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Spiritual Distress among Patients with Acute Coronary Syndrome in Cardiac Intensive Care Unit

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ABSTRACT
Background. Engaging patients' spiritual needs with Acute Coronary Syndrome (ACS) is still primarily ignored compared to their physical needs. One thing that has been forgotten is spiritual distress assessment, even though the stress experienced can aggravate ACS conditions, especially in acute situations. This study aimed to identify spiritual distress among ACS patients in the Cardiac Intensive Care Unit (CICU). **Methods.** This study was a quantitative research with a population of ACS patients treated in CICU at one of the hospitals in West Java. The sampling technique used was consecutive sampling and obtained 34 respondents during one month. Collecting data using a modified instrument from the Spiritual Distress Assessment Tool (SDAT) and obtained a validity range of 0.33 - 0.45 and a reliability of 0.80. Data analysis using mean and frequency distribution. **Results.** 82.35% of respondents had mild spiritual distress, and 17.65% of respondents had moderate spiritual distress. The most disturbing spiritual distress was in the "Need for value acknowledgment," while the "Need to maintain control" was the least problematic among respondents. **Conclusions.** The spiritual distress experienced among ACS patients in the ICU was mostly mild. However, some patients experienced moderate distress. To reduce this distress level can be executed by paying more attention to the patient's needs to be respected regarding their values and beliefs.

Introduction

ACS patients in the acute phase may encounter changes in physical, psychological, and spiritual aspects. Patients' physical changes while being treated at CICU may include chest pain, shortness of breath, and activity intolerance (Aitken et al., 2012). In terms of psychosocial and emotional aspects, patients often experience anxiety and depression (Gustad et al., 2014; Lane et al., 2003). Further, according to Arnold et al (2007), those who experience emotional distress also tend to experience spiritual health problems. Whereas on the other hand, spirituality is beneficial as a source of coping and even becomes one of the factors that affect the quality of life of ACS patients.

Spiritual distress increases the psychological and physical problems among ACS patients. Huffman et al. (2010) and Ho et al. (2010) stated that spiritual distress could be seen as depression and anxiety. These induce psychological effects associated with increased platelet activity, increased inflammation, decreased pulse rate, increased catecholamines, and endothelial dysfunction, which exacerbate the condition and increase the risk of mortality from ventricular arrhythmias and sudden cardiac arrest in ACS patients.

Based on the previous description, it can be seen that the spiritual aspect is essential for ACS patients. Moeini et al (2012) stated that biological, psychological, and social health is challenging to achieve optimally if spiritual well-being is not achieved. However, Nur'aeni et al (2013) care for ACS clients mostly focused on the physical aspects, while the psychological aspects, especially the spiritual aspects, were still ignored.

Spiritual distress had similar symptoms to depression (Caldeira et al., 2014). On the other hand, Krisnayanti (2013) stated that depression was still common in ACS patients. Therefore, spiritual distress among ACS patients cannot be described clearly, even though spirituality was a resource that needs attention because it represents a critical role in the disease's healing process (S. M. Monod et al., 2010a).

What needs to be done to find out problems in ACS patients' spiritual aspect is through an assessment of spiritual distress. The study of spiritual distress among ACS patients was still little discussed in Indonesian studies, so authors were interested in identifying the spiritual distress among ACS patients treated in the critical care unit.

Method

Research Design and Respondents

This research was a quantitative study with a cross-sectional approach. The population was ACS patients undergoing treatment at the Cardiac ICU and the Cardiac High Care Unit at one of West Java hospitals' referrals. The sampling technique used consecutive sampling with inclusion criteria: the patient did not experience chest pain within 24 hours. Data collection was carried out for one month and obtained 34 respondents who were involved in this study.

Instrument and data analysis

This instrument was modified into 41 questions to measure spiritual distress, with a score range of 0 - 123. A score of 0 means that all spiritual needs are met or, in other words, the respondent was assumed not to experience spiritual distress. The following is a categorization of the measurement results used in the study: score 0 means no distress; score range, 1 - 41 mild distress; score range, 42 - 82 moderate distress; and a score range of 83-123 severe distress.

The validity range of the standard instrument Spiritual Distress Assessment Tool (SDAT) is

0.33 - 0.45 with a reliability of 0.87 (S. Monod et al., 2012), and the results of the constructed test for this modified SDAT instrument were 0.36 - 0.68 for validity range while for reliability 0.80. Data analysis to get a description of spiritual distress using mean and frequency distribution.

Ethical Consideration

Ethical clearance for data collection had been obtained from the Research Ethics Committee of Universitas Padjadjaran. All respondents had been informed and signed the consent when they agreed to participate in this study. To protect the respondents from unexpected conditions, considering they were patients who were in the acute phase, respondents who were selected to participate in the study were respondents who had been declared free of chest pain for at least 24 hours.

Results

From this study, it was recognized that half of the respondents were in the age range of 60-69 years (50%), almost all respondents were Muslim (85.3%), and most of them were male (85.3%). Most of the respondents were Sundanese (85.29%). More than half of the respondents have had a heart attack for the first time (64.7%), and half of the respondents had received medication and reperfusion therapy (50%).

Table 1. Spiritual distress among ACS patients handled at the Cardiac Intensive Care Unit and High Care Unit

The Category of Spiritual Distress	Frequencies (n)	Percentage (%)
No Spiritual distress	0	0
Mild spiritual distress	28	82.35
Moderate spiritual distress	6	17.65
Severe spiritual distress	0	0
Total	34	100

Table 1 shows that most of the respondents (28 respondents) had mild spiritual distress, and the rest (6 respondents) had moderate spiritual distress.

Table 2. Spiritual distress among ACS patients handled at the Cardiac Intensive Care Unit and High Care Unit, based on sub variable (dimension)

Sub-variable	f	%	Mean	Standar Deviation
Life balance				
• Do not experience interference	0	0		
• Minor annoyance	20	58.83		
• Moderate distraction	12	35.29	1.07	5.07
• Severe Disturbance	2	5.88		
Religious				
• Do not experience interference	3	12.5		
• Minor annoyance	24	70.59		
• Moderate distraction	6	17.65	0.78	2.58
• Severe Disturbance	1	2.94		
Need for value acknowledgement				
• Do not experience interference	0	0		
• Minor annoyance	0	0		
• Moderate distraction	30	88.24	1.86	0.75
• Severe Disturbance	4	11.76		
Need to maintain control				
• Do not experience interference	18	52.94		
• Minor annoyance	15	44.12		
• Moderate distraction	1	2.94	0.14	3.24
• Severe Disturbance	0	0		
Social life				
• Do not experience interference	1	2.94		
• Minor annoyance	29	85.29		
• Moderate distraction	4	11.76	0.56	4.96
• Severe Disturbance	0	0		

Table 2 shows that most of the respondents experienced mild disturbances in the dimensions of life balance, religion, and social life. Meanwhile, for the sub-dimension "Need for value knowledge," it was found that almost all respondents felt moderate disturbances and for the sub-dimension "Need for maintain control," it was found that most respondents did not perceive interference.

Discussion

Based on the research, it was recognized that most of the respondents, 28 out of 34 respondents, had mild spiritual distress and the remaining respondents had moderate spiritual distress. Mild spiritual distress indicated that almost all of the respondents' spiritual needs had been met. The cultural background of the respondent could generate this condition. According to Perry and Potter (2005), a person's spirituality was influenced by culture, developmental status, life experiences, values, and ideas about one's life. Based on this context, almost all respondents have a Sundanese cultural background. According to Friedman et al (2003), eastern society (Indonesia) has traditional values such as familism, family as central, interdependence, and maintaining harmony. In these values, the need to be loved and be close to loved ones can be fulfilled, which affected the low spiritual distress (S. M. Monod et al., 2010b). This condition followed the research results on the dimensions of social life, which showed that most respondents had mild disorders.

The religious culture of Indonesian people may also affect a person's spiritual condition. Nuraeni et al. (2013) stated that ACS patients were still grateful even though they had a heart attack. According to them, the disease they were had was a warning to get closer to God. This study showed the same thing that most of the respondents had mild disturbances in the religious dimension. Respondents stated that despite their limitations, they could still carry out their spiritual practice. Thus this could help alleviated the incidence of spiritual distress in the respondent. Also, in this study, almost all respondents were in a stable condition. Furthermore, it was the first time they had a heart attack, indicating that respondents had not felt the prolonged effects of illness and medication on their daily lives. This condition potentially reduced anxiety and allowed a decrease in spiritual distress levels.

Moreover, the less spiritual distress in respondents could also be produced by the sub-dimensions of values and beliefs, i.e., the need to be involved in any decision-making based on the respondent's values and beliefs. The results showed that most respondents did not feel interference in this sub-dimension. Based on this research, most of the respondents stated that they were always involved in every action taken by doctors, nurses, or other health workers. They also stated that they had received sufficient information about the disease and the purpose of treatment.

However, some patients who encountered moderate distress cannot be overlooked. Moderate distress showed that some of the respondents' spiritual needs were not being sufficed. Kozier et al (2004) affirmed that the diagnosis of terminal diseases, diseases that cause disability or weakness, pain, loss of body parts or functions, surgical therapy, and dietary restrictions could affect a person's spirituality. Besides, previous research also showed that most respondents stated that they had difficulty carrying out spiritual practices and did not get help from health workers. According to Kozier et al (2004), this could also create spiritual distress.

The research results on the sub-dimensions of values and beliefs, specifically the need to be respected by health workers for the values they believe in, showed that 30 out of 34 respondents did not feel fulfilled in the partial to complete category. According to Elliott et al (2020) and Willemse et al (2018), health workers should try to help meet the client's spiritual needs as part of the client's overall needs, among other things, by facilitating the fulfillment of the client's spiritual needs. However, based on respondents' statements, they did not get facilities or assistance from nurses to carry out their spiritual practices. According to Rankin (2019), the nurse was not prepared to face the client's spiritual problems, and the nurse considered it part of the psychosocial and was the clergy's duty.

High spiritual distress can also be caused by disruption of the life balance of the respondent. Based on the results of the study, it was found that all respondents experienced disturbances in their life balance. Furthermore, it was known that the dimension of life balance was the second most disturbing dimension. Based on the results of the study, most of the respondents were elderly. At this stage of elderly development, the physical condition deteriorates physiologically, and the level of dependence on other people increases, resulting in the elderly feeling useless and unneeded. This condition makes it difficult for the elderly to maintain their balance of life following an illness. The limitations experienced by these respondents produce the potential to increase spiritual distress.

Conclusions

Most respondents with acute coronary syndrome treated in intensive care had mild spiritual distress, and the rest experienced moderate spiritual distress. Most of them experienced mild disturbances in the dimension of life balance, religious, and social life. However, they also stated that in the sub-dimension-the need to be respected by health workers for respondents' belief values, some had not been fulfilled. Hence nurses and other health professionals need to pay more attention to meeting patients' needs by considering their beliefs when providing health care to ACS patients in intensive care units.

References

Aitken, L., Marshall, A., & Chaboyer, W. (2012). *ACCCN'S Critical Care Nursing* (Second). Elsevier Australia.

Arnold, S., Herrick, L., Pankratz, V., & Mueller, P. (2007). Spiritual well-being, emotional distress, and perception of health after a myocardial infarction. *Internet Journal of Advanced Nursing Practice*, *9*(1), 4.

Caldeira, S., Carvalho, E. C. de, & Vieira, M. (2014). Between spiritual wellbeing and spiritual distress: possible related factors in elderly patients with cancer. *Revista Latino-Americana de Enfermagem*, *22*(1), 28–34.

Elliott, R., Wattis, J., Chirema, K., & Brooks, J. (2020). Mental health nurses' understandings and experiences of providing care for the spiritual needs of service users: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, *27*(2), 162–171. https://doi.org/10.1111/jpm.12560

Friedman, Bowden, & Jones. (2003). *Family Nursing : Research, Theory and Practice* (5th ed.). Appelton & Lange.

Gustad, L. T. L. ., Laugsand, L. . L. E., Janszky, I., Dalen, H., & Bjerkeset, O. (2014). Symptoms of anxiety and depression and risk of acute myocardial infarction: the HUNT 2 study. *European Heart Journal*, *35*(21), 1394–1403. https://doi.org/10.1093/eurheartj/eht387

Ho, R. C., Neo, L. F., Chua, A. N., Cheak, A. A., & Mak, A. (2010). Research on psychoneuroimmunology: does stress influence immunity and cause coronary artery disease. *Ann Acad Med Singapore*, *39*(3), 191–196.

Huffman, J. C., Celano, C. M., & Januzzi, J. L. (2010). The relationship between depression, anxiety, and cardiovascular outcomes in patients with acute coronary syndromes. *Neuropsychiatric Disease and Treatment*, *6*, 123–136. http://www.ncbi.nlm.nih.gov/pubmed/20505844

Kozier, B., Berman, A., & Snyder, S. (2004). *Fundamental of nursing : Concept, process, and practice*. Pearson Prentice Hall.

Krisnayanti. (2013). Depresi dan cemas pada pasien dengan sindrom koroner akut. *E-Jurnal Medika Udayana*, *2*(8).

Lane, D., Carrol, D., Lip, G. Y. H. H., Carroll, D., & Lip, G. Y. H. H. (2003). Anxiety, Depression, and Prognosis after Myocardial Infarction. *Journal of the American College of Cardiology*, *42*(10), 1808–1810. https://doi.org/10.1016/j.jacc.2003.08.018

Moeini, M., Ghasemi, T. M. G., Yousefi, H., & Abedi, H. (2012). The effect of spiritual care on spiritual health of patients with cardiac ischemia. In *Iranian journal of nursing and midwifery research* (Vol. 17, Issue 3, pp. 195–199).

Monod, S. M., Rochat, E., Büla, C. J., Jobin, G., Martin, E., & Spencer, B. (2010a). The spiritual distress assessment tool : an instrument to assess spiritual distress in hospitalised elderly persons. *BMC Geriatrics*, *10*(1), 88. https://doi.org/10.1186/1471-2318-10-88

Monod, S. M., Rochat, E., Büla, C. J., Jobin, G., Martin, E., & Spencer, B. (2010b). The spiritual distress assessment tool: an instrument to assess spiritual distress in hospitalised elderly persons. *BMC Geriatrics*, *10*(1), 88.

Monod, S., Martin, E., Spencer, B., Rochat, E., & Büla, C. (2012). Validation of the Spiritual Distress Assessment Tool in older hospitalized patients. *BMC Geriatrics*, *12*(1), 1–9.

Nur'aeni, A., Ibrahim, K., & Agustina, H. R. (2013). Makna Spiritualitas pada Klien dengan Sindrom Koroner Akut. *Jurnal Keperawatan Padjadjaran*, *79*(1).

Nuraeni, A., Ibrahim, K., & Rizmadewi, H. (2013). Makna Spiritualitas pada Klien dengan Sindrom Koroner Akut. *Jurnal Keperawatan Padjadjaran*, *1*(2).

Perry, A. G., & Potter, P. A. (2005). *Buku Ajar Fundamental Keperawatan; Konsep, proses, dan praktik. Volume 1*.

Rankin, W. W. (2019). *Confidentiality and clergy: Churches, ethics, and the law*. Wipf and Stock Publishers.

Willemse, S., Smeets, W., van Leeuwen, E., Janssen, L., & Foudraine, N. (2018). Spiritual Care in the ICU: Perspectives of Dutch Intensivists, ICU Nurses, and Spiritual Caregivers. *Journal of Religion and Health*, *57*(2), 583–595. https://doi.org/10.1007/s10943-017-0457-2