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ORIGINAL PAPER

Self-Preservation in Both Sides: Pathology of Spiritual Care in Iran

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Abstract The aim of this study was to create a deeper understanding of the variables that may restrain or progress spiritual care in Iran. This manuscript provides an in-depth description of barriers to delivering spiritual care by nurses as well as patients' compensatory mechanisms against deprivation from spiritual care termed "self-preservation in both sides" emerged from an empirical study. It brings issues such as structural, hierarchical, social and personal concerns, which may prevent advancing spirituality within health care, to light. Thirty-five participants, nurses ($n = 10$), patients ($n = 22$) and their relatives ($n = 3$), took part in this study, and data were analyzed using qualitative content analysis method. Being aware of these results may help nurses and healthcare professionals to engage with and overcome some of the structural, hierarchical and social variables affecting spiritual care.

Keywords Nursing · Qualitative research · Self-preservation · Spiritual care

Introduction

Many studies have shown that patients' spirituality plays an imperative role in their healing and general well-being, and strong evidence supports primary care providers consolidating patients' spirituality into their care (Cotton et al. 2006; Koenig 2004; Krupski et al. 2006; Tanyi and Werner 2003). Growing interest is due in part to the positive impacts of spirituality on well-being (Ellis et al. 2002; MacLean et al. 2003; Stranahan 2001; Tanyi and Werner 2003).

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Spiritual care is a vital, but regularly neglected and inadequately realized, part of holistic nursing practice for adults in primary healthcare settings. As the literature shows the connection between spirituality and well-being more and more, there is a propelling need for nurses to address the spiritual care needs of patients (Carron and Cumbie 2011). Nurses assume to give holistic care that realizes the vitality of the physical, mental, social and spiritual needs (Van Leeuwen and Cusveller 2004; Chan et al. 2006).

Advances in health care demonstrate an increasing attention toward the imperatives of patients' spiritual needs, e.g., the expanding number of exploration reports dealing with spirituality in nursing. Research shows that a few patients consider the nursing staff as an asset for spiritual issues (Balboni et al. 2007). There is also a willingness among nursing staff to consider the spiritual needs of patients (Strang et al. 2002; Lundmark 2006), but it is an overall thought, not focusing on Islamic countries. Although valuable information is available from the studies performed in, for example, the USA (Bussing and Koenig 2010), because of a different spiritual climate in the USA compared with Iran, scholars cannot transfer those results directly to Islamic countries. Various nursing specialists agree that the most significant sense of spirituality is an important dimension of people and a key center for nursing attention.

To gain knowledge about the current circumstance of spiritual care in Iranian health care, it is important to study elements of spiritual care in Iran. This knowledge is necessary not only to be able to evaluate the present situation in spiritual care, but also to project the situation in the foreseeable future, point out practical goals for tomorrow and, finally, decide which instruments we need to reach the goals. Many variables prompt the compelling spiritual care by nurses. These components principally incorporate the nurses' personal belief, perception of spiritual needs and care, life experience and a willingness and sensitivity on spirituality, all assumed to be critical in nursing care (Ross 1994). Besides the working environment and conditions, communication with other caregivers and patients' openness to communication also impact spiritual care (Narayanasamy and Owens 2001) and previous studies reflect the cultural, religious and ethnic diversity existing within contemporary societies. Thus, this paper provides an in-depth description of barriers to delivering spiritual care by nurses as well as patients' compensatory mechanisms against deprivation from spiritual care termed "self-preservation in both sides" emerged from an empirical study. It brings issues such as structural, hierarchical, social and personal concerns, which may prevent advancing spirituality within health care, to light.

Study Design

To get access to the pattern of spiritual care in the healthcare context of Iran, researchers directed qualitative exploration using a qualitative content analysis. An explanation behind using this method is that qualitative method allows the researcher to find attitudes, meanings and attributes and to investigate a phenomenon that is not promptly visible.

Aim and Objective

The aim of this study was to create a deeper understanding of the variables and drives that can inhibit or advance spiritual care in Iran.

Sampling Methods

We used two types of sampling. During data collection, a broad range of nurses and patients were enrolled by purposeful sampling to evaluate the diversity of belief, professional experience, age and type of disease. By analyzing interview transcripts and emerging themes, the sampling got to be more focused. Inclusion criteria for nurses and patients who confessed to the units were above 19 years of age, at least one week of experience of the service and able to give informed consent. Patients admitted to the units and fulfilling the criteria were approached to take part in the study.

Ethical Approval/Issues

Isfahan University of Medical Sciences and Ardabil University of Medical Sciences approved this research, and research committees of the universities approved the investigation and arranged institutional consent and access to the service managers. All participants gave verbal and written consent preceding all interviews. The first author kept all transcripts and information of participants in a locked filing cabinet and gave a code to participants to guarantee anonymity and confidentiality.

Rigor

Researchers paid attention to keeping rigor (trustworthiness) throughout the research by taking the following approaches:

- Prolonged engagement, persistent observation, member check and expert review, including two professors of nursing from Ardabil University of Medical Sciences and Isfahan University of Medical Sciences, strengthened credibility.
- Sufficient contextual information (audit trail) to make similar judgments possible by others provided auditability.
- Being honest about representing the process of data analysis, interaction with the data, including being present at the interview, listening to the tape, transcribing, reading the transcription, thinking, interpretation and understanding, and forming the findings, themes, codes and categories ensured confirmability.
- Finally, rich and verbatim description of the participant's views of spiritual care in hospitals allowed the readers to judge about the validity of the results and their potential transferability to other healthcare settings and situations. Reliability of the study, as noted by Creswell (2007), was ensured by a professional transcription of the participant audiotapes and inter-coder agreement between the two study authors on the common themes and categories.

Participants

Thirty-five participants (16 men and 19 women) aged 20–70 were recruited and gave consent for interviewing. The participants included nurses ($n = 10$), patients ($n = 22$) and relatives ($n = 3$) and were from three areas: area I (hospitals of Ardabil), area II (hospitals of Isfahan) and area III (hospitals of Qom). Areas II and III were in the same region in the center of Iran. An area I was in northwest of Iran. Using three different regions ensured the ethnic diversity.

Data Collection/Analysis

In this study, participants' perspectives were analyzed using unstructured interviews and self-reflection.

In line with the qualitative method, there was a concurrent data collection and analysis. Codes led to the formation of categories, properties and central themes. After achieving data saturation, when no new themes or categories were identified, researchers halted data collection and analysis. Semi-structured interviews were conducted, ranging in length from 30 to 90 min. In these interviews, the opening invitation "Tell me about being in hospital" remained constant throughout the study.

Other questions were: How do they relieve their spiritual needs? What kind of care is used for satisfying their spiritual needs? What factors make them to satisfy their spiritual needs? How do they preserve their needs? What is the meaning of illness for them? What role nurses have in meeting spiritual needs? What role family plays?

Coding

First author repeatedly listened to tape recordings, analyzed, coded and recoded to make sense of the data for common concepts and ideas, and developed the emerging themes.

The way the interviews were developed depended on each respondent following an individual agenda. Themes that emerged from one interview were tested at next interviews to develop deep exploration. In this way, data were treated as a collection of a body of information, constantly being updated and elaborated on and analyzed concurrently.

The tapes were transcribed and codes were made next to phrases, words or comments in the text. Labels were given to emerging themes and coded. In this phase, 2600 codes emerged which were stratified into 305 codes. This process led to identifying concepts, properties and dimensions within participants' transcripts, for example how participants understood and defined spiritual care. Codes were then sorted into categories and redefined into further focused categories.

Throughout the process, the researcher explored the causal conditions arising from the data, for example by asking questions such as "what is going on?", "what does this mean?" and "under what conditions and what consequences does this happen?"

For example, the researcher developed links between "seeking care" and "struggling to cope." Also there was a link between "occasional spiritual care" and "self-preservation from superego." Among the variety of categories emerged were "self-preservation in patients" and "self-preservation in nurses." This was finally written up as "self-preservation in both sides."

Findings

The results of this qualitative study highlighted some significant findings in patients' and nurses' practice of spiritual care and identified barriers to such practice. Researchers used excerpts of transcripts to explain and confirm some of the findings.

Self-preservation was a central and fundamental theme that was central to the pattern of spiritual care with respect to both sides of interaction: patients and nurses. Nevertheless, each side of interaction made it by different reasons. Nurses preserve themselves from rules, burnout, insecurity and superego. On the other hand, patients preserve themselves from the distress of disease and deprivation from care (Fig. 1).

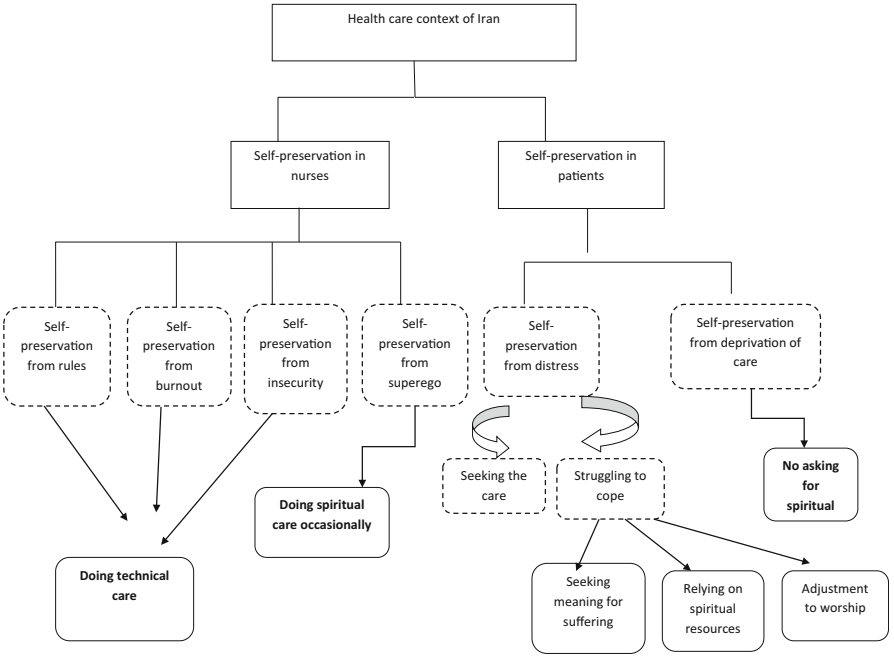

Fig. 1 Conceptual model of self-preservation in both sides

Components of Self-Preservation

Self-Preservation in Nurses

1. *Self-preservation from rules*: The findings of this investigation inferred that when nurses try to preserve themselves from rules of healthcare setting, they provide technical care instead of spiritual care. This kind of care has the characteristics such as lack of attention to patients, poor communication, neglecting the patients' spiritual needs, insensitivity to patient needs, giving indirect patient care, giving effort only to doing physicians' orders, caring habitually instead of considering patients uniquely, talking impolitely with patients and companions and the rest. As noted, this kind of caring is in the opposite point of spiritual care in that nurse gives no attention to patient needs, even physical ones. Data gathered in this study showed that the prominent way of care in Iran's hospitals is technical care because the rules do not have any stress on spiritual care. Researchers also noted that nurses spent most of their energy for providing technical care and it is not a matter whether it is desirable for patients or not.

One of the patients said in this view: "*I have been here since 3 days ago, hungry and thirsty, I ask, please pay attention, but it seems as if I am not here, they do not see me (crying)*". (P 3)

Another patient declared: *nurses do their work (giving medicines, writing nursing notes,* etc.*) with their head below without any communication with us. They do caring as a robot and their efforts aimed to apply physicians' orders. If patients ask any question, nobody respond usually* (p 5).

2. *Self-preservation from burnout*: Some nurses commented it was demanding dealing with patients' spiritual needs and, because of the emotional implications, others stated they avoid dealing with patients' spiritual issues. The notion of avoidance was evident in one nurse's transcript: "*By not having the answers that patients want to hear, thus rather than dealing with that you'd better do not do it! Using avoidance rather than, you know, I think, possibly using avoidance rather than dealing with it*" (N 1).

The notion of preserving from burnout further reflected in the following excerpt: "*I akin to work in the operating room or wards as dialysis unit because patients do not have many demands. Indeed, they are not alive to have any seek*" (N 7).

Another nurse in response to researcher's question "Why you don't talk with patients when doing their work?" echoed: "*we do not have enough energy to waste for unnecessary talking. We must save our energy for working at nights and sequential shifts. Also we have duty for caring our family.*" (N 5)

3. *Self-preservation from insecurity*: The evidence that supports this conclusion came from observations: "making communication with patients' companion when feeling secure, not responding to visitors' questions and not allowing companions being present near the patient." When researcher asked nurses about these behaviors, one of them responded: "*Because of violence, the companions became angry when they confront with their relatives disease and we are amid danger. We lock the door at night for protection of ourselves from the aggressive acting*" (N 10).

Another nurse said: "*When a patient dying, we ask companions to leave the ward. We do not allow them to be present near the patients. They are dangerous now. If we assure they will act safely, we shall allow*" (N 9).

4. *Self-preservation from superego*: Another category found in this study was preserving the self from superego. Nurses do the physical care in the best way and spiritual care sometimes. This reason has an important role in giving quality care for patients; indeed, nurses provide good care to patients because of orders of conscience. One nurse stated: "*if we provide a care out of our duty (spiritual care), its reason is only fear of God. I assume the patient is one of my family members; therefore I do the care that I expect to receive in my family member. Management does not control for doing spiritual care*" (N 3).

However, nurses delivered spiritual care just somewhat and it was not continuous. One nurse expressed: "*If we give spiritual care, it is not continuous. If we recognize a patient needs spiritual support, we shall provide it but it is not a usual acting*" (N 10). This kind of care (spiritual care) includes attention, listening to patients' conversation, empathy, talking with patients, giving hope, easing of worship, having communication with their family members, praying for patients, giving knowledge and humor.

The following excerpt shows the nurses' effort in simplifying patients' communication with their families. "*If we see a patient lying on the bed and crying, it may be for the missing of family, therefore we call his family for visiting their patients*" (N 9). Therefore, nurses decided to give spiritual care to the patients. The nurses' sensitivity to the emotional and spiritual issues makes up the quality care. Although the spiritual care has a good effect on the patients, because of its noncontinuous nature, it does not have the desired effect on patients. Especially, the conscience cannot have a strong effect on nurses at all times.

Self-Preservation in Patients

1. *Self-preservation from the distress of disease*: The present study showed that patients use two main tactics for preserving themselves from the distress of disease: seeking care and struggling to cope.

- *Seeking care*: Participants in this study seek care to be relieved from the disease. By seeking physical care and information, they tried to preserve themselves from distress.

The following excerpt shows this notion: "*I came here to be cured, my expectation is this. I want medicine; I have not any other expectation. I have trusted to power of God but everybody (doctors and nurses) are mean of God*" (p 20).

The patients' need for information was echoed by the following quotation: "*It is good to tell us the diagnosis (cancer). If we know that, we can adapt with the disease. In addition, we want to get information about how to manage our disease, but nobody gave us it. At first, we insisted to get an explanation, but when we did not get the result, we receded; instead we began to make fun of doctors. One of us became doctors, visited others, and faked the doctors. When we saw that we couldn't dominate them, we decided to satisfy ourselves in this manner*" (p 17).

- *Struggling to cope*: When healing was impossible, patients tried to cope with the disease. The mechanisms they use for coping with the disease and hospitalization were *justification for disease, relying on spiritual resources (transcendent and humanistic) and adjustment to worship*.

Justification for disease: A strategy that patients used for coping is finding reason for their disease. They go back to their past life and seek meaning for their disease. Often, religion helps them to find meaning. Most of the patients perceive spirituality as a potent resource in times of illness and hospitalization. They use spiritual resources for preserving themselves from the distress of disease. However, if these resources are to be harnessed and the quality of the patients' life heightened, sufficient resources should be made available by organizations and institutions to enable healthcare professionals to achieve this goal. A patient mentioned this view:

"*When I got heart pain I thought maybe it was for that I'd forgotten the God and he wanted to alert me. If the reason of my disease is I thank God for his compassion*" (p 15)

Relying on spiritual resources: Patients tried to cope up with their incurable disease with the support of spiritual resources (based on their culture and religion). These sources of strength impacted positively on coping strategies and underpinned the richness and meaning that participants gave to their experiences. Spiritual resources of Iranian Muslim patients included transcendent spiritual resources that comprise Allah (God), holy Quran and fourteen innocents (prophet of Islam, his daughter and Imams) and humanistic spiritual resources consisted of family, relatives, friends and companion. Patients in the present research take on to cope with disease and preserve themselves from the harms of disease, distress through the worship, praying, trust in God, patience and hope to God (relying on transcendent spiritual resources).

In Iran, the family is the traditional foundation of society that extends beyond the immediate relatives to include all the members of the tribe. They wanted companion to do their basic cares, listen to them and help them in worship. In addition, they wanted someone to be present beside them. For example, a patient declared:

"*Because I had severe pain, I was so anxious, I took my son's hand was with me at that time, and I thought I have a better sense if all of my kids were there*" (p 18). Or

Or "*If I don't have any companion, I'll be in trouble because of loneliness. I feel better now but until yesterday I needed them (companions), they do all of my caring responsibilities*" (p 14). Besides, companionship of family member was the will of most patients. Therefore, the real need of patients is having companionship and a large number of visitors, although it may seem disrupting nursing duties. These findings support current initiatives to change policies that favor unrestricted visiting in hospitals and family presence on the bedside during their patient's hospitalization.

Adjustment to worship: On the other hand, hospitalized patients experience enormous distress because the wards' conditions are not suitable for their worship. A patient affirmed: "*I have been here since 3 days ago; I haven't prayed anymore, it makes me so sad, please tell them to give me clean trousers*" (P 4).

They adjust themselves for this constriction through adjusting quantity and quality of worship. Some of the tactics for this adjustment included prayer while seated or lying on the bed, postponing worship for after discharge, doing prayer without standing in front of the Qibla (Mecca) and so on.

Another participant proved this adjustment in the following passage:

"*We must worship in any condition, as a passenger in any direction*" (p 12). Therefore, adjustment helps patients do worship or at least feel connected with Allah and results in relieving distress of hospitalization

2. *Self-preservation from deprivation of usual care*: In this way, patients seeking care make an effort to be polite and "good patient" because of fearing of deprivation from physical care. The most important tactics they used were avoiding from communication with nurses and seeking not more than critical care. Patients ignore their spiritual desires for achieving physical needs and try to meet their needs by themselves or companion.

Relying on companion was credited in the following quotation of a patient

"*My companion brings me water for ablution, changes my clothes or washes my face. She does all of my caring, I don't know what I do if I didn't have any companion*" (p 13)

Thus, we can explain that patients take an avoidance approach and try not to seek spiritual needs, which leads to unsuitable communication between nurses and patients and not meeting the spiritual needs of patients.

Discussion

The freely expressed experiences suggest that nurses aim to provide spiritual care; however, it is often adversely affected by several physical, professional and personal barriers. Difficulties expressed with regard to the provision of spiritual care concerned insecurity, time constraints and being too busy. Nonetheless, participants reported a high degree of self-satisfaction when implementing spiritual care interventions. In this respect, spiritual care interventions promote a sense of well-being for nurses as well as being a valuable part of total patient care (Milligan 2004). Barriers often cited by nurses in practice include a lack of knowledge, a lack of time, failure by staff to be in touch with their own spirituality, confusion about the nurse's role in providing spiritual care and fear of imposing their own philosophy on others (Hubbell et al. 2006; Milligan 2004).

The findings of this investigation suggest that management within the hospital settings must be aware of ensuring that sufficient resources were available for staff being on duty, to meet not only the physical but also the spiritual needs of patients. Thomason (2000) reported the 14 potential barriers, most often cited lack of time (71 %), while half the respondents concerned lack of training or experience in spiritual assessment as a barrier. In this regard, the acute trusts must be plagued with staff shortages and underinvestment about staff having time and ability.

Feudtner et al. (2003) mentioned three barriers to providing spiritual care: inadequate staffing of the pastoral care office, inadequate training of healthcare providers to detect patients' spiritual needs, and being called to visit with patients and families too late to provide all the care that could have been provided. In this regard, Baldachino (2011) investigated the perceived impact of the study unit on spiritual coping in illness and care on qualified nurses. The positive impact was demonstrated by the two themes emerged from the data, namely increase in knowledge on the spiritual dimension in care and self-awareness on the nurse's role in spiritual care. Also, Balboni et al. (2014) reported that lack of spiritual care (SC) training was the only barrier that was endorsed by most nurses, but this theme was not mentioned in our study.

Time constraints were recurring themes, in this study, that adversely affected the nurses' interpersonal skills in the provision of spiritual care. These findings concur with Kihlgren et al. (2004) who found that, although nurses appreciated the need to take time to listen and validate patients' feelings, the emergency environment had many negative effects in the interpersonal encounter. Indeed, many people today experience the lack of time in the caring system as an enormous problem (Sorlie et al. 2004). Nevertheless, this view has been contended by several authors who asserted that patient-centered communication does not take up more of the nurse's time or require extra resources, and it is initiated by nurses in the words and body language that they choose to use when approaching the patients (Astedt-Kurki and Haggman-Laitila 1992; Williams 1998; Mc Cabe 2004).

Again, many nurses expressed concern for personal safety of themselves and those in their care. Some workplaces described by the nurses in this study did not have adequate systems of security. A significant challenge expressed by many nurses was the perceived lack of support by management for ensuring their safety, coupled with a sense of feeling ill-prepared to anticipate and manage escalating events. In these cases, nurses avoided from building close rapport with patients and their relatives. Therefore, obviously, self-preservation from insecurity is a barrier for spiritual care because this self-preservation inhibits nurses from making a good communication with patients and their companions. Nurses in particular are a target group for experiencing violence due to the nature of their contact with clients (NICE 2005).

On the other hand, self-preservation in patients was evident in our study. Mogobe (2005) stated preserving self means developing strategies to prevent or reduce harm inflicted by others. In her study, patients develop strategies such as looking for deeper meaning, working it out, giving into feelings, getting more involved, getting away and doing adoption.

Thomas and Retsas (1999) in their study found that people with terminal cancer develop a spiritual perspective that strengthens their approaches to life and death. They enacted discovery of spiritual meaning through a process of transacting self-preservation.

Labun (1988) reflected that the (religious) institution codifies and provides pathways for expressing beliefs and values held by the person. It provides meaning in the day-to-day chores of life and comforts the person through hardships such as illness, pain and personal disaster. The opinion that a religion works to provide meaning useful in times of stress is

also widespread. For instance, McGrath and Philips reported that some individuals faced with the crisis of a terminal illness will turn to the comforting ritual of their chosen faith (2008).

Relying on companions was a recurrent theme that was used by patients as spiritual resources. Omeri's (1997) study of care meanings, expressions and practices of Iranian Muslim immigrants in Australia found the importance of communication with family. As marked in that study, family visiting and support (emotional, social and physical) are important ways of "being together." Johnson (2001) affirmed that Islam obliges followers to visit patients and to inquire about their health. Karimollahi et al. (2007) mentioned that companion is important for most patients who take care of and support them. Joolaee (2006) mentioned that the need for companionship, and the participants stressed that the presence of their companion was an important part in providing and protecting their rights. Every patient want to have a companion because they are fully aware that not having one inevitably result in their most basic needs not being met while on the ward. Should they need anything to be gained from outside the hospital, such as medication or disposable equipment, their companion is the only person who might be relied on to provide them with this service.

Failure to address these key elements within healthcare practice and education will result in the spiritual needs of patients being only partially met. Components of self-preservation were identified throughout the data analysis. With the use of the content analysis method, researchers found self-preservation to be a recurrent and crosscutting theme featuring explicitly or implicitly within participants' transcripts. In summary, the self-preservation was a central and fundamental theme that was central to the pathology of spiritual care.

Conclusion

The present study was the result of a qualitative research with the aim of exploring spiritual care pattern in hospitalized patients that managers can use for planning spiritual care for patients. This article is a very worthy and informative report about pathology of spiritual care, which can be used for designing corrective and reformative action plans in this regard. Assessing the relationship between the emerging concepts showed that spiritual care process includes self-preservation by patients and nurses that finally leads to spiritual distress in patients. We conclude with the notion that self-preservation in nurses and patients are the main inhibiting factors to giving spiritual care in the Iranian context of caring.

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