NURSING SCIENCE

Spiritual Care in Southeast Asia: A Systematic Review of the Evidence for Spiritual Care Models, Interventions, and Outcomes

Ali H. Abusafia[1)], Zakira Mamat[1)], Nur Syahmina Rasudin[2)], Mujahid Bakar[3)], Rohani Ismail[3)], Ola K. Taleb[4)]

ABSTRACT

Background: **The pandemic of COVID-19 has expanded the importance of spiritual care to the patients suffering and dying from this virus, as well as to their families and communities. Sincerely, there is a need for spiritual care specialists to address spiritual disorders caused by this crisis. This study aims to systematically review the status of spiritual care among nurses and patients in Southeast Asia.**

Methodology: **An online search conducted in the Scopus database from 2000 to 2020 on spiritual care in Southeast Asia. The main keywords, "spiritual care", "nursing", "patients" and "Southeast Asia" were used. A total of 94 articles were primarily determined; however, based on the criteria, only seven articles were appropriate to review.**

Results: **The seven articles identified in this study were from Indonesia (n = 3), Thailand (n = 3), and Singapore (n = 1), with nothing from other Southeast Asia countries. The review of articles highlighted five essential topics on spiritual care: Introduction and history of spiritual care, communication therapy and the relationship of nurses with patients and their families, spiritual care competence, knowing when to refer to spiritual care professional, and the nursing process as a guideline for nurses to provide spiritual care.**

Conclusion: **Without adequate educational or training intervention, the provision of appropriate spiritual care is likely not to happen; the requirement for an excellent and validated model is essential to implement spiritual care in the region need for it.**

KEY WORDS

spiritual care, systematic review, southeast Asia, nursing

INTRODUCTION

Southeast Asia is eleven countries of impressive variance in religion, culture, and history: Brunei, Burma (Myanmar), Cambodia, Timor-Leste, Indonesia, Laos, Malaysia, the Philippines, Singapore, Thailand, and Vietnam. It has a combined population of about 655 million, about 8.5% of the world's population, and it's one of the most efficient areas of the world economically (Storey, 2013). Considering the developing size of this populace, the current study reviews an intervention, training, and spiritual care model for patients and nurses in Southeast Asia. It is broadly perceived that spiritual needs obvious during hospitalization and that healthcare professionals should provide spiritual care to optimize the patient's spiritual needs (Koenig, 2012; Koren and Papamiditriou, 2013).

Literature defines spiritual care as recognizing, respecting, and meeting patients' spiritual needs; facilitating participation in religious rituals; communicating through listening and talking with clients; being with the patient by caring, supporting, and showing empathy; promoting a sense of well-being by helping them to find meaning and purpose in their illness and overall life; and referring them to other professionals, including the Imam or chaplain (Melhem *et al*., 2016).

Across the world, spiritual care is a growing topic of interest in health care. However, today, the coronavirus disease 2019 (COVID-19) pandemic has expanded the importance of spiritual care to too many patients suffering with and dying from this virus, and their families, friends, communities, as well as to the health care workers. Seriously, there is a need for spiritual care specialists and advisers to address spiritual suffering and disorders such as isolation, loneliness, and vulnerability caused by this crisis (Ferrell *et al*., 2020). Despite the fact, spiritual care has long been perceived as one of the health domains, it is regularly not completely incorporated into practice for healthcare providers (Isaac *et al*., 2016).

Therefore, nurses need suitable training to improve their competence to provide spiritual care to patients. This study reviews the previous studies that come out with a model, intervention, or training to the nurses or patients on spiritual care in Southeast Asia. We conclude the section by identifying the critical topics that could be included in the Nursing spiritual care model in the future.

Received on December 13, 2020 and accepted on March 12, 2021

1) Nursing Program, School of Health Sciences, Universiti Sains Malaysia
2) Biomedicine Program, School of Health Sciences, Universiti Sains Malaysia
3) Interdisciplinary Health Sciences Unit, School of Health Sciences, Universiti Sains Malaysia
4) Unit of Biostatistics and Research Methodology, School of Medical Sciences, Universiti Sains Malaysia
Correspondence to: Ali H. Abusafia
(e-mail: ali.h.abusafia@hotmail.com)

METHODOLOGY

The study implemen berati *et al*., 2009).

Search Strategy

The systematic process consisted of four main steps: Step 1 included identifying the target articles through the Scopus database between 2000 and 2020 using spiritual care as the main keyword. Reference lists from retrieved articles were subsequently hand searched. See search terms and inclusion-exclusion criteria subsection below:

Search terms

The union of the following keywords:

spiritual, spirituality, spirit, spiritual care, coping, Spiritual Well-being, spiritual life, end of life, nurses, nursing, nursing curriculum, nursing, educators, nursing students, and patients.

Intersected with the union of the following keywords

Malaysia, Singapore, Indonesia, the Philippines, Brunei, Burma, Thailand, Laos, Cambodia, Vietnam, and Timor-Leste.

Inclusion Criteria

- Data on care for human subjects

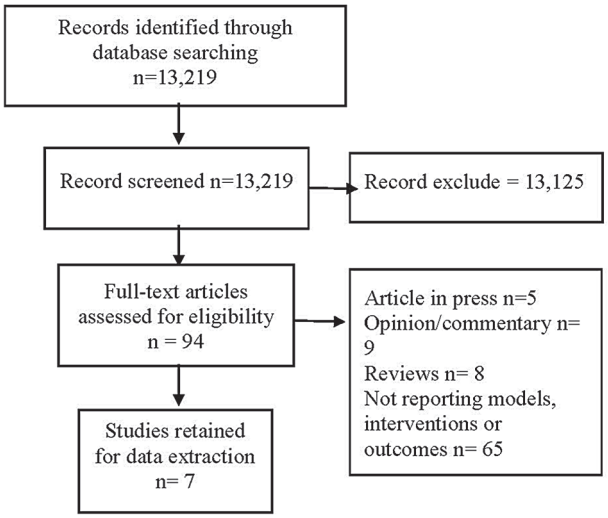

Figure 1: PRISMA flow chart of the search strategy.

- Reported in the English language
- Peer-reviewed journal publication
- Data from at least one of the Southeast Asia countries
- Data were reporting spiritual care models, interventions, or outcomes.

The inclusion criteria regarding the population were patients, stu-

Table 1: Evidence of spiritual care models, interventions, or outcomes from Southeast Asia

	References	Study design and sample size	Service/Intervention	Measurement	Findings
1	Nasution *et al*. (2020), Indonesia.	- Quasi-experimental method. - 108 patients	- Intervention session includes: 1. Introduction and relaxation 2. Control, identity, and relationship 3. prayer therapy.	- Brief COPE Scale (Rosyani, 2012). - Functional Assessment of Chronic Illness Therapy-Spiritual Therapy (FACIT-Sp-12).	Coping and spiritual well-being in the intervention group increased significantly after receiving spiritual intervention.
2	Wisuda *et al*. (2019), Indonesia.	- Quasi-experimental research. - 44 patients	- N/A	N/A	The influence of the application of spiritual nursing care to patient satisfaction. It is hoped that the head of the hospital provides training to all nurses about spiritual nursing care to improve patient satisfaction
3	Bakar *et al*. (2018), Indonesia.	- A cross-sectional design - 70 patients	- In this research, the Islamic caring model is the development of the Caroline Care Model's emphasis on Islamic values that character of maintaining belief, compassion, and competence.	- Partial Least Squares Structural Equation Modeling (PLS-SEM) (Abdurrouf *et al*., 2013)	The Islamic caring model is a nurse's behaviour that emphasizes Islamic values to enhance the patients' psycho-spiritual comfort.
4	Chimluang *et al*. (2017), Thailand.	- Quasi-experimental research study. - 48 patients	- The intervention based on basic Buddhist principles included: (1) Precept training. (2) Concentration training (3) wisdom training.	- Spiritual Well-being Scale (SWBS) Modified by Tantitrakul and Thanasilp (2009).	An intervention based on basic Buddhist principles improved the spiritual well-being of patients with terminal cancer. This result supports the beneficial effects of implementing this type of intervention for patients with terminal cancer.

5	Yang *et al*. (2017), Singapore.	- A cluster-controlled trial - 144 patients.	- The session was conducted by a palliative medicine physician who covered the following topics: 1. Taking a spiritual history 2. Identifying spiritual problems Knowing when to refer to a spiritual care professional.	- The Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being (FACIT—Sp) scale (Cheung *et al*., 2005)	- In conclusion, our study suggests that a spiritual care training program on spirituality and spiritual assessment could result in improved global patient QoL. - Nonetheless, it may still be worthwhile for palliative care staff to perform a spirituality assessment in clinical practice, perhaps using the FICA Spiritual History Tool, as it is inexpensive and unlikely to cause harm.
6	Pilaikiat *et al*. (2016), Thailand.	- N/A	- Buddhist Spiritual Care Model (BSCM) is developed based upon several spiritual concepts, such as spiritual history, spiritual needs, spiritual distress, spiritual well-being, and spiritual practices. - The process of SC in this model Used the nursing process in 5 steps: 1. Spiritual history taking. 2. SC assessment. 3. SC plan 4. SC implementation 5. SC evaluation	N/A	- The BSCM could guide nurses, physicians, nursing support staff, nursing, and medical students, and physical therapists to provide SC for people at the end of life and their family members.
7	Lundberg and Kerdonfag (2010), Thailand.	- An explorative qualitative study - 30 nurses	- Five subjects related to spiritual care provided by the nurses: 1. Giving mental support. 2. Facilitating religious rituals and cultural beliefs. 3. Communicating with patients and patients' families. 4. Assessing the spiritual needs of patients.	- Three semi-structured and open-ended questions: 1. How do you perceive the spiritual needs of your patients and their families? 2. What kinds of spiritual care do you provide to your patients and their families? 3. How do you think spiritual care could be improved at hospitals?	- Spirituality was an essential part of the care for the Thai nurses. - Nursing education should enhance nurses' understanding and awareness of spiritual issues and prepare them to respond to human spiritual needs. - Nurses should expand their knowledge and understanding of spirituality, develop tools for assessing spiritual needs, and improve communication with patients and relatives.

dents, and staff nurses who provide their services within nursing care, including hospitals, healthcare centers, private practices, nursing and care homes for elderly people, mental health, rehabilitation, and end-of-life care facilities. Other health care providers (medical, social sciences, psychiatry) and Non-professional healthcare providers, such as voluntary workers, the general public, families, parents, and ethnic/traditional healers, were excluded.

Exclusion Criteria

letters to the editors and editorials, reviews, conference abstracts, brief communications, case studies, books, and theses.

Data extraction and analysis

The data were extracted from the three authors' included papers (AHA, MZ, and RNS). The other three authors checked and verified the

extracted data (BM, IR, and TOK) to ensure the accuracy of the data included. Data were extracted from the retained papers and entered standard tables. The standard data extraction headings were country, study design and sample, spiritual care intervention, model and outcomes, instruments measurements, and findings. This enabled study designs, intervention or models, and findings to be potentially compared. Once the search was conducted, a post-hoc decision was made not to apply quality criteria or to conduct a meta-analysis due to the heterogeneity of aims and designs and low volume of outcome data.

RESULTS

The papers yielded by the search strategy are reported using the PRISMA flow chart in Figure 1. A total of seven studies were retrieved and met the inclusion criteria. The data extraction findings are reported in Table 2.

Summary of aims and countries of origin

Of the seven articles retained, four reported service experimentally (Chimluang *et al*., 2017; Yang *et al*., 2017; Wisuda *et al*., 2019; Nasution *et al*., 2020), one reported service with qualitative data (Lundberg and Kerdonfag, 2010), and one reported service descriptive (Bakar *et al*., 2018) and one not reported the service (Pilaikiat *et al*., 2016). Three studies reported data from Indonesia (Bakar *et al*., 2018; Wisuda *et al*., 2019; Nasution *et al*., 2020), Three from Thailand (Lundberg and Kerdonfag, 2010; Pilaikiat *et al*., 2016; Chimluang *et al*., 2017), and one from Singapore (Yang *et al*., 2017). No articles were found originating from Malaysia, Philippines, Brunei, Burma, Laos, Cambodia, Vietnam, and Timor-Leste. Of these Seven papers, the first was published in April 2010, and the last was in June 2020.

Intervention program

The 7th studies addressed different care models, interventions, and outcomes, including education and training programs, the nursing process as the guiding principle for health care providers, religious perspective (2 based on the basic Buddhist principles and one based on the Islamic model), communication and prayer therapy. The intervention programs are well addressed among patients and nurses by professionals in spiritual and palliative care.

In terms of findings, all studies support and recommend the beneficial effects of implementing the intervention programs of spiritual care among patients to increase their awareness and treat their spiritual disorders. It also provides training and education programs for nurses to increase their knowledge, attitude, and practice in providing spiritual care to patients.

Methodology designs and measurement

Five studies aimed at patient participants (Chimluang *et al*., 2017; Yang *et al*., 2017; Bakar *et al*., 2018; Wisuda *et al*., 2019; Nasution *et al*., 2020) and one at nurses (Lundberg and Kerdonfag, 2010) and one did not include participant data (Pilaikiat *et al*., 2016). The study design in three studies was a quasi-experimental method and one a cross-sectional design, one a cluster-controlled trial, one qualitative study was used, and one not straightforward design. The method used to measure the intervention programs were variance, including the Spiritual Well-being Scale (SWBS), The Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being (FACIT—Sp) scale, Partial Least Squares Structural Equation Modeling (PLS-SEM), and semi-structured and open-ended questions. Another Two studies not clearly provide measurement methods.

DISCUSSION

It is notable that despite the importance of providing spiritual care to the patients and nurses' responsibility regarding that, there is minimal evidence base from which to determine optimal models and interventions of spiritual care. In terms of the evidence of feasibility and acceptability of spiritual care, Indonesia and Thailand have the most robust available literature from the Southeast Asia region. The search found no articles originating from Malaysia, Philippines, Brunei, Burma, Laos, Cambodia, Vietnam, and Timor-Leste. Underlines the importance of undertaking work in these countries. Qualitative studies are also needed to understand better the cultural context of spirituality for patients and their families in Southeast Asia.

The literature review of seven intervention studies may reveal five important topics on spiritual care: Introduction and history of spiritual care, communication therapy and the relationship of nurses with patients and patients' families, spiritual care competence, knowing when to refer to spiritual care professional, and the nursing process as guidelines for nurses to provide spiritual care.

For the introduction and history of spiritual care, the researchers emphasized the importance of the introduction session to the participants due to lack of knowledge and not clear definition about spirituality and spiritual care. The introduction session can involve the definition of spirituality and spiritual care, the history of spiritual care and health, appreciation of the importance of spiritual care for patients, and how we can improve our own spirituality (Yang *et al*., 2017; Nasution *et al*., 2020). Based on the literature, spirituality means the use of intellect, tendencies, and abilities to experience awareness of the origin of the universe, worshipping God, seeking the satisfaction of God, humility, submission, and trust, which is demonstrated by a human in all his actions (Mahkam *et al*., 2013; Nasution *et al*., 2020). However, Yang *et al*. (2017) showed that spiritual intervention might support patients to use their spirituality strategies; cultivate a great connection with themselves, family, and friends; develop self-care practice; practice religion; improve optimistic viewpoint; listen effectively, and encourage patients' certainty.

For the communication therapy and relationship between nurses and patients and patients' family, based on Lundberg and Kerdonfag (2010), the communication is a human, interactive process that sends some meaning, information, message, emotions, and beliefs from one human being to another person or a group of people. Connectedness and interrelationships between and among human beings occur because communication occurs (Kourkouta and Papathanasiou, 2014). However, nurses and patients relationship is defined as a therapeutic nurse-patient relationship (Lundberg and Kerdonfag, 2010). It refers to a helping relationship based on mutual trust and respect, nurturing of faith and hope, being sensitive to self and others, and assisting with the gratification of your patient's physical, emotional, and spiritual needs through your knowledge and skill (Penda, 2017). However, studies portrayed that spiritual care's quintessence is simply the manner nurses interact and commit themselves in the nurse-patient relationship instead of just applying a lot of nursing rules (Lundberg and Kerdonfag, 2010; Nasution *et al*., 2020).

Nevertheless, Nurses referenced the spiritual care can be given by listening and talking with patients and families (Chimluang *et al*., 2017). Along these lines, relationships and trust are set up. However, the absence of time is frequently difficult, which keeps nurses from providing spiritual care (Lundberg and Kerdonfag, 2010).

For the nursing process, a study conducted by Pilaikiat *et al*. (2016) used the nursing process in their developed model. The BSCM model uses the nursing process as the guiding principle for health care providers. However, the model developed to help health care providers learn and implement Spiritual Care in their clinical practice, whether inpatient or outpatient. Using the well-understood nursing process as a guiding structure allows for easy implementation of Spiritual Care practices among health care providers. It's important to remind the nurses about the nursing process and use a nursing care plan to identify and implement the most effective interventions to promote patient health. The more we use the nursing process, the more focused, effective, visible, and evidence-based nursing interventions will be (Rutherford, 2008).

When referring to a spiritual care professional, Yang *et al*. (2017) is the only research addressed topic about when to refer patients to a spiritual care professional. As part of training nurses, it's essential to train nurses how, when, and who can refer the patients. However, its recommended to the nurses provide spiritual care to the patient but at times, it may be necessary to refer them for various types of pastoral care or expert health care providers, the purpose of that for receiving the best possible care from experts or spiritual advisers.

For Spiritual care competence, Bakar *et al*. (2018) addressed that the Islamic caring model is a guide for Indonesian nurses to encourages them to maintain their faith and to be sincere, compassionate, and competent, based on the Holy Quran and Prophet Muhammad's sayings. Based on Bakar *et al*. (2018), a competent nurse means being a professional in their work following the discipline's principles, being honest and responsible, willing to help, and co-operative. It is also considered that work smartly and knowledgeably. The provision of spiritual care by nurses has been strongly recommended to review the competency of

nurses. However, the lack of such training as part of the nursing curriculum has resulted in a lack of competence and expertise in providing such care (Jamshidi *et al*., 2016).

CONCLUSION

In conclusion, the body of evidence for spiritual care in Southeast Asian countries is not reflective of the population's size in need. Considering the limited resources accessible for health systems, the proofs are even more essential to guide appropriate and effective services. Without adequate educational or training intervention, the provision of suitable, evidence-based spiritual care is probably not going to happen; the requirement for a well-designed and validated model to improve outcomes is central to advancing spiritual care in the region need for it.

ACKNOWLEDGEMENTS

The authors would like to express their thanks to Malak Zakaria for her contribution to this study.

REFERENCES

Abdurrouf, M., Nursalam, N. & Purwaningsih, P. (2013). Islamic Caring Model on Increase Patient Satisfaction. *Jurnal Ners*, 8(1), 153-164.

Bakar, A., Nursalam, Adriani, M., Kusnanto, Qomariah, S. N. & Efendi, F. (2018). The development of islamic caring model to improve psycho-spiritual comfort of coronary disease patients. *Indian Journal of Public Health Research and Development*, 9(10), 312-317. doi:10.5958/0976-5506.2018.01362.1

Cheung, Y.-B., Goh, C., Thumboo, J., Khoo, K.-S. & Wee, J. (2005). Variability and Sample Size Requirements of Quality-of-Life Measures: A Randomized Study of Three Major Questionnaires. *Journal of Clinical Oncology*, 23(22), 4936-4944. doi:10.1200/jco.2005.07.141

Chimluang, J., Thanasilp, S., Akkayagorn, L., Upasen, R., Pudtong, N. & Tantitrakul, W. (2017). Effect of an intervention based on basic Buddhist principles on the spiritual well-being of patients with terminal cancer. *Eur J Oncol Nurs*, 31, 46-51. doi:10.1016/j.ejon.2017.08.005

Ferrell, B. R., Handzo, G., Picchi, T., Puchalski, C. & Rosa, W. E. (2020). The Urgency of Spiritual Care: COVID-19 and the Critical Need for Whole-Person Palliation. *Journal of Pain and Symptom Management*, 60(3), e7-e11. doi:10.1016/j.jpainsymman.2020.06.034

Isaac, K. S., Hay, J. L. & Lubetkin, E. I. (2016). Incorporating Spirituality in Primary Care. *Journal of religion and health*, 55(3), 1065-1077. doi:10.1007/s10943-016-0190-2

Jamshidi, N., Molazem, Z., Sharif, F., Torabizadeh, C. & Najafi Kalyani, M. (2016). The Challenges of Nursing Students in the Clinical Learning Environment: A Qualitative Study. *The Scientific World Journal*, 2016, 1846178. doi:10.1155/2016/1846178

Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. *ISRN psychiatry*, 2012.

Koren, M. E. & Papamiditriou, C. (2013). Spirituality of staff nurses: application of modeling and role modeling theory. *Holistic Nursing Practice*, 27(1), 37-44.

Kourkouta, L. & Papathanasiou, I. V. (2014). Communication in nursing practice. *Materia socio-medica*, 26(1), 65-67. doi:10.5455/msm.2014.26.65-67

Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J. P. A., Clarke, M., Devereaux, P. J., Kleijnen, J. & Moher, D. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. *Journal of Clinical Epidemiology*, 62(10), e1-e34. doi:10.1016/j.jclinepi.2009.06.006

Lundberg, P. C. & Kerdonfag, P. (2010). Spiritual care provided by Thai nurses in intensive care units. *Journal of Clinical Nursing*, 19(7-8), 1121-1128. doi:10.1111/j.1365-2702.2009.03072.x

Mahkam, R., Moslehi, J. & Jahangirzade, M. (2013). Islamic Approach to Spiritual Health. *Tehran: Hoghoghi Publications*.

Melhem, G. A. B., Zeilani, R. S., Zaqqout, O. A., Aljwad, A. I., Shawagfeh, M. Q. & Al-Rahim, M. A. (2016). Nurses' Perceptions of Spirituality and Spiritual Care Giving: A Comparison Study Among All Health Care Sectors in Jordan. *Indian journal of palliative care*, 22(1), 42-49. doi:10.4103/0973-1075.173949

Nasution, L. A., Afiyanti, Y. & Kurniawati, W. (2020). Effectiveness of Spiritual Intervention toward Coping and Spiritual Well-being on Patients with Gynecological Cancer. *Asia-Pacific journal of oncology nursing*, 7(3), 273-279. doi:10.4103/apjon.apjon_4_20

Penda, C. (2017). Establishing therapeutic nurse-client relationship with mentally ill patients in a community.

Pilaikiat, R., Fongkaew, W., Sethabouppha, H., Phornphibul, P. & Voss, J. G. (2016). Development of a Buddhist Spiritual Care Model for People at the End of Life. *Journal of Hospice & Palliative Nursing*, 18(4), 324-331. doi:10.1097/njh.0000000000000255

Rosyani, C. R. (2012). Hubungan antara resiliensi dan coping pada pasien kanker dewasa. *Skripsi Fakultas Psikologi Universitas Indonesia*.

Rutherford, M. (2008). Standardized Nursing Language: What Does It Mean for Nursing Practice? *Online Journal of Issues in Nursing*, 13. doi:10.3912/OJIN.Vol13No01PPT05

Storey, I. (2013). Southeast Asia and the rise of China: *The search for security*: Routledge.

Tantitrakul, W. & Thanasilp, S. (2009). Factors related to spiritual well-being of terminal cancer patients. *Journal of Bureau of Alternative Medicine*, 2(3), 27-36.

Wisuda, A. C., Neherta, M. & Kusumawaty, I. (2019). The influence of application of nursing of spiritual nursing to patient satisfaction in regional general hospital of palembang and regional genaral hospital of Martapura. *Indian Journal of Public Health Research and Development*, 10(8), 2249-2254. doi:10.5958/0976-5506.2019.02193.4

Yang, G. M., Tan, Y. Y., Cheung, Y. B., Lye, W. K., Lim, S. H. A., Ng, W. R., Puchalski, C. & Neo, P. S. H. (2017). Effect of a spiritual care training program for staff on patient outcomes. *Palliative and Supportive Care*, 15(4), 434-443. doi:10.1017/S1478951516000894