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Qualitative Exploration of Spirituality in Heart Failure Patients

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ABSTRACT**Background.**

Heart failure (HF) is a severe, progressive disease that afflicts large numbers of individuals around the world. One significant factor affecting quality of life in persons with HF is the extent to which spiritual needs are met.

Developing an understanding of spirituality in the HF patient is essential in order for the healthcare professional to provide the highest quality care possible. This study focused on examining spirituality in HF patients by means of conducting in-depth interviews with individuals diagnosed with HF and completing a descriptive analysis of the responses. The goal of this study was to gain insight into how spirituality affects the healthcare professional-patient relationship in regards to HF.

Methods.

This project was a qualitative descriptive study in which six people with established diagnoses of HF were interviewed in-depth utilizing a reliable spiritual assessment tool, FICA (Faith, Importance, Community, Address in care), as a base accompanied by follow up questions. The data were transcribed and critically analyzed.

Results.

Five of six participants in this study verified important spiritual beliefs and described various ways these impact their day-to-day lives, relationships, and healthcare practices. One participant denied spirituality or religion to be significant in her life.

Conclusion.

The findings of this study support the premise that spirituality is unique to each individual. By inquiring into a patient's spiritual beliefs, one can access a wealth of information regarding the individual's background, personality, psychological state, ideals, and more. The possible positive impact addressing spirituality could have for both patients and providers will remain unknown until further research is conducted.

LITERATURE REVIEW

Heart failure (HF) afflicts numerous individuals including approximately 5.1 million people in the United States. Of those suffering from HF, about fifty percent die within five years of their diagnosis (Go et al., 2013). Ensuring that such individuals maintain the highest quality of life possible throughout their disease process is the ultimate goal of health professionals. One important aspect of quality of life is spirituality. Despite the fact that HF is known to cause spiritual distress, health care providers often do not address this distress leading to negative consequences for the patient (Molzahn et al., 2012).

HF is a serious, chronic disease that develops when the heart is no longer able to pump blood sufficiently, causing circulatory needs of the body to go unmet (McCall, 1994). HF is highly prevalent and exceedingly expensive, as it is estimated to have cost the U.S. \$39.2 billion in 2010 (CDC, 2010). When diagnosed with HF, individuals may experience symptoms including but not limited to shortness of breath, increased respirations, pulmonary crackles, activity intolerance, edema of the lower extremities, increased abdominal girth, and

weight gain (Konick-McMahan, Bixby, & McKenna, 2003). In order to reduce the severity of such symptoms, improve functional status, and delay disease progression, many lifestyle alterations are required of such patients. These consist of following stringent medication regimens, adhering to a low-sodium diet, incorporating daily exercise, and avoiding excess tobacco, alcohol, and fluid (Black, Davis, Heathcotte, Mitchell, & Sanderson, 2006).

Patients diagnosed with HF tend to experience a decreasing quality of life as their disease progresses towards the end stage and they are less and less able to perform activities of daily living (Rector et al., 2006). A study performed with 101 end stage HF patients found that those experiencing a religious struggle experienced greater depression, marginally decreased life satisfaction, and increased number of nights subsequently hospitalized (Park, Wortmann, & Edmondson, 2011).

Health is generally taught to be multidimensional encompassing multiple, yet different realms including physical, social, intellectual, emotional, and spiritual health. If medical professionals aim to treat patients holistically, balance and depth between these distinctive areas of health must be attained (Cottrell, Girvan, & McKenzie, 2002). In focusing on the spiritual aspect of health, the term “spirituality” must be defined (Molzahn et al., 2012). In the past, spirituality was used interchangeably with religion. While religion is related to spirituality it is important to address the fact that the modern understanding of spirituality encompasses not only religion but also much more (Koenig, 2008, p. 349). Spirituality itself is seen by many to be multifaceted, including elements of the

meaning and purpose in life, inner peace, hope and optimism, faith, wholeness and integration, experiences of awe and wonder, and spiritual connection and strength (WHOQOLSRPB Group, 2006). Dr. Christina Puchalski, designer of the FICA spiritual assessment tool, described spirituality simply as the values and beliefs that allow a person to experience transcendent meaning and purpose in life (Puchalski & Romer, 2000). Another approach explored by Roberts and Yamane (2011) that will be utilized for the purposes of this study clarifies religion as a social or group phenomenon as opposed to spirituality being more of an individual experience. While there continues to be discussion surrounding the definition of spirituality in the healthcare world, there is no debate that it is an influential element in the healing process and important to many patients suffering from chronic illnesses such as HF (Koenig 2002; Murray et al. 2004).

The process of coping with severe illnesses, including HF, frequently produces a significant amount of stress among those diagnosed (Molzahn et al., 2012). Spirituality is an important tool by which patients may cope with this stress (Murray et al., 2004). Individuals with chronic diseases are living longer and it is late in life that many demonstrate heightened concern for spiritual issues (Mackenzie et al., 2000). Those afflicted often reflect upon life's meaning and the major existential and spiritual questions that accompany this process (Frank, 1995; Charon, 2006; Remen, 2006). The presence of a spiritual struggle or strained meaning system as reported by cardiac patients is significantly connected to adverse effects in regards to individuals' mental and physical wellbeing (Ano & Vasconcelles, 2005; Zwingmann et al., 2006).

At the same time, increasing amounts of literature have been published supporting the connection between spirituality and psychological and bodily health (Koenig et al., 2004; Koenig 2009). A study by Sloan, Bagiella, and Powell (1999) found 79% of Americans believe that healing can be facilitated by spirituality. Since the start of the 21st century the idea that mind and body work together to impact health and illness has continued to increase in acceptance (Black et al., 2006). Some recognize that chronic diseases, such as HF, may even develop into a spiritual encounter for several patients (Narayanasamy, 2002).

Properly caring for patients with diseases like HF can prove to be challenging and may cause the healthcare worker to feel helpless at times (Molzahn et al., 2012). Some healthcare educators believe inquiring about patients' spirituality can be mutually beneficial to the healthcare provider-patient relationship. A study by Ehman et al. (1999) found that two-thirds of the pulmonary outpatient study participants would appreciate questions about spirituality in a medical history but only 15% of participants reported having been asked about spirituality. Many individuals in today's society find it uncomfortable to openly discuss spirituality, and the health professional is no exception. Information provided in healthcare textbooks in regard to the subject is limited and often only briefly discussed (Puchalski & Romer, 2000). The personal beliefs and spiritual needs of patients are seldom integrated into healthcare plans and are regularly overlooked by healthcare workers (Black et al., 2006). This lack of expertise concerning the spiritual aspect of health may have a negative impact on the holistic care of the HF patient.

Fostering a professional understanding of the complexities of spirituality as a whole could allow healthcare professionals to better understand their patients' individual spiritualities and provide for higher quality patient-centered care. Addressing the realms of holistic health and stepping beyond scientific technicalities permits the healthcare worker to reconnect with the compassion that originally lead them into the healthcare profession and is beneficial to the patient (Puchalski, 2001). Much remains to be explored in regards to the advantage of incorporating the spiritual realm of health into patients' plans of care. Therefore, the purpose of this study was to examine spirituality in patients with HF.

METHODS

Design. This project was a qualitative descriptive study utilizing semi-structured open-ended interviews to examine spirituality in patients with established diagnoses of HF.

Subjects. Participants were recruited through the Washington Regional Medical Center Heart Failure Clinic. Six individuals were selected based upon the following criteria: resides within Northwest Arkansas, currently well compensated with a history of stage II or III HF, speaks and understands English, upper level cognitive functioning and hearing are intact, and displays interest in participating in the study.

Ethics. This study was conducted following approval from the Institutional Review Boards at the University of Arkansas and Washington Regional Medical Center.

Protocol. Data collection for the study was performed between November and December 2015. Demographic information including ethnicity, race, education level, age and gender was collected. For this project's purpose, a definition of spirituality was not provided to participants preceding interviews. In-depth semi-structured interviews lasting 30 to 45 minutes were conducted at Walker Heart Institute following participants' pre-arranged appointments. Each discussion was digitally audio-recorded and transcribed verbatim using a transcription service. Transcripts were de-identified by assigning pseudonyms.

Measures. Interviews were conducted using the FICA spiritual assessment tool as a base accompanied by follow up questions asked as they presented themselves in the dialogue. FICA is an acronym useful for recalling elements to ask about during a spiritual history with F prompting questions about what faith or beliefs an individual claims, I inquiring the importance and influence of said beliefs in one's life, C discovering whether the individual is a part of a spiritual community and how it is supportive to them, and A for address in which the provider asks the patient how these issues can be focused on in the individual's health care. Studies have found FICA to be a feasible way in which clinical spiritual assessments can be completed to help address spiritual needs essential to increasing quality of life (Borneman, Ferrell, & Puchalski, 2010).

Data Analysis. Qualitative description of patient responses was completed. The interview transcripts were analyzed with the intention of exposing participant's individual opinions (Ludvigsen et al., 2016). To aid in the descriptive analysis, a table with rows for individual patients and columns

representing the questions was utilized. Consistent with qualitative research study design, the researcher kept a “field notes journal” to record personal observations immediately following each interview.

RESULTS

The patient demographics were as follows:

Frank	25% Blackfoot Indian 75% Caucasian; Community college graduate; age 75
Robert	Caucasian; High school graduate – some college; age 76
Brenda	Caucasian; GED; age 60
Albert	Caucasian; High school and trade school graduate; age 88
Willie	Caucasian; 4 th grade; age 77
Catherine	Caucasian; Two bachelor’s degrees; age 61

Question One: What is your faith or belief?

All of the participants identified with a variety of Christianity. Some preferred to further distinguish themselves with a specific denomination or form as Frank and Willie described themselves as Baptists, Robert articulated preference for a bible-based church, and Catherine identified as Roman Catholic. In answering the question a number of those interviewed added brief anecdotes of how they came to that belief system. Some were raised believing in the tenets of their religious affiliations, others came to find belief later in life, and regardless most cited family as the source of introduction to faith. Brenda, for example, stated, “My mother was a Christian fanatic you might say.” Robert, Willie, and Catherine noted that though their parents raised them in a certain belief system, they each came to truly identify with their personal faith on their own.

Question Two: Do you consider yourself spiritual or religious?

Initially most of the participants expressed difficulty understanding this question. Brenda was the only one to answer immediately and was also the only to deny being either spiritual or religious. The others interviewed responded similarly to Frank who questioned, “Now, aren’t they kind of on the same level?” After taking moments to reflect, Frank and Albert responded that they considered themselves religious whereas Robert, Willie, and Catherine decided upon being “a little bit of both.” While most did not offer clear explanations of the reasoning behind their answers, Albert and Catherine made follow up statements. Albert, who aligned with religiosity, explained this by stating, “I do believe, I do attend church, I do read the Bible, I do try to live by it, and that’s my way.” Catherine, who answered to be both spiritual and religious, also referenced church attendance in addition to having attended catholic school most of her life as attributing to her religious side. When addressing spirituality she spoke more of prayer referencing how she had prayed the Hail Mary, a traditional catholic supplication prayer, during her ejection fraction test. She was petitioning for positive results, which she received stating, “it worked.”

Question Three: What things do you believe in that give meaning to your life?

Half of the participant’s responses to this question were simple in nature, alluding to such things as family, love, and God. Brenda was the only one to not elaborate, stating solely, “Not a whole heck of a lot.” She later went on to explain, “Basically I believe in live and let live,” noting that, “everybody’s going to die of something.” For Frank and Albert, their battles with heart failure have increased

their focus on family and other personal principles. Albert was distinctive in listing a number of personal values he had developed, which he prefaced in saying; “I have practiced all my life...there’s things that has paid me off really well.” Among these were ideals such as honesty, reliability, and a strong work ethic. Catherine was much more descriptive as she listed multiple Catholic principles she believes in and draws purpose from such as the resurrection, the trinity, prayer, and charity.

Catherine continued on to detail her story of vacationing in Europe when an infection found its way to her heart. She was able to make it home and to treatment despite multiple misdiagnoses abroad and what could have been detrimental prescriptions. She concluded in saying, “there but for the grace of God, am I still here...I’m not dead yet.” Robert, a man of strength and pride, described the weakness he felt when an exacerbation led him to be care-flighted to have a Left Ventricular Assist Device (LVAD), an advanced technological treatment for HF, placed. When reflecting on his faith and illness, Robert said he initially questioned God but concluded, “I’m still here so there’s still something out there that He’s got for me to do.” Willie discussed the great loss he has experienced as he watched both of his parents and six of his eight brothers pass away in close succession stating, “You never got over the hurt from one till the other come on.” He discussed the fact that he is still alive and stated, “I’ve had reasons you know to...believe in the good Lord for all the things He’s done for me.”

Question Four: Is it important in your life?

The men resoundingly asserted the importance of their faith in their lives. Robert demonstrated this in expressing, “We try to get Christ in our life in all things that we do.” Brenda reflected on her mother reciting, “I felt like she was cramming religion down me.” She went on to explain that as a result of her mother’s extreme views, she has come to be on the opposite end of the spectrum as she draws basic moral standards from Christianity but does not find faith significant in her life beyond this. Catherine described her beliefs as being influential in an intellectual manner but outside of this she called herself “a quiet Catholic” who attends church on Sundays.

Question Five: What influence does it have on how you take care of yourself?

Most of the participants answered this question by referencing specific parts of their daily routine, such as showering, diet, and avoidance of stimulants, which they adhere to in order to care for their body. It was commonly explicated that God calls his followers to treat their bodies well. Brenda described her self-care practices to be related to the teachings of her Grandmother not her beliefs whereas Robert connected faith and caring for himself saying, “I rely on Christ to help guide me.”

Question Six: How have your beliefs influenced your behavior during this illness?

Each participant acknowledged that their beliefs have impacted their outlook and actions throughout their experience with HF. For some, including Albert and Willie, answers given were along the same lines as those provided for

question five. For the remaining participants, the scope of the influence varied based on the individual. In Frank's case, this consisted of the idea that despite the course of his illness he finds peace in his health being, "in the Lord's hands." Robert discussed how he questioned God in regards to his diagnosis and concluded that God has a plan for him. Brenda related her belief that "life's too short" and described how she sometimes chooses not to comply with her healthcare plan for this reason. Catherine explained an optimism and perseverance provided by her beliefs that she has maintained throughout her battle with HF.

Question Seven: What role do your beliefs play in regaining your health?

Participants' responses to this question continued to touch on the same material as the previous two questions with an added emphasis on the power of prayer. Willie's statement, "A lot of times I've asked Him to help me," demonstrates the prayers discussed by himself, Robert, and Catherine. Obedience to authority, accountability to care for one's body, trust in a higher plan, and maintenance of optimism despite one's circumstances were among other cited ideals. Patients noted these learned practices as influential of their ability to adhere to the diet restrictions, lifestyle alterations, and medication regimens that accompany a HF diagnosis. The only participant to admit to conscious non-adherence was also the only participant who did not indicate active spiritual practice, Brenda. In regards to her low-sodium diet she claimed, "If I want to eat something, I'm going to eat it regardless...to me it doesn't really matter one way or the other..."

Question Eight: Are you part of a spiritual or religious community?

All of those interviewed, with the exception of Brenda who claimed no community at all, named a specific church body that they regularly attend. Some, such as Frank, Robert, and Albert, related the depth of their involvement as active members. For these three their religious communities are, “very supportive” as Frank included. For Willie and Catherine, church is a part of their lives but they also explained active relationships outside of their churches that are important to them.

Question Nine: Is there a person or group of people you really love or who are really important to you?

Participant’s answers to this question were exceptionally alike. Brenda alone differed, answering, “not really.” All other patients included spouses, family, and friends in their answers. Robert also mentioned his church group in his response.

Question Ten: How would you like your health care providers to address these issues in your health care?

Whether or not participants desired health care workers to address these issues as well as to what extent was varying. Robert expressed a special appreciation for a faith-based group of healthcare providers he interacted with throughout the placement of his LVAD. Brenda denied being asked about beliefs and did not know what she thought about the question, therefore she was unable to answer. Albert and Willie expressed an appreciation for healthcare workers who have been available to discuss beliefs and pray with them. Willie described

how he has felt in the hospital stating, “I’m in there and I don’t know whether I’m going to live or die...so, yes, I like for them to come and talk to me.” Catherine recapped her personal experience in the hospital during her initial crisis, recalling the fact that she was not asked about her beliefs until a follow up appointment. She was not upset by this and would be content in the future as long as her providers know she is catholic and may need a priest in the worst-case scenario. Despite their differing responses, all of the participants who offered up answers agreed upon the fact that their care has already been highly satisfactory. Most related the idea that there is not much more they could have asked for from their already exceptional health care providers. Robert summarized this sentiment in stating, “I’m not sure how they could add anything to what they did for me.”

Field notes:

Interviews took place immediately following patients’ appointments at the clinic in a specified examination room. For a couple of the patients, the outcomes of their appointment affected their mood and behavior during their interview. Catherine was in a particularly chatty and happy mood since she had just undergone an ejection fraction test with positive results allowing her to be released from wearing a defibrillator vest. Robert’s meeting was focused on checking in with his transition to the LVAD and as a result the events leading up to Robert’s LVAD placement and the placement itself were clearly on he and his wife’s minds during the interview. It did not appear that any of the participant’s appointments had negative outcomes which poorly affected their interviews.

The setting was private, quiet, and conducive to successful interviews. Albert, Brenda, and Catherine were alone for their interviews while Robert's wife accompanied him, Frank's wife and young granddaughter accompanied him, and Willie's wife and two young great granddaughters accompanied him. Those who had family members with them had more distractions occur throughout their interviews than those who were one on one. Robert's wife had to be discouraged from answering for him while Willie's wife's participation was often needed to help clarify Willie's answers due to his thick southern accent. Frank's granddaughter had a quiet presence that seldom affected his interview but Willie's two great granddaughters played in the corner of the room throughout the interview causing some distraction.

Individual observations of each participant:

- Frank: A family man, he was exceedingly affectionate with his wife and granddaughter. He was easy to talk to and the interview went smoothly.
- Robert: Kind and tender most times with the occasional cavalier comment. He seemed intelligent, proud, and steady. His wife was eager and active in her husband's care.
- Brenda: A complicated woman who appeared worn out and older than her age. She had sweetness about her when off topic, but she was feisty and almost aggressive at times when speaking on less superficial subject matter.
- Albert: Had a friendly, energetic, and healthy presence. He looked younger than his age. A hard working man and gifted storyteller.

- Willie: A gentle, pleasant man. His thick southern accent, slow speech, and education level made it hard to understand him frequently. His equally endearing wife interpreted for him when needed.
- Catherine: Not your typical HF patient in appearance, she was very petite and fit for her age. Extremely intelligent, articulate, and engaging.

Completing this research as a future healthcare professional did, as the creator of FICA Christina Puchalski describes in her work, reconnect me to the reasons I chose this career path (Puchalski, 2001). In conducting these interviews and speaking with patients about their beliefs, values, and relationships, I was able to connect with them on an intimate and meaningful level in a relatively short period of time. Ordinarily it would be easy to view these people solely in the context of their HF if I were to interact with them in the healthcare field, however, by completing spiritual assessments I was reminded that there is so much more to a person than their body. My perspective shifted as I saw each participant as a human soul with his or her own unique qualities and needs. After completing this study I strongly believe in the mutually beneficial impact spiritual inquiry can have to the patient-healthcare provider relationship and hope to be able to implement spiritual assessments in my future practice (Ehman, Ott, Short, Ciampa & Hansen-Flaschen, 1999).

DISCUSSION

This sample of patients proved to be more interesting than one may initially anticipate. Despite their similarities in race, age, and claims of Christianity, each individual's distinct characteristics became clearer and more significant as their interviews progressed. Education varied widely from a fourth grade level to double bachelor's degrees. Some patients noted economic restraints while others did not. Chosen denominations of Christianity, devoutness to belief systems, and, of course, individual spirituality differed from person to person. Furthermore, every patient's experience with HF and response to their disease process was unique.

Christianity being designated as the predominate belief was not surprising as this study was conducted in Northwest Arkansas, an area historically described to be part of the "Bible belt." A survey of adults in Arkansas in 2014 had the following results: 79% claimed Christianity, 70% of these identified with a form of Protestantism, and 70% of adults in general affirmed religion to be "very important" in their lives (Pew Research Center, 2014). What could not be expected is which of the participants would deviate from the majority, and in this study it was the women.

Although Brenda initially stated she was a Christian, she continued on to deny any association with the church, emphasized numerous times that she was not religious, and noted any values to be derived from personal experience rather than being faith-based. She proved to harbor a sizeable amount of bitterness towards the church and maintained a particularly isolated social life. For a

majority of the questions asked during the spiritual assessment, Brenda's answers strayed furthest from the rest of the participants. At the same time, Catherine aligned with traditional Catholicism which made her stand out in a predominantly protestant state. She was also distinguished by her profound intellectualism and her HF's origin. Catherine was diagnosed with acute HF resulting from a severe infection while the other participants suffered from chronic heart failure.

Consistent with Koenig (2008), patients' experienced difficulty designating if they viewed themselves as spiritual or religious. The participants confirmed that there is common confusion of the two terms. Despite the fact that those who participated in this study portrayed lifestyles influenced by faith and belief, almost all of them were forced to take added time to contemplate this question. While this study aimed to conceptualize spirituality as an individual experience and religion as that of a group, it is difficult to discern the opinions of the participants on the topic (Roberts & Yamane, 2011). Though each was able to provide feedback after reflection and follow-up questions, a majority of responses were vague, lacking in confidence, and the most common answer was "both." These findings are supported, as there are countless differing interpretations of spirituality and religion documented in today's literature (Molzahn et al., 2012). The framing of this question, which places spirituality opposite of religion, appeared to have caused confusion as many view the two to be intermingled (Koenig, 2008).

As researchers inquired into the importance of the participants' beliefs and what they find most meaningful, it became apparent that these patients had

already been pressed to thoughtfully reflect on their lives as a result of their battle with HF (Frank, 1995; Charon, 2006; Remen, 2006). Many of them expressed details surrounding various crises they have experienced in relation to their chronic illness, discussing having felt close to death and expressing the overwhelming thankfulness that comes with survival. For some of those interviewed, this reflection related to their spiritual beliefs while for others it was more impactful in regards to their personal values.

This study's findings also confirmed that there is a strong connection between spirituality and self-care, as a majority of the participants' faith seemed to positively influence the ways in which they actively manage their HF (Koenig et al., 2004; Koenig, 2009). When questioned about the influence belief has had on behavior, care, and regaining health, most participants referenced various faith-based principles as part of their reasoning and motivation to comply to their recommended healthcare plan.

Consistent with other studies, results also established that being a part of a spiritual or religious community as well as having loved ones in their lives proved to be substantially supportive to a majority of the participants in regards to their diagnoses (Koenig, 2002, 2004; Murray et al., 2004). The depth of involvement in their prospective communities varied, yet all who affirmed membership in church or described love for family and friends referenced various means by which the cited people provide them with assistance and encouragement. Meeting together regularly, cooking for each other, advocating for one another in prayer, and

helping out around the house were all examples mentioned. Most participants affirmed appreciation for such support, but Brenda displayed a different view. She reported having struggled financially throughout her lifetime and expressed that the church had failed her and her mother by not providing for them, stating, “If the churches can’t help me when I need help, then I can’t help them either.”

Brenda also denied having persons in her life she loved or who were important to her. It’s likely that her social isolation, low socio-economic status, and difficult childhood may be large contributors to the poor maintenance of her HF (Greysen et. al, 2014; Louie & Ward, 2011).

Responses to the last and arguably most important question included in FICA, which inquires how patients would like healthcare professionals to address beliefs in providing care, were fascinating. Brenda’s response was unique as usual, as she simply did not know how to answer. Despite reframing and allowing time for thought, she stood by having no answer and later apologized on this account. This was the only instance throughout the study that a participant was not able to provide a response. It is understandable that questioning a person who does not prioritize spirituality about how she would like it to be incorporated into her care would have difficulty answering.

Additionally, the women continued to be the exception as both Brenda and Catherine denied having been asked about their spiritual preferences during their hospital stays. Catherine related that she was not asked about her beliefs until she came in for a follow up appointment one month prior to her initial admission. However, she simply stated that she found this occurrence to be interesting and

that she did not feel she was lacking in her hospital experience which she called “lovely”. Having had described herself as “extremely private” and a “quiet catholic” her reserved nature was further revealed as she stated she was “happy not getting the visits from the priest.” One third of the participants in this study denying being asked about spirituality during their healthcare experience actually exceeds the findings by Ehman, et. al (1999). This finding could be related to the same sample size.

On the other hand, those who did identify their spiritual/religious needs being met were very appreciative. In particular, the men shared an appreciation for healthcare workers who address these issues. Strikingly, they also decidedly agreed that the care they have received has been gratifying towards this end. Frank and Robert both claimed they could not think of anything more they could ask of their healthcare providers. Robert referenced again his experience in receiving his LVAD and described those involved as “a faith-based group of people” who were his “dream team.” Albert expressed his fondness for the facilitation of visits from members of his church saying it, “perks you up.” Willie discussed sharing prayer with his healthcare providers and expounded upon how wonderful his doctors and nurses have been and how thankful he has been for their care.

Limitations.

It is recognized that spirituality and religion are frequently confused and as a result interviews were structured anticipating the use of follow up questions aimed at navigating the dialogue towards the concept of spirituality being an

individual experience as opposed to religion being a group experience (Roberts & Yamane, 2011). Despite this effort, participants' confusion was still apparent. It is also understood that the participants might not have been able to clearly articulate their beliefs and that some aspects of their spirituality may be outside the scope of the semi-structured interviews.

The sample size of this study was small and a number of the participants may have experienced comprehension issues related to older age and lack of advanced education. The study was geographically influenced, as Arkansas has a history of strong religious culture. Lastly, another factor that could have affected this study was the presence of family members during half of the interviews, which may have caused the participants to be distracted or to censor their answers.

The FICA tool was developed for clinical assessments of spirituality and not as a research tool. However, use of the FICA spiritual assessment tool proved to be efficacious in completing exploratory research. It allowed researchers to gain well-rounded representations of participants' spiritual and religious perspectives and preferences. The tool's four-pronged approach provided for insight not only into the participants' faiths and beliefs, but also into cherished relationships, experiences managing their illnesses, personal values, and opinions on care they have received and will receive in the future. The tool was used as a base from which to expand upon so that lengthier interviews could be accomplished which allowed for more in-depth exploration of spirituality. In the average nursing assessment, it can be completed in a matter of minutes with similarly beneficial results.

Whether assessment tools such as FICA would benefit with higher quality answers from those interviewed by defining spirituality and religion or asking the participants to provide personal definitions should be investigated. Although Black et al. (2006) did not find a significant relationship between compliance and spirituality in HF patients, this study suggested that a relationship between spirituality and healthy disease management exists. It may be advantageous in the future to complete a self-care assessment along with FICA to truly determine if this correlation is significant.

Implications.

The findings of this study support the premise that spirituality is unique to each individual. For some, it is a highly meaningful facet of everyday life, but for others it is an afterthought. Regardless of how it affects each singular person, spirituality is still a universal human experience (Moreno, 1977; Niebuhr, 1989; Forsyth, 1997; Rotenstreich, 1998). By inquiring into a patient's spiritual beliefs, one can access a wealth of information regarding the individual's background, personality, psychological state, ideals, and more. Such communication can connect healthcare providers to their patients in a powerful way. Still, though it is potentially impactful on a patient's overall quality of life, spirituality is difficult to quantify with data. As such, it is a factor that healthcare professionals should address with each person to whom they provide care, if only to learn individual patients would not like to discuss it.

What remains to be uncovered in regards to spirituality's part in healthcare is extensive. The findings of this study demonstrate that spiritual beliefs have a

tendency to be neglected when assessing patient's cases therefore indicating a need for healthcare professionals to increase their understanding of its significance. This dimension of health and innovative methods of incorporating it into care are yet to be explored in countless patient populations. The possible positive impact addressing spirituality could have for both patients and providers will remain unknown until further research is conducted. Future studies may benefit from the use of FICA spiritual assessment tool in combination with other instruments to gain insight into the intriguing topic of spirituality and how it is related to health.

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