การปฏิบัติทางจิตวิญญาณและความผาสุกทางจิตวิญญาณของผู้หญิงที่ใช้ชีวิตอยู่กับเชื้อเอชไอวี: ข้อค้นพบเบื้องต้นจากจังหวัดสุพรรณบุรี

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บทคัดย่อ

ความสำคัญ: จากทั่วโลกในบรรดาผู้ติดเชื้อเอชไอวีนั้นเป็นผู้หญิงมากกว่าหนึ่งในสี่ การติดเชื้อเอชไอวีเป็นหนึ่งในสาเหตุหลักของการเสียชีวิตของผู้หญิงวัยผู้ใหญ่ นอกจากนี้ยังมีการศึกษาวิจัยมากมายเกี่ยวกับจิตวิญญาณในกลุ่มผู้หญิงที่ติดเชื้อเอชไอวีเหล่านี้ ในการศึกษานี้ได้ใช้ Fitzpatrick's model of life meaning (2008) เพื่อเป็นกรอบในการศึกษา

วัตถุประสงค์: เพื่อศึกษามิติทางจิตวิญญาณ 2 มิติ คือ การปฏิบัติทางจิตวิญญาณและความผาสุกทางจิตวิญญาณ และศึกษาความสัมพันธ์ระหว่างมิติทั้ง 2 มิตินี้ในผู้หญิงที่ใช้ชีวิตอยู่กับเชื้อเอชไอวี

วิธีการศึกษา: การศึกษานี้เป็นการศึกษาเชิงปริมาณแบบพรรณนาที่คลินิกเอชไอวี โรงพยาบาลอู่ทอง จังหวัดสุพรรณบุรี โดยใช้การเลือกกลุ่มตัวอย่างแบบตามสะดวกเพื่อหากลุ่มตัวอย่าง จำนวน 100 คน

ผลการศึกษา: พบว่า อายุเฉลี่ยของกลุ่มตัวอย่างคือ 41.19 ปี การปฏิบัติทางจิตวิญญาณ 3 อันดับแรกที่กลุ่มตัวอย่างปฏิบัติได้แก่ การทำกิจกรรมกับครอบครัว การฟังหรือเล่นดนตรี การคิดหรือทบทวนความคิดของตนในทางบวก และความผาสุกทางจิตวิญญาณของกลุ่มตัวอย่างอยู่ในระดับสูง และความผาสุกทางจิตวิญญาณกับการปฏิบัติทางจิตวิญญาณมีความสัมพันธ์กันในทางบวก

สรุปและข้อเสนอแนะ: ผลการศึกษานี้สามารถนำไปเป็นข้อมูลเพื่อช่วยในการพัฒนาความรู้ทางการพยาบาล จากผลการศึกษานี้ควรมีการพัฒนาโปรแกรมที่ช่วยในการเสริมสร้างความผาสุกทางจิตวิญญาณในผู้หญิงไทยที่ติดเชื้อเอชไอวี พยาบาลมีความรับผิดชอบทางวิชาชีพที่ต้องประเมินความผาสุกทางจิตวิญญาณของผู้ป่วย โดยเฉพาะผู้หญิงไทยที่ติดเชื้อเอชไอวี

คำสำคัญ: จิตวิญญาณ การปฏิบัติทางจิตวิญญาณ ความผาสุกทางจิตวิญญาณ ผู้หญิงชาวไทย

Background

The World Health Organization (WHO) estimated that half of the 37.2 million people living with HIV are women (Kaiser Family Foundation, 2008). Today, women account for more than one quarter of all persons newly diagnosed with HIV in the United States (Centers for Disease Control and Prevention, 2008). Women living with HIV need the support of others to not only manage their illness but also to learn to

live with HIV. Nurses are in a key position to assist these women throughout their health and illness experiences. Women often are the major caregivers for the elderly, the sick, children, and others in their family (Squires, 2003), and they tend to place their own health second to the care of others. Additionally, many women are in positions of economic dependence and are often isolated and stigmatized in their own communities as a result of their HIV status; this can lead to a delay in seeking care. Understanding women's perceptions of their own spiritual well-being and the spiritual practices they use is an important step in designing future intervention programs for these women. According to Baldacchino and Draper (2001), use of spiritual coping or spiritual practices may enhance self-empowerment, leading individuals to find meaning and purpose in their lives. HIV is a devastating illness with multiple and profound effects on all aspects of physical, psychological, and spiritual being. It is important that nurses caring for women with HIV recognize this dimension.

In the existed literature, spirituality has been described in various ways, and several dimensions of spirituality have been investigated. Spirituality was considered as a search for meaning in life, a life force that leads individuals to seek a connection within themselves and to others, and also a connection to existence outside of the self (Meraviglia, 1999). A review of spirituality in nursing and health research, Chiu and others (2004) examined 73 articles published between 1990 and 2000. They aimed to identify common themes of spirituality. In their findings, the following themes were reflected: existential reality, transcendence, connectedness, and power/force/energy (Chiu, Emblen, Hofwegen, Sawatzky, & Meyerhoff, 2004). Moreover, there have been other studies focused on various aspects of spirituality among people living with HIV. Dalmida (2007), in a study of 20 women with HIV, reported a positive relationship between existential well-being and immune status and identified spirituality as a source used by women living with HIV to maintain psychological well-being. Based on the research, Dalmida suggested that spirituality may positively affect health-related quality of life. In an HIV adherence study conducted among African American (AA) women in an urban clinic, it was reported that religiosity and faith significantly influenced adherence (Holstad, Dilorio, & Magowe, 2006). Sowell and others (2000) investigated spiritual activities in 184 AA women living with HIV. As spiritual activities increased, emotional distress decreased; hence, providing support for the benefits of spiritual practices is needed. Woodward and Sowell (2001) examined the meaning

and use of spiritual beliefs and practices among 21 women living with HIV. The women were interviewed what spirituality was and what it meant to them. The findings showed a common theme of ''God in control.'' Many women said they spoke to God directly and that church attendance was not important for prayer. The women also described two types of partnerships: spiritual and medical. They also believed that the medical profession was serving God's purposes. They were positive about the potential of health care providers discussing spirituality with patients. Further support for the benefits of spiritual practices was reported in the study conducted by Tarakeshwar and others (2005). They aimed to study the effect of an 8-session spirituality oriented intervention for adults living with HIV. The sessions included: (1) HIV and Our Bodies; (2) Stigma, Shame and Guilt; (3) HIV and Relationships; (4) Control Versus Active Surrender; (5) Spirituality and Mental and Physical Health; (6) Personal Goals; (7) Hope; and (8) review and group closure. Following the intervention, group members reported an increase in positive spiritual coping and a decrease in negative spiritual coping.

Spiritual practices and beliefs act as a buffer when individuals faced with negative life events. The studies reported that most Americans believe that spirituality is an important part of their overall health and can promote recovery from and coping with illness. These studies have reported that people with HIV and other chronic illnesses often turn to spiritual practices to help them cope (Boudreaux, O'Hea, & Chasuk, 2002). Most of the literature on women living with HIV has been focused on medical factors such as side effects of antiretrovirals and adherence to treatment. Yet, there is study reported that positive beliefs, comfort, and strength gained from spiritual practices including religion, prayer, yoga, and meditation can contribute to healing and a sense of well-being.

Following the critical review, the Fitzpatrick's model of life meaning (2008) was used to guide this study. The core proposition in this model is the search through meaning reflecting in health and wellness. Within the Fitzpatrick's model of life meaning (2008), nursing interventions were proposed to help persons enhance wellness through understandings that help them derive meaning from life experiences. Spiritual practices are interventions that can enhance life meaning (Fitzpatrick, 2008).

Purpose

This study aimed to examine two dimensions of spirituality: spiritual practices and spiritual well-being, and to determine relationships between these two dimensions of spirituality among Thai women living with HIV. The study was planned as a first phase in gaining understandings that could be helpful in nursing practice to address the spiritual needs of Thai women living with HIV. The long-term goal is to develop interventions that can be used with women who are living with HIV to help them to increase the meaning in their lives and achieve higher levels of wellness.

Methods

This quantitative descriptive study was conducted in an HIV clinic in U-Thong Hospital, Suphanburi province, Thailand. The clinic served approximately 400 patients including 150 women; all these women are Thai-speaking. All of the female patients who obtain care at the clinic are Thai. The age range of the population is 18 to 62 years.

The researcher recruited a convenience sample of women living with HIV at the clinic. The potential participants were asked to participate in the study during their regular visits at the clinic. Based on a medium effect size, an alpha level of .05 and a power of .80, the calculated sample size need to be at least 83 participants (Cohen, 1992). Inclusion criteria for participants were as follows: Thai female, 18 years of age or older, Thai-speaking, and documented patient at the clinic where data was collected. Participants' HIV status was confirmed with a Western blot contained in their medical records. The study obtained the approval of the Boromarajonani College of Nursing, Suphanburi (BCNSP)'s institutional review board, Thailand and permission of the U-thong hospital before approaching the participants. Also, the consent for participation was obtained from the subjects.

Instruments

Demographic questionnaire. Demographic variables were included in the instruments. These included age, religious, marital status, employment status, education level, length of time since HIV diagnosis, CD4 count, and monthly income.

Spiritual well-being (SWB). The JAREL Spiritual Well-Being (JAREL-SWB) scale (Thai version) was originally developed by JAREL (Hungelmann, Kensel-Rossi, Klassen, & Stollenwerk, 1996) as a general measure of spiritual well-being. It is a 25-item

Likert-type scale containing multiple choice questions scored for analysis. Scores can be obtained from 3 domains including belief/faith, self-responsibility, and life satisfaction. Scores for each item range from 1 (lowest) to 5 (highest). Possible scores range from 25 to 125. A Thai translation of the scale, which had documented content, and convergent and divergent validity, was used. Internal consistency of this scale was high, with a Cronbach's alpha of .88. The JAREL Spiritual Well-Being scale has been used to study several groups of patients with chronic illnesses including people living with HIV. In all of the previous studies, greater spirituality was associated with overall psychological well-being and general well-being, results that supported the construct validity of the instrument (Daaleman & Kaufman, 2006; Daaleman, Perera, & Studenski, 2004).

The Spiritual Practices Checklist

The Spiritual Practices Checklist (SPC) had 12 items originally developed in English by Quinn Griffin and others (Quinn Griffin et al., 2008). The 12 spiritual practices (praying alone, praying with others, recalling positive thoughts, family activities, helping others, listening to or playing music, going to a house of worship or quiet place, exercise, reading spiritual material, relaxation, meditation, and yoga) are included in the SPC. The participants were not asked to identify these practices as spiritual practices and they are not given a definition of spiritual practices. Instead, the SPC is labeled as a spiritual practices checklist and the participants are asked to "indicate yes or no as to whether you use each of the following spiritual practices". Then, the list is provided. After participants answer the yes or no questions, they are asked to identify which 3 of the 12 spiritual practices they use most frequently. Also, there is a space for them to add other spiritual practices. For this study, the SPC was translated into Thai by the researcher and was validated by 3 experts working with Thai people living with HIV. Content validity was also previously reported (Quinn Griffin et al., 2008).

Findings

Sample Characteristics

A total of 100 women participated in the study. The average participant age was 41.19 (SD=7.68) years. More than half of the participant finished elementary school (n=59, 59%). A large majority of the participants indicated that they were

married (n=46, 46%), and about half of them (n=55, 55%) stated that they were employed outside the home. More than half of the participants had monthly household income of 5,000-10,000 Baht (n=59, 59%). All of the women in this study were Buddhist. The sample characteristics are included in Table 1.

The participants were also asked to respond to a series of questions about their health. There was a wide range of time since being diagnosed HIV (less than a year to more than 7 years) (Mean=3.24; SD=1.16). The average CD4 count for these participants was 505.53 cells/mm^3. A majority (n=95, 95%) of the participants indicated that they adhere to antiretroviral therapy.

Frequencies and percentages were calculated on the survey responses from the SPC to determine the spiritual practices of the participants. A total score of the number of spiritual practices used by the participant was obtained by adding the number of yes responses the person checked. Family activities (n=84, 84%), listen to/play music (n=80, 80%), and recall positive thoughts (n=75, 75%) were the practices most used.

A small number of the participants (n=10, 10%) indicated that they participated in yoga. Approximately half of the participants indicated that they practiced meditation, or visited a temple/quiet place (49%, and 53%, respectively). The frequencies and percentages for the participants' responses are listed in Table 2.

Each participant was also asked to indicate the three practices she used with the most frequency. The three practices most frequently used were praying alone (n=53, 53%), helping others (n=47, 47%), and visiting a temple/quiet place (n=38, 38%). Praying alone was the only practice that was reported as a most frequently used practice by more than half of the participants. Yoga, exercise, and reading spiritual materials were the practices used with the least frequency. These results are shown in Table 3.

Cronbach's alpha for the JAREL-SWB for the sample was calculated to assess the internal consistency. Cronbach's alpha was equal to .88 for the overall instrument; and .81, 83, and .85 for the belief/faith, self-responsibility, and life satisfaction dimensions, respectively. The sample mean for overall JAREL-SWB scores was 87.65 (SD=22.09); and for the three subscales, the means were belief/faith, 32.15 (SD=8.78), and self-responsibility, 24.07 (SD=14.95), and life satisfaction, 20.43 (SD=4.76).

The overall spiritual well-being was significantly related to the number of spiritual practices used ($r=.29$, $p<.01$). Furthermore, there were significant positive relationships among three dimensions of spiritual well-being and number of spiritual practices used as follows: belief/faith dimensions and number of spiritual practices used ($r=.80$, $p<.01$); self-responsibility dimensions and number of spiritual practices used ($r=.91$, $p<.01$); and life satisfaction dimensions and number of spiritual practices used ($r=.30$, $p<.01$).

Discussion

A total of 100 Thai women living with HIV participated in this study. All of them were Thai; the average age of the participants was 41.19 years. Most of the women were daily employed and lived at the poverty level. The average length of time since diagnosis of HIV was 3.24 years, with a range of less than a year to more than 7 years. All of these women were Buddhist and had an average CD4 count of 505.53 cells/mm^3. All of participants who participated in this study constituted approximately 100% of the women who attended the outpatient clinic and who met the inclusion criteria.

All of the participants used some spiritual practices. The most used practices were family activities, listen to/play music, and recall positive thoughts. Scores on the JAREL-SWB were high; the mean score was 87.65 (SD=22.09) out of the possible scores of 25-125. The positive relationship between spiritual well-being and the use of spiritual practices suggested that spiritual well-being also increased with increased numbers of spiritual practices.

The findings of the current research are related to those of previous studies linking spirituality and health. In discussing the relationship between these variables, Delgado (2007) proposed that spirituality transcends religious or cultural boundaries and is characterized by faith, a search for purpose in life, and connection with others. Dalmida (2007) identified spirituality as a resource used by HIV-infected women to maintain psychological well-being and enhance health-related quality of life. Baldacchino and Draper (2001) asserted that spiritual coping strategies involving relationships with others helped patients cope with their illnesses. These researchers also reported that positive beliefs, comfort, and strength gained from religion, prayer, and meditation contributed to healing and a sense of well-being.

Helping people living with HIV requires more attention to whole person (McSherry, Draper, & Kendrick, 2002).

Whereas the results of this preliminary study are important to future research and practices, the generalizability is limited by the demographic characteristics of the sample. Data were collected in an HIV clinic located in a rural area of Suphanburi province, Thailand; the patients were primarily provided with services through a primary care of the Thai government. Nevertheless, these preliminary data provide important directions for future work with Thai women living with HIV.

Plans for future research are to expand the diversity of the sample and to compare women who have HIV with women with other chronic illnesses along the same dimensions of spirituality. The examination of various dimensions of spirituality, including spiritual well-being and spiritual practice, in relation to various physical and psychological outcomes of HIV management is also of interest.

Conclusion

Spirituality is an important component in the lives and care of women living with HIV. So far, health care interventions alone go only in providing comfort and care. This current study provides preliminary information about spiritual practices and spiritual well-being among Thai women living with HIV. Nurses can implement many interventions based on an awareness of the importance of life meaning and spiritual practices that reflect one's connection to self, others, and existence outside of the self. It is most important for nurses to recognize the power of the spiritual dimension of their patients and of themselves; hence they can add this dimension into nursing care. The preliminary findings of this study provided the empirical information to conduct future research.

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Table 1. *Sample Characteristics (N = 100)*

Variable	Frequency	%
Age (*M* = 41.19, *SD* = 7.68, Range = 20-62 years)		
20-30	9	9
31-40	28	28
41-50	52	52
51-60	10	10
61-70	1	1
Marital status		
Single	12	12
Married	46	46
Widowed	33	33
Divorced	1	1
Separated	8	8
Employment status		
Employed outside the home	55	55
Not employed outside the home	45	45
Education level		
No certificate	3	3
Elementary level certificate	59	59
High school certificate	35	35
Diploma/Associates/Technical/Vocational certificate	1	1
Others	2	2
Monthly income (in bahts, 30 bahts = U.S. $1)		
No income	3	3
Less than 5,000	37	37
5,000-10,000	59	59
10,001-15,000	1	1
Time since HIV diagnosis (years)		
Less than 1	4	4
1-3	27	27
4-5	29	29
6-7	21	21
More than 7	19	19

Note. *M* = mean; *SD* = standard deviation

Table 2. *Frequencies and Percentages for the Spiritual Practices Checklist*

Practice	Yes	
	n	%
Family activities	84	84
Listening to music	80	80
Recalling positive memories	75	75
Helping others	73	73
Praying alone	70	70
Visiting a temple or quiet place	66	66
Exercise	56	56
Reading spiritual materials	52	52
Praying with others	49	49
Relaxation	44	44
Meditation	41	41
Yoga	10	10

Table 3. *Frequencies and Percentages for Most Frequently Used Spiritual Practices*

Practice	n	%
Praying alone	53	53
Helping others	47	47
Visiting a temple/quiet place	38	38
Family activities	30	30
Listening to music	22	22
Recalling positive memories	22	22
Praying with others	17	17
Relaxation	15	15
Meditation	13	13
Reading spiritual materials	12	12
Exercise	5	5
Yoga	1	1

Spiritual Practices and Spiritual Well-Being among Thai Women Living with HIV: Preliminary Findings from Suphanburi Province

Abstract

Background: Globally, women account for more than one quarter of all HIV diagnoses. HIV is one of the leading causes of death among women in adult age. Also, there is a growing body of research regarding spirituality among those women who are infected with HIV. The Fitzpatrick's model of life meaning (2008) was used to guide this study.

Purpose: This study aimed to examine two dimensions of spirituality (spiritual practices and spiritual well-being). The relationships between these two dimensions among Thai women living with HIV were also investigated.

Methods: This quantitative descriptive study was conducted in an HIV clinic in U-Thong Hospital, Suphanburi province. A convenience sampling method was used to recruit 100 participants into the study.

Findings: The results revealed that the average age of the women was 41.19 years. The three most frequently used spiritual practices included family activities, listen to/play music, and recall positive thoughts. A high level of spiritual well-being was evident among the participants, and a positive association was shown between spiritual well-being and a number of spiritual practices used.

Conclusion and Recommendation: The findings of this study help to advance the knowledge base for nursing. Based on the results in this study, interventions could be developed to enhance spiritual well-being among Thai women living with HIV. Nurses have a professional responsibility to assess spiritual well-being of all patients, especially women living with HIV.

Keywords: spirituality, spiritual practices, spiritual well-being, Thai women