Spiritual Well-Being Of Health Failure Patients

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Abstract

Introduction: Decreasing heart function raises problems both physical, psychological and spiritual. Patients faced this health issue, and they need an individual's spirit and encouragement related to self- management and illness. The purpose of this study was to describe the spiritual well-being of heart failure patients. Method: The method used in the research was a quantitative descriptive method with a cross-sectional approach. The population in this research was all patients with heart failure who underwent inpatient and outpatient care. Samples were taken by consecutive sampling technique for one month and 61 respondents were obtained. Data were collected by using the Spirituality Index of Well-Being instruments. Univariate data analysis uses the mean values and frequency distribution. Result: The result showed that patients with heart failure who had high spiritual well-being were 53 people (86,9%). In life scheme sub-variable, 55 people (90,2%) were included in the high category. In self-efficacy sub-variable, 48 people (78,7%) were included in high category but 13 people (21,3%) were into the low category with a low mean score of 3 statements. Conclusion: almost all respondents have high spiritual well-being reinforced by life scheme but there is a part of self-efficacy that still needs to be improved such as the knowledge about how to overcome the burden of life, the ability to help themselves, and the understanding related to the disease. Therefore, it is important to give information related to the patient's illness to improve the patients' spiritual well-being which can affect the health condition of the patient. In addition, physical, psychological and social management also have an important role in improving self-efficacy.

Keywords: Heart failure, spiritual well-being.

Introduction

Heart disease is the number one cause of death in the world. According to the World Health Organization (WHO) in 2017 around 17.7 million people or around 31% of total deaths worldwide were caused by heart disease. WHO predicts that by 2020 23.6 million people will die of heart disease. The main cause of death in Indonesia is non-communicable diseases, one of which is heart failure. According to data from Basic Health Research in 2013, there were 530,068 people with heart failure in Indonesia. West Java Province was the province with the highest number of heart failure sufferers, which was around 0.3% or 96,487 people (Ministry of Health, 2014).

Heart failure affects all aspects of a patient's life because the body's metabolic needs are not met due to heart failure in pumping blood to the tissues (Hall, 2016). Physically, the signs and symptoms of heart failure patients include shortness of breath, tightness at night, fatigue which results in activity tolerance and swelling in the ankles with specific signs in the form of increased JPV, hepatojugular reflux, S3 heart sound (Gallop), and heart noise (Ponikowski, 2016). Other physical problems are sexual problems and hypotension, these signs and symptoms continue to develop causing severe complications if this disease is not controlled properly (Price & Wilson, 2006).

The impact of heart failure also affects the psychological and spiritual aspects. The psychological changes include anxiety, fear of death and depression (Kaplan, Sadock, & Grebb, 2010). Research conducted by Yohannes et al., (2010) and research conducted in China by Fan et al., (2014) showed that the results of depression in heart failure patients reached 60%. This is also supported by research conducted in Indonesia by Fitria and Nuraeni (2016) in one hospital that provides religious spiritual care, which found that many heart failure patients experience depression. From 51 respondents found patients who experienced mild depression as much as 62.7% and moderate depression as much as 5.9%.

Depression is very dangerous for health failure patients if it is not treated, it worsens the condition of patients, and becomes a risk factor for death (Sherwood et al., 2011). Further consequences of physical and psychological problems such as depression will have an impact on the spiritual aspects of patients, it would lead to spiritual distress because depression influences the patient's spiritual and vice versa (Strada-Russo 2006, in A'la, 2015; Westlake et al., 2008).

Meeting spiritual needs is one of the factors that support the formation of a spiritual well-being patient. Chang et al. (2012) explained that the improvement of spiritual problems to the formation of spiritual well-being in patients with terminal illness or dying will improve the quality of life of patients. In line with the research of Naghi et al. (2012), it was explained that good spirituality improves quality of life, decreases anxiety, depression, and increases adherence during treatment in heart failure patients.

Heart failure patients should be able to adapt to existing conditions and this is closely related to an individual's adaptability. Anema (2009) revealed that spiritual well-being can be a source of coping that can be used by patients by changing signs and symptoms, uncertainty and psychosocial adaptation in a more positive direction. Patients need to be taught about managing heart failure so that patients are able to adapt to their physical, psychological and spiritual changes. Several studies have shown that spiritual well-being influences the conditions experienced by patients. The higher the spiritual welfare, the lower the level of depression (Bekelmen et al., 2007; Mirwanti & Nuraeni, 2016).

The high rate of depression in heart failure patients in hospitals results in more religious-spiritual care. based on the concept when the spiritual aspect is given well then psychological problems will also be handled, so it is important to see the spiritual intervention that has been given by the hospital is able to improve the spiritual well-being of the patient or not. Therefore researchers are interested in describing the spiritual well-being of heart failure patients.

Method

The study design

This type of research was a quantitative descriptive study with cross-sectional study design. The population in this study were all heart failure patients undergoing inpatient and outpatient cardiac polyclinics in one hospital in Bandung. Samples were taken using consecutive sampling technique within 1 month. So that the number of samples obtained was 61 respondents (50 people from outpatient care and 11 people from inpatient care), almost all respondents were patients who had received spiritual intervention from Al-Islam Hospital and a small number were referred patients from other hospitals to do outpatient care. at Al-Islam Hospital.

Instrument

The variable in this study was spiritual well-being. The instrument used is the Spirituality Index of Well-Being (SIWB) by Daaleman and Frey (2004) which consists of 12 statements to measure spiritual well-being with a reliability value of 0.805. subvariable from SIWB consists of self-efficacy and life scheme. This research obtained an Ethical Clearance from the Research Ethics Commission of the University of Padjadjaran with Number: 225 / UN6.KEP / EC / 2018. All respondents involved in this study were willing to become respondents.

Data analysis

Univariate analysis was carried out to describe the spiritual well-being of patients with heart failure using average values and frequency distributions, then categorized into high and low groups based on the mean values for SIWB 36 (high category), SIWB <36 (category low). Sub-variable value of SIWB (self-efficacy and life scheme) ≥18 (high category), and 18 for the low category.

Result

Tabel 1. Characteristic of respondents

Characteristic	Frequency(f)	Percentage (%)
Gender		
Male	**38**	**62.3**
Female	**23**	**37.7**
Age		
17-25 years	**2**	**3.3**
36-45 years	**3**	**4.9**
46-55 years	**9**	**14.8**
56-65 years	**23**	**37.7**
>65 years	**24**	**39.3**
Ethnic		
Sundanese	**49**	**80.3**
Javanese	**4**	**6.6**
Batak	**2**	**3.3**
Others	**6**	**9.8**
Religion		
Islam	**60**	**98.4**
Christiani	**1**	**1.6**
Education		
Elementary School	**10**	**16.4**
Junior High School	**7**	**11.5**
Senior High School	**18**	**29.5**
University	**26**	**42.6**
Occupation		

Employee	**16**	**26.2**
Unemployeed	**45**	**73.8**
Marital status		
Marriage	**48**	**78.7**
Unmarriage	**2**	**3.3**
Widower	**3**	**4.9**
Widow	**8**	**13.1**
Income		
< Rp. 2,8 millions rupiah	**35**	**57.4**
2,8 - 5 millions rupiah	**22**	**36.1**
> 5 million rupiah	**4**	**6.6**
Length of disease		
< 6 months	**3**	**4.9**
6 – 12 months	**8**	**13.1**
> 12 months	**50**	**82**
Health payment methods		
Non-government insurance	**5**	**8.2**
Government insurance	**56**	**91.8**

Table 2. Spiritual Well-being in heart failure patients

No	Spiritual Well-being	(f)	(%)
1	**High**	**53**	**86.9**
2	**Low**	**8**	**13.1**
Total		**61**	**100**

Table 3. Spiritual Well-being: subvariable of Self-efficacy

No	Self-efficacy	(f)	(%)
1	**High**	**48**	**78.7**
2	**Low**	**13**	**21.3**
Total		**61**	**100**

Table 4. Average of Respondents' Answers to Self-efficacy Subvariables

Respondents' Statement	Mean
Respondents have known how to startin solving their problem.	**3.66**
Respondents have made efforts to make a difference in their lives	**3.66**
Respondents were able to complete and get a way out of things that have started.	**3.61**
Respondents understood the problem that they faced.	**3.23**
Respondents helped themselves.	**3.16**
Respondents were fine when facing difficulties or personal problems.	**3.13**

Table 5. Spiritual Well-Being in Subvariabel Life Scheme

No	Life Scheme	(f)	(%)
1	**High**	**55**	**90.2**
2	**Low**	**6**	**9.8**

Total	**61**	**100**

Table 6. Respondents' Average Answers to the Variable Life scheme

Respondents' Statement	Mean
The respondent knows who he is, where he came from, or their future.	3.97
The respondent understands the meaning of his life.	3.97
In this world, respondents know where they feel comfortable.	3.95
Respondents have a purpose in life.	3.92
There is no emptiness in his life so far.	3.82
Respondents have found	3.49

Table 1 shows that the majority of respondents (62.3%) were male. Respondents in the 65-year-old group and above were more compared to other age groups (39.3%). Almost all respondents came from the Sundanese (80.3%) and were Muslim (98.4%). (42.6%) respondents have higher education. Most respondents (73.8%) were unemployed. Most of the respondents were married (78.7%). The income of respondents is in the category <2.8 Million (57.4%). Almost all respondents have been diagnosed with heart failure for more than 1 year (82.0%) and almost all of them have BPJS insurance (91.8%). Respondents outpatient were 50 people (82.0%), and inpatient 11 people (18.0%)

Spiritual Well-Being

Table 2 shows that almost all respondents (n = 53) had high spiritual well-being (86.9%), and 8 respondents had low spiritual well-being (13.1%).

Based on Table 3, 48 respondents had high self-efficacy (78.7%), and 13 respondents had low self-efficacy (21.3%).

Table 4 shows the average respondent's statement on the variable self-efficacy. Respondents' statements were sorted from the largest to the smallest average. The answer with the highest average was the respondent's statement about efforts to make a difference in his life with a mean of 3.66. This value indicated that the respondent already knew how to solve the problem and a lot has been done to make a difference in their life. The lowest statement was respondents' statement about their feeling when facing difficulties or personal problems with a mean of 3.13, much can be done to help themselves with a mean of 3.16, and respondents understand the problems faced with a mean of 3.23.

Based on Table 5, data obtained 56 respondents have a low life scheme (56%), and 44 respondents have a high life scheme (44%).

Table 6 shows the averages on variable life scheme statements. The average value was sorted from the largest to the smallest. The highest respondent's answer was the respondent's statement about who he is, where he came from, or the future plan with a mean of 3.97, and the respondent's understanding about the meaning of life with a mean of 3.97. While the lowest statement was the respondent finding of life purpose with a mean of 3.49).

Discussion

This study conducted on 61 heart failure patients in one of the religious-based hospitals in Bandung, it was found that most respondents had high spiritual well-being (86.9%) (Table 1). This may be caused of several factors, such as of the majority of respondents' age in the elderly category, at that age, the respondents understood the purpose of life so that it increased their spirituality (Suprajitno, 2004; Hamid & Yani, 2009). In addition, cultural environmental factors, especially religion, may affect spirituality, the majority of respondents are Muslims and Sundanese, they are known as a religious community (Rahmawati 2012, in Ariyani, Suryani, & Nuraeni, 2014). Research shows that hospitals that provide more religious-spiritual services compared to other hospitals increase the spirituality of respondents (Purwaningrum, 2013). The length of heart failure diagnosis is also a

factor in the high spirituality of respondents because respondents are able to change negative perceptions about the disease in a positive direction and get closer to the lord (Nuraeni, Ibrahim, & Agustina, 2013; Mailani & Setiawan, 2015). Age, cultural environment, characteristics of the hospital, and the length of time diagnosed with heart failure may be factors that cause a high level of spiritual well-being for heart failure patients in this study.

The linkages between sub-variables and variables (Table 4) are life schemes contributing greatly to the high level of the spiritual well-being of heart failure patients. A total of 53 respondents (86.9%) had high spiritual well-being and as many as 55 respondents (90.2%) had a high life scheme. This shows that the respondent's spiritual well-being is supported by aspects of the life scheme. The percentage of a high life scheme score may be due to the spiritual intervention provided at the hospital supporting the meaning and purpose of life, not how to solve the problem of the disease. This study result was supported by research conducted by Jhonstone, Yoon, and Cohen (2012) which states that Islam has a high value on aspects of life's meaning, values and beliefs, daily spiritual experiences, and spiritual coping.

According to the results, the domain of self-efficacy has a lower average value difference compared to the life scheme aspect (Table 2). This shows that there are many respondents who have low scores on aspects of self-efficacy. This also shows that there are respondents who have not been able to deal with the problem. Analysis of welfare per item on sub-variable self-efficacy shows the statement item with the lowest proportion including respondents burdened when faced with difficulties or personal problems, there are not many respondents can do to help themselves, and respondents do not understand the problems they face. This shows that the average respondent still feels burdened, does not understand, and not much can be done when facing difficulties or personal problems.

The study also found that a small proportion of respondents, 13.1%, had low spiritual well-being (Table 1). The low level of welfare is influenced by age, another concept states that in old age people start leaving various activities, so they may feel isolated, the level of dependence on other people increases, and feel that they are no longer useful in the world, and lack social support (Hurlock, 1980). The impact of disturbing aspects of life (physical, psychological) in heart failure patients will affect the patient's spirituality and decrease the patient's confidence to be able to deal with the problems they experience so that the patient experiences spiritual distress, a low level of spiritual well-being are found.

External factors also affect one's spiritual condition, namely social support or support from the closest person. Based on the concept of family factors affect the condition of one's spiritual well-being where one of the supports that can be given by the family is social support which aims to provide comfort in one's life and affect health both physical and psychological problems (Sarafino & Smith, 2012). Research conducted by Chaerunnisa, Nuraeni, and Hernawaty (2017) which states that the higher social support to patients, they do not experience depression and vice versa.

Even though the hospital has provided more spiritual interventions related to religion to respondents but informing spiritual well-being, 2 important domains are needed, including self-efficacy and life scheme. Domain self-efficacy has 3 items with low values, which are physical problems, not yet understanding the disease, and not being able to help themselves, so some of the respondents feel burdened.

In addition to the religious approach, patients need to improve their physical condition with medication or counseling. This is supported by research by Newita, Almasfy, and Harisman (2016) stating that drug counseling significantly increases patient knowledge and compliance. Moreover, factors that may improve spiritual well-being, especially self-efficacy, can be done with the presence of social and psychological support, providing complete information regarding the disease, as well as spiritual interventions according to the needs of patients. Nurses as one of the people closest to the patient need to be involved in treatment so that the patient does not feel sad because of his own, and feels helped by everyone.

Conclusion

The results of the study showed that almost all respondents included in the high category of spiritual well-being. Patients were mainly reinforced by aspects of the life scheme in addition to self-efficacy, where life schemes are aspects that may improve patients' ability to understand their meanings and goals. However, a small percentage of respondents still have low spiritual well-being, especially in the aspect of self-efficacy. The fulfillment of spiritual needs for patients is one of the factors that can support the formation of spiritual well-being, but the life scheme aspect is not enough, there are some aspects that still need to be improved to maximize the spiritual well-being, namely the aspect of self-efficacy. To improve aspects of self-efficacy can be done in several ways, including overcoming physical problems, increasing adherence in treatment by the following counseling, and overcoming psychological problems with social support for patients by involving families in treatment.

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