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Caring Behaviors, Spiritual, and Cultural Competencies: A Holistic Approach to Nursing Care

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Abstract

Holistic approach to nursing care is a comprehensive model which involves all facets of care which involves mental, spiritual, and social needs of patients. However, studies have shown that most nurses are not familiar with this model of caring and only considers the corporeal needs of the patient. Thus, the aim of the study was to assess the caring behaviors, spiritual and cultural competencies of nurses. Also, the extent of influence of cultural and spiritual competencies to the caring behaviors of Filipino nurses were determine. The study utilized a causal research design and a purposive sample of 124 Filipino medical-surgical nurses who were employed in Level 3 hospitals were included. The data were collected through survey using three (3) questionnaires which includes Nurse Cultural Competence Scale developed by Perng and Watson (2012), the Nurse Spiritual Care Therapeutic Scale developed by Mamier and Taylor (2014) and the Caring Nurse Patient Interaction Scale developed by Cossette et al. (2006). The data collected was analyzed using frequency, percentage, mean, standard deviation and univariate linear regression analysis. The findings revealed that Filipino nurses rated themselves good in terms of spiritual and cultural competencies. Specifically, the subscales of cultural competencies which includes cultural skills, cultural knowledge and cultural sensitivity were also rated as good. On the other hand, the caring behaviors of Filipino nurses were rated as excellent. The same findings were also noted for two of its subscales, the clinical care and comforting care while both relational and humanistic care were rated as very good. Spiritual competencies showed a significant influence in the caring behaviors of nurses, however, no significant influence was noted between the cultural competencies and caring behaviors of nurses.

Keywords: Caring behaviors, cultural competencies, holistic care, spiritual competencies

Introduction

Caring plays a vital component in the role of nurses and provides a guiding framework in the practice of nursing. It involves a holistic approach in providing an optimal level of care to patients. Holistic care is described as a behavior that recognizes a person as a whole and acknowledges the interdependence among one's biological, social, psychological, and spiritual aspects (Zamanzadeh, Jasemi, Valizadeh, Keogh & Taleghani, 2015). It involves a broad range of approaches which includes therapeutic management, communication, self-help, education and complementary treatment. According to Selimen and Andsoy (2011), holistic nursing is concerned with all facets of patient care and considers its effects on the treatment process and the patients' thoughts, emotions, cultures, opinions, and attitudes are considered contributing factors to recovery, happiness and satisfaction.

Indeed, the process of caring is an interactive and inter-subjective human process which occurs during moments of shared vulnerability between two or more people, both the self and other directed process (Wolf, Giardino, Osborne & Ambrose, 1994). It has been the core focus of nursing practice which was emphasized by nursing theorists, such as Leininger and Watson. Given the vital role that caring plays in the practice of nursing, it is critical to understand which behaviors of the nurse are exemplified as caring based on the theory of Watson (1985). Larson defined nurse caring behaviors as acts, conduct and mannerisms enacted by professional nurses that convey concern to patient's safety, attention, and feeling cared for; the sensation of well-being and safety resulted from enacted behaviors of another (Larson, 1984 as cited by Wolf, Dillon, Townsend & Glasofer, 2017).

Aside from nurse caring behaviors, another aspect that should be emphasized is the spiritual care competence of nurses. Spirituality is the core of human existence which includes immaterial aspects of human life and is experienced through the relationship of a human's life with God, him or herself, others and nature (Khorrami-Markani, Yaghmaie, Khodayarifard, & Alavimajd, 2012). Spirituality can help patients in the process of illness recovery by facilitating their autonomy and assisting them to live and grow beyond the limitations imposed by their illness (Mizock, Millner & Russinova, 2012). According to Burkhardt and Jacobson (2002), people with high spiritual well-being have a holistic approach to life and they deal with the issues around them with an open mind and flexibility. Hence, assessment of spiritual care competencies among nurses is an essential part of holistic nursing care. Furthermore, the Canadian Nurses Association (2010) encourages nurses to

“demonstrate sensitivity to and respect for diversity in spiritual beliefs, support of spiritual preferences and attention to spiritual needs as nursing competencies” (p. 2).

Along with spirituality comes a multicultural society. As health care professionals, we find ourselves providing services in an environment where patients and their families may be of different cultures, traditions, languages and spiritual backgrounds (Wintz & Cooper, 2009). Thus, in order to meet the ever changing health care needs of patients in a multicultural society, provision of care in a way that is suitable and culturally sensitive for all patients becomes a necessity.

In addition, Zamanzadeh et al. (2015) stated that there is a compelling evidence that most nurses have been educated with a biomedical allopathic focus and do not have a good understanding of the meaning of holistic care. He further added that nurses are not familiar with holistic care, neglect this model of caring, do not use this method and consider patients' corporeal needs only. In this regard, patients' other needs and sometimes more serious problems are not addressed (Solimen & Andsoy, 2011; Olive, 2003; Tjale & Bruce, 2007). The mental, spiritual, and social needs of patients are neglected and patients are considered as biological machines (Porter, 1997; Kolcaba, 1997).

Thus, the study explored the extent of influence of spiritual care competencies and cultural competencies on the caring behaviors of nurses.

Operational Framework

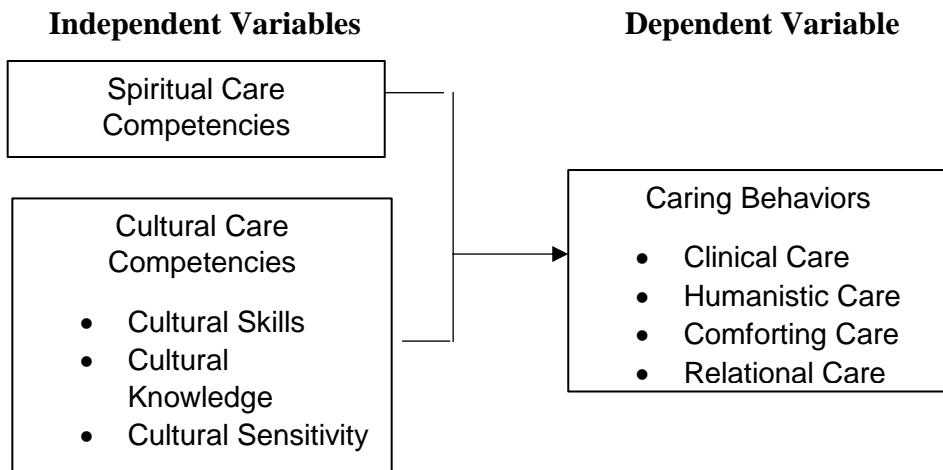


Figure 1. Conceptual Framework

The study determined the two sets of variables which include the independent and dependent variables. The independent variables include the spiritual competencies of nurses and cultural competencies which include cultural skills, cultural knowledge and cultural sensitivity. On the other hand, the dependent variables include the caring behaviors of nurses which are described as clinical care, humanistic care, comforting care and relational care. The extent of influence of the spiritual and cultural competencies to the caring behaviors of Filipino nurses were also examined.

Methodology

Research Design

The study utilized a causal research design. This design is used to measure what impact a specific change will have on existing norms and assumptions. Causal effect (nomothetic perspective) occurs when variation in one phenomenon, an independent variable, leads to or results, on average, in variation in another phenomenon, the dependent variable (Bachman, 2007).

In the study, the influence of the spiritual and cultural competencies in the caring behaviors of Filipino nurses were determined.

Setting of the Study

The study was conducted in selected Level 3 Hospitals located in the City of Manila since they provide more health care services compared to level 1 and Level 2 Hospitals. Level 3 Hospitals in the Philippines are those that are teaching/training hospital; has provisions for physical medicine and rehabilitation unit, ambulatory surgical clinic, dialysis facility and blood bank. It must also have a DOH licensed tertiary clinical laboratory with standard equipment necessary for the performance of histopathology examination and a DOH licensed Level 3 imaging facility with interventional radiology (DOH Administrative Order No. 012, 2012).

Respondents of the Study

In this research study, the number of respondents was based on the total population of staff nurse in different shifts assigned in medical and surgical ward.

Staff nurses that were included are those with a minimum of 1-year length of service as a medical and/or surgical staff nurse because they have already adjusted well enough to this area of care. Total

enumeration of staff nurses that work in the medical and surgical wards was included in the study.

Sampling Technique

The participants of the study were selected using purposive sampling since the researcher believes that selected nurses were the best source of information for the study undertaken. This refers to selection of sites or participants that will best help the researcher understand the problem and the research question; they must be willing to reflect on and share this knowledge (Creswell, 2003).

In the study, a total of 124 Filipino nurses assigned in the medical surgical wards of selected hospitals in Manila were included.

Ethical Consideration

The research was approved by the Arellano University Ethics Review Board. The participants were advised about the nature and purpose of the study, as well as their rights in order to secure their consent to be involved in the study. It was also made clear to all informants that they reserve the option to withdraw from the study at any point during the data collection phase. They were also assured that data collection was conducted according to their convenience. Also, the possibility of the study to be presented and published in a research journal was made known to the participants. All the gathered data from the participants will be kept secured and accessible only to the researcher and will be destroyed through appropriate means (e.g. shredding) after 5 years.

Reasonable steps were taken to ensure privacy, anonymity, and security of information gathered during the course of the study.

Research Instrument

The researcher utilized standardized research instrument tools, which are divided into four parts. First is the demographic profile which contains the age, sex and the length of service of the respondents, second is the Nurse Cultural Competence Scale developed by Perng and Watson (2012) which was used to determine the cultural competencies of Filipino nurses, third was the Nurse Spiritual Care Therapeutic Scale developed by Mamier and Taylor (2014) which was used to assess the spiritual care competencies of Filipino nurses and lastly, the Caring Nurse Patient Interaction Scale developed by Cossette et al. (2006) which was used to determine the caring competencies of Filipino nurses. The researcher secured permission from the authors to use their research instruments.

Nurse Cultural Competence Scale

The Nurse Cultural Competence Scale is a 20 item tool developed by Perng and Watson (2012). It is subdivided into four constructs: cultural knowledge (items 3, 9, 11-12 and 13), cultural sensitivity (17 and 20), and cultural skills (items 1, 2, 4-8, 10, 14, 16, 18-19)

Nurse Spiritual Care Therapeutic Scale

This tool is a 17-item instrument developed by Mamier and Taylor (2014) used to measure the frequency of nurse therapeutics or practices intended to support patient spirituality.

Caring Nurse Patient Interaction Scale- Nurse

Caring Nurse Patient Interaction Scale or CNPI-23 adapted in the study of Cossette et al. (2006) describes the attitudes and behaviors that can be seen in clinical practice and that can be measured according to importance, frequency, satisfaction, competency and feasibility. It is divided into three parts: demographic data, survey scale and open ended questions.

The Survey Scale comprises of 23 items, grouped under four dimensions: Clinical Care (Statements 1 to 9), Relational Care (Statements 10 to 16), Humanistic Care (Statements 17 to 20) and Comforting Care (Statements 21 to 23).

Table 1.

Interpretation of the Scales

Scale	Value Range	Verbal Interpretation
5	4.20-5.0	Excellent
4	3.40-4.19	Very Good
3	2.60-3.39	Good
2	1.80-2.59	Fair
1	1.0-1.79	Poor

The tool is a 5-point Likert scale with five response options ranging from “Excellent” (five points), “Very Good” (four points), “Good” (three points), “Fair” (two points) and “Poor” (one point). Table 1 shows the verbal interpretation of the scale used in the study.

Reliability Procedures

After establishing the validity of the instruments, reliability test using Cronbach's Alpha Statistics was conducted. An alpha within the range of 0.70-0.95 was accepted as satisfactory for internal consistency (Polit & Beck, 2014).

The CNPI-Nurse, Nurse Cultural Competence Scale and the Nurse Spiritual Care Therapeutic Scale underwent a reliability test to ensure its applicability for use in the Philippine setting. Results showed that the CNPI-Nurse, Nurse Cultural Competence Scale and the Nurse Spiritual Care Therapeutic Scale has an alpha coefficient of 0.731, 0.986 and 0.962 respectively which satisfies the acceptable range.

Data Collection Procedure

In order to gather the necessary information, the researchers sought permission to conduct the study among staff nurses from the hospital administrators and chief nurses in eleven (11) Level 3 Hospitals in Manila. Also, a letter was sent to the original author of the instrument to ask for their consent to use the tool.

Then, the researcher asked permission for willing participants that fits in the inclusion criteria set. The purpose of the study was then explained to the participants. Then, the Nurse Cultural Competence Scale, Nurse Spiritual Care Therapeutic Scale and Caring Nurse Patient Interaction Scale CNPI-Nurse Scale was administered to all nurses assigned in different shifts at the medical and surgical ward. The participants were not under any time pressure while answering the questionnaires and the researchers were present to answer questions or to make clarifications. The collection of data lasted for a week in each hospital.

Statistical Treatment of Data

This research study utilized five (5) statistical treatments which included frequency, percentage and weighted mean to determine the level of spiritual and cultural competencies as well as the caring behaviors of nurses. Standard deviation was used to determine the homogeneity and heterogeneity of the data. Finally, univariate linear regression was used to determine the influence of the spiritual and cultural competencies to the caring behaviors of Filipino nurses.

Results

Table 1.*Demographic Profile of the Respondents (n = 124)*

Characteristics	Frequency (f)	Percentage (%)	Mean (SD)
Age (Years)			29.37 (± 6.94)
Sex			
Male	24	19.35%	
Female	100	80.65%	
Length of Service (Years)			4.55 (± 5.91)

Table 1 illustrates the demographic profile of the respondents. It can be noted that the mean age of the respondents was 29.37 years old (± 6.94). In addition, majority of the respondents were female (80.65%). It is also noted that the mean length of service was 4.55 years (± 5.91).

Table 2.*Descriptive Statistics of Spiritual Care Competency, Cultural Care Competency, and Caring Behaviors among the Respondents (n = 124)*

	Mean	Standard Deviation	Interpretation ^a
Spiritual Care Competency	3.33	± 0.82	Good
Cultural Care Competency	3.24	± 0.92	Good
Cultural Skills	3.26	± 0.85	Good
Cultural Knowledge	3.22	± 0.90	Good
Cultural Sensitivity	3.23	± 0.98	Good
Caring Behaviors	4.20	± 0.53	Excellent
Clinical Care	4.37	± 0.50	Excellent
Relational Care	3.89	± 0.72	Very Good
Humanistic Care	4.16	± 0.64	Very Good
Comforting Care	4.48	± 0.59	Excellent

^a**Legend:** Poor = 1.00 to 1.79 Fair = 1.80 to 2.59 Good = 2.60 to 3.39

Very Good = 3.40 to 4.19 Excellent = 4.20 to 5.00

As presented in Table 2, the mean spiritual care competency score was 3.33 (± 0.82), which can be interpreted as a good level of competence. Similarly, results showed that the overall mean cultural care competency score and the mean cultural skills, mean cultural knowledge, and mean cultural sensitivity scores were between 3.22 and 3.26, denoting that these were of good level. Results also showed that the overall mean caring behavior score was 4.20 (± 0.53), interpreted as excellent. The same findings can be noted for 2 of its subscales – clinical care and comforting care. However, both relational and humanistic care dimensions had mean scores of 3.89 (± 0.72) and 4.16 (± 0.64), respectively, interpreted as very good.

Table 3.

Univariate Linear Regression Analysis of the Influence Spiritual Care Competency and Cultural Care Competency on the Clinical Care Dimension of Caring Behaviors among Respondents (n = 124)

		Clinical Care Dimension (Caring Behaviors)			
Predictors	Care	Standardize d Regression Coefficient	Standard Error	p-value (two-tailed)	R ²
Spiritual Competency	Care	0.18*	0.05	0.050	0.031
Cultural Competency	Care				
<i>Cultural Skills</i>		0.05	0.05	0.572	0.001
<i>Cultural Knowledge</i>		0.04	0.05	0.692	0.001
<i>Cultural Sensitivity</i>		0.04	0.05	0.697	0.001

*Significant at 0.05

†Significant at 0.01

The linear regression analysis for the influence spiritual care competency and cultural care competency on the clinical care dimension of caring behaviors is presented in Table 3. As shown above spiritual care competency significantly influenced clinical care ($\beta=0.18$, $p=0.050$), denoting that for every 1-unit increase in spiritual care competency, clinical care score increases by 0.18-unit. It is also notable that spiritual

care competency measured approximately 3.10% of the total variance of clinical care.

Table 4.

Univariate Linear Regression Analysis of the Influence Spiritual Care Competency and Cultural Care Competency on the Relational Care Dimension of Caring Behaviors among Respondents (N = 124)

Predictors	Relational Care Dimension (Caring Behaviors)			
	Standardized Regression Coefficient	Standard Error	p-value (two-tailed)	R ²
Spiritual Care Competency	0.29 [†]	0.08	0.001	0.086
Cultural Care Competency				
<i>Cultural Skills</i>	0.05	0.07	0.575	0.003
<i>Cultural Knowledge</i>	0.10	0.07	0.291	0.009
<i>Cultural Sensitivity</i>	0.10	0.07	0.284	0.009

*Significant at 0.05

[†]Significant at 0.01

On the other hand, the three dimensions of cultural care competency, specifically cultural skills ($\beta=0.05$, $p=0.572$), cultural knowledge ($\beta=0.04$, $p=0.692$), and cultural sensitivity ($\beta=0.04$, $p=0.697$) did not significantly influence the clinical care domain of caring behaviors.

Table 4 illustrates the univariate linear regression analyses for the influence of spiritual and cultural care competencies on the relational care dimension of caring behaviors. As gleaned from the table spiritual care competency significantly predicted relational care ($\beta=0.29$, $p=0.001$). This result indicated that for every 1-unit increase in spiritual care competency, relational care score increases by 0.29-unit. Interestingly, spiritual care competency accounted 8.60% of the total variance of relational care. Results also showed that cultural skills ($\beta=0.05$, $p=0.575$), cultural knowledge ($\beta=0.10$, $p=0.291$), and cultural sensitivity ($\beta=0.10$, $p=0.284$) did not significantly predict the relational caring dimension of caring behaviors.

Table 5.

Univariate Linear Regression Analysis of the Influence Spiritual Care Competency and Cultural Care Competency on the Humanistic Care Dimension of Caring Behaviors among Respondents (N = 124)

Predictors	Humanistic Care Dimension (Caring Behaviors)				R ²
	Standardized Regression Coefficient	Standard Error	p-value (two-tailed)		
Spiritual Care Competency	0.28 [†]	0.07	0.002		0.078
Cultural Care Competency					
<i>Cultural Skills</i>	0.04	0.06	0.635		0.002
<i>Cultural Knowledge</i>	0.06	0.06	0.529		0.003
<i>Cultural Sensitivity</i>	0.05	0.06	0.550		0.003

*Significant at 0.05

†Significant at 0.01

The univariate linear regression analyses for the influence of spiritual and cultural care competencies on the humanistic care dimension of caring behaviors is depicted in Table 5. As presented, spiritual care competency significantly influenced humanistic caring, with a standard regression coefficient of 0.28 and a computed *p*-value of 0.002. This result indicates that for every 1-unit increase in spiritual care competency, the humanistic caring score increases by 0.28-unit. Moreover, the computed R² is 0.078 meant that spiritual care competency measured 7.80% of the total variance of humanistic caring. However, results also showed that none of the dimensions of cultural care competency significantly predicted humanistic caring behaviors

Table 6.

Univariate Linear Regression Analysis of the Influence Spiritual Care Competency and Cultural Care Competency on the Comforting Care Dimension of Caring Behaviors among Respondents (N = 124)

		Comforting Care Dimension (Caring Behaviors)			
Predictors		Standardized Regression Coefficient	Standard Error	p-value (two-tailed)	R ²
Spiritual Competency	Care	0.28 [†]	0.06	0.002	0.078
Cultural Competency	Care				
	<i>Cultural Skills</i>	0.07	0.06	0.472	0.004
	<i>Cultural Knowledge</i>	0.09	0.06	0.318	0.008
	<i>Cultural Sensitivity</i>	0.03	0.05	0.753	0.001

*Significant at 0.05

†Significant at 0.01

Table 6 illustrates the univariate linear regression analyses of the influence of spiritual care competency and cultural care competency on the comforting care dimension of caring behaviors. As presented, spiritual care competency significantly influenced comforting care ($\beta=0.28$, $p=0.002$), denoting a 0.28-unit increase in comforting care score for every 1-unit increase in spiritual care competency values. In addition, spiritual care competency measured 7.80% of the total variance of comforting care. As presented in the table, cultural skills ($\beta=0.07$, $p=0.472$), cultural knowledge ($\beta=0.09$, $p=0.318$), and cultural sensitivity ($\beta=0.03$, $p=0.753$) did not significantly influence comforting care.

Discussion

Caring plays a vital component in the role of nurses as it provides a guiding framework in the practice of nursing. It involves a holistic approach to reach optimal level of care to patients. Hence, it is important to understand the factors that influence caring among nurses.

Studies have revealed that nurses who have a high level of understanding of spirituality provides spiritual care to their patients (Wong, Lee, L. & Lee, J., 2008; Musa, 2017; Mamier, Taylor & Winslow,

2018). In the study, Filipino nurses were shown to have a good level of spiritual care (3.33 ± 0.82). Filipinos are known to be spiritual and religious which was primarily influenced by 300 years of Spanish colonial rule, this is the reason why Filipino nurses consider the spiritual care as an essential part of integrated care. Also, Yilmaz and Okyay (2009) stated that nurses viewed spirituality as a part of the integrated care. In addition, the study of Hellman, Williams and Hurley (2015) found that 80% of nurses asserted that they could attend to patients' spirituality while taking care of their physical needs, however, they were uncertain about their ability to produce an oral or written report. According to the American Association of College of Nursing (AACN) one of the responsibilities of nursing education is to prepare nurses to identify spiritual distress and to provide spiritual care (Meyer, 2003). However, McSherry and Jamieson (2011) concluded that there is a low percentage of nurses who were equipped to provide spiritual care. In another study, McSherry (2006) stated that the concept of spirituality is poorly understood and inappropriately defined to the extent that nurses do not consider spiritual care as part of their responsibility.

Another factor that should be considered is cultural competence. According to Saha, Beach and Cooper (2008), cultural competence has been identified as the essential capacity to provide quality and effective healthcare to clients. The cultural competence of nurses is an important index to measure the overall medical service quality of hospitals and was shown to have significant associations with patient satisfaction and patient trust, thus, fostering the cultural competence of nurses is crucial for increasing satisfaction in patients' medical experience (Tang et al., 2018). However, the study of Lin, We and Hsu (2019) revealed that nurses were unprepared when encountering different cultures. Also, certain studies have shown that nurses have a high level of cultural awareness but has a low to moderate level of cultural competency (Kawashima, 2008; Bunjipimol, Somrongtong & Kumar, 2016; de Beer & Chipps, 2014). In the study, Filipino nurses were found to have a good level of competency with a mean rating of $3.24 (\pm 0.92)$ which showed that nurses are equipped with necessary skills to provide culturally sensitive care to patients. The Philippines has a very diverse culture, having been influenced by several countries including China, United States and Japan and is evident in various practices of the Filipinos. In addition, living in an environment with culturally diverse people, and experience in caring for patients from diverse cultures and special population groups were shown to be predictors of cultural competence (Cruz, Estacio, Bagtang & Colet, 2016).

In another aspect of holistic care, Filipinos nurses have an excellent level of caring behaviors, with comforting care as the highest, followed by clinical care, humanistic care and relational care. The concept of caring has been embedded in the curriculum of nursing, thus, caring has been a common language and innate to all nurses. The findings were supported by the study of Calong Calong and Soriano (2018) among Filipino nurses. They further concluded that caring behaviors has a significant relationship with patient satisfaction. Kuan (1993) stated that caring for Filipinos is more than kindness because ideal caring is a total gift of self to others done with the best of one's ability together with love and devotion without expecting anything in return.

It was found in the study that cultural competency has no significant influence to caring behaviors of nurses. On the other hand, spiritual competency significantly influences caring behaviors. Atashzadeh-Shoorideh, Abdoljabbari, Karamkhani, Shokri Khubestani, and Pishgoorie (2017) stated that caring behaviors and spiritual health are related to each other. Furthermore, spirituality was shown to have significant relationship with caring behaviors (Bakar, 2017; Priambodo, 2014). Hence, developing an understanding of spirituality could lead to provision of spiritual care to patients and may influence the caring behaviors of nurses.

Conclusions

In conclusion, spiritual competencies showed a significant influence in the caring behaviors of nurses, however, no significant influence was noted between the cultural competencies and caring behaviors of nurses.

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THAT IN ALL THINGS GOD MAY BE GLORIFIED

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