spiritual support often appear in nurses with personal beliefs.

The conclusion regarding inter-dimensional dynamics is that personal belief is the most essential capability of a nurse to do spiritual care, in which personal belief is directly connected with spiritual knowledge, spiritual comfort, spiritual implementation, and spiritual support. Personal belief is what is hoped to be manifested foremost within the nurses. This dimension will affect the formation of other spiritual care dimensions. These dimensions will evolve but also complete one another in the process.

In accordance to the founding of dimensions and their indicators as well as inter-dimensional dynamics, thus it can be concluded that spiritual care or behaviour of spiritual care is a spiritual based activity by a nurse to a patient. This study is important to achieve a wholly healthy state in biological, psychological, social, and especially spiritual terms.

To give a depiction of how the dimensions and indicators are presented, numbers of responses of subjects are summarized altogether in Table 3. The number of percentages in Table 3 shows that responses regarding personal belief and spiritual comfort dominate other dimensions. It indicates that subjects emphasize their work on spiritual care toward the process of personal belief and getting spiritual comfort that each of the nurse experience. The comfort that is being explored in this research is the comfort in emotions, peace, sincerity in helpfulness, doing

good for tranquillity, and empathy filled with sincerity. On the other hand, spiritual knowledge has the lowest number of responses compared to other dimensions, just below spiritual support and spiritual implementation respectively.

According to these results, the exploration of spiritual care is depicted by hospital nurses as personal belief towards spirituality that can be experienced through spiritual comfort, which is manifested through routine worships, prayers, and intense presence as spiritual implementations and support.

Table 3. Response percentage of research subjects

Dimensions (Themes)	Indicators (subthemes)	Response				Sum of Amount (Percentage)
		Male	Female	Amount	Percentage (%)	
Personal belief	Self principle, pre-eminence, self potential	2	9	11	19,29	21 (36,84 %)
		3	4	7	12,28	
		2	1	3	5,26	
Spiritual knowledge	Self acknowledgement, spiritual experience, policy understanding	1	1	2	3,50	5 (8,7 %)
		-	2	2	3,50	
		-	1	1	1,75	
Spiritual comfort	Comfort and peace building, helpfulness, kindness, sincerity	2	5	7	12,28	14 (24,56 %)
		-	3	3	5,26	
		1	1	2	3,50	
		1	-	1	1,75	
		-	1	1	1,75	
Spiritual implementation	Religious devotion, prayers, presence	1	3	4	7,01	10 (17,54 %)
		1	2	3	5,26	
		2	1	3	5,26	
Spiritual support	Providing motivation and spirit, helping others in need	2	2	4	7,01	7 (12,28 %)
		1	1	2	3,50	
		-	1	1	1,75	
Total		19	38	57	100	57 (100%)

DISCUSSION

Findings of this research show that spiritual care consists of several dimensions: personal belief, spiritual knowledge, spiritual comfort, spiritual implementation, and spiritual support. This research aims to increase nurses' capabilities to provide spiritual care towards patients.[12] Identification results pertain experience, level of comfort, knowledge, interactions between nurses and patients linked to patients' spirituality, needs, spiritual support in regulating health, and basic education program for nurses are needed in spiritual care management.

The exploration results of hospital nurses refer that personal belief consists of a set of behaviors which are self-principle, pre-eminence, and self-potential. Another support regarding personal belief is self-potential in the meaning of life, kind helpfulness to others, and readiness in facing patients in the hospital.[13] As a whole, spiritual care consists of four main virtues. First are humility. Humility, in which there is an acceptance self-limitation amidst receiving mistakes from surroundings, and accepting

the realities in life. The second is tranquillity. Tranquillity, in which this benevolence can be achieved through prayers and peacefulness. The third one is being grateful, aware, solicitous, as well as responsible by leading a good life. the last one an affectionate life that is healthy and peaceful.[14] This also shows that the effect on personal belief grows spiritual comfort that is humility, tranquility, gratefulness and peacefulness.

As one of the concepts within the context of nursery and psychology, spiritual care exhibits basic belief to have faith in God, in having happiness as a life goal, and in human creation. There are two meanings of 'belief': the first one is evaluative attitude, which is depicted by believing the doctor's assessments or believing to medicine and medical care and the second is belief with affective attitude, which is devotion towards kings, angels, fairies, and tales. Faith in God is not just belief in a practical meaning but also contains evaluative meaning.[15]

Aside from exploring spiritual care in the context of nursery and psychology, there is also a challenge that nurses are supposed to face in the hospital. The challenge is to perceive the responses of participants in this research about personal belief, spiritual knowledge, spiritual comfort, spiritual implementation, and spiritual support.

There are many perceptions regarding spiritual care by hospital nurses. First of all is spiritual care that has been applicated so far is not fully holistic. Health treatment involves physical, mental, social and spiritual care. Hindrances in holistic treatment begin from perceptions of the policymakers, irregular fundings, and the lack of communication in interdisciplinary experts due to conflicting principles as well as on how to respond toward spiritual care. The second one is health staffs. Health staffs (doctors, nurses, and spiritual guides) feel uncomfortable about the limitations of spiritual care, as some perceive that spirituality is a personal matter. The third one is because spiritual care intervention is not acknowledged as an integral component of hospital patient treatment. The fouth one is because spiritual care is viewed as a sensitive service since it is related to how to respond meaning to religion, transcendence and closeness to God. The last one, spiritual service should begin with spiritual awareness. Thus existing facilities and support in spiritual care has not reflected the real spiritual aspect within yet.[16]

Spirituality has a profound meaning to possess spiritual knowledge, including the capability to define principles and attitude towards the rules of life. Spiritual care is the implicative extension of spirituality. Spiritual care responds to humans' spiritual needs when facing trauma, pain, or sorrow. This is carried out by nurses by supporting patients through ritual worships, prayers, meditation, spiritual counselling, or listening to patients' stories thoroughly. Spiritual care is based on a caring attitude as a foundation of spiritual knowledge in health services. It manifests into endearment, heartening, reducing pain, and having a mutual feeling of unpleasant that patients' undergo.[17]

Nurses treat themselves and their patients with respect, kindness, endearment, affection, and empathy because, in the process of human life, health is also treated with care in spiritual terms. Acts of support in spiritual terms, such as acceptance, respect, mindfulness, openness, a reflection of the decision, admission, and health promotion.[18]

In implementing spiritual care, neurophysiological principles and inter-personal empathy are found. The result is the capability to listen and experience the patients' pain or suffering by involving empathy as a proof -based method in spiritual care.[19] This is to respond to the spiritual issue toward patients who undergo end-of-life care, that there is a close relationship between pain and spiritual distress. Spiritual prosperity becomes the patients' purpose of achieving the quality of life that is related to health. Even if there was a treatment carried out by spiritual guides, but this finding describes spiritual implementation by nurses.[20]

Mental health approach through recovery model founds a new dimension for treatment and enables people with mental illness to control

their lives to make it meaningful. This research's aim is to be carried out interdisciplinary through complementary approach, in medical, psychological, as well as spiritual matters.[21] Religion and spirituality are important in providing treatment to patients with terminal illnesses and chronic medical conditions. Needs wants, and perspectives of patients regarding spiritual matters should be handled in standard clinical treatments. Intervention with modern medicine is directed toward holistic treatments in hospitals.[22]

Spiritual care is an important aspect of holistic treatment. The result of a research to identify spiritual perceptions toward spiritual care by Nigerian nurses shows that 68,7 % nurses have low perceptions of spiritual care which is caused by the lack of confidence to provide spiritual service in hospitals.[23] Self-confidence in doing spiritual care by nurses can be increased if nurses can fulfil their patients' spiritual needs, which are meaning-purpose, love-relatedness, and forgiveness. If the nurses' spiritual belief and spiritual comfort are supported with sufficient amount of spiritual knowledge and support, it can bring a beneficial impact on the quality of health in hospitals.[24]

The description above points out that the dimensions of spiritual care found in this research have a strong root in the context of hospital health services. At least it is exhibited from the emergence of forms of behaviour by nurses in doing spiritual care and indicators of spiritual care behaviour as universal dimensions. Regardless, personal belief, spiritual knowledge, spiritual comfort, spiritual implementation, and spiritual support become unique findings in this research.

Limitations that appear in this research is the produced description in the dynamics of spiritual care still needs further empirical testings. In subsequence, dynamics of inter-dimensional relations in spiritual care can be produced, hopefully, more accurate and widely accepted.

Dimensions of spiritual care can be used by future researchers as a conceptual base in researches regarding spiritual care. The follow-up for the findings of this research is to test the dynamics of spiritual care empirically. There also needs to be a subsequent research to arrange norms if the findings are used to look up the standards of spiritual care.

CONCLUSION

According to the findings pertained above, dynamically and integratively based on values of divinity and humanity. The main services of spiritual care comprise of caring for the ones who are ill, identifying spiritual needs, and increasing spiritual prosperity. This explorative study concludes that there are dimensions in the spiritual care of hospital nurses: personal belief, spiritual knowledge, spiritual comfort, spiritual implementation, and spiritual support.

Conflict of interest

There are no conflicts of interest.

ACKNOWLEDGMENT

Authors thanks to Adika Zhulhi Arjana for help in this manuscript preparation.

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