

Nurses' Spiritual Intelligence and the Fulfillment of Patients' Spiritual Needs in an Internal Medicine Ward in Gorontalo, Indonesia

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ABSTRACT

Background: Spiritual care is an important dimension of holistic nursing, particularly for hospitalized patients facing illness, uncertainty, and changes in daily religious or meaning-making practices. Nurses' spiritual intelligence may support their ability to recognize and respond to these needs. Objective: To examine the relationship between nurses' spiritual intelligence and the fulfillment of patients' spiritual needs in the internal medicine ward of Prof. Dr. H. Aloei Saboe Regional General Hospital, Gorontalo, Indonesia. Methods: This quantitative correlational study used a cross-sectional design and total sampling. The sample comprised 36 nurses. Data were analyzed using the chi-square test. Results: Eighteen nurses (50.0%) were classified as having high spiritual intelligence. The most frequent category for fulfillment of patients' spiritual needs was high, reported for 17 respondents (47.2%). The thesis abstract reports a p-value of 0.029. The statistical appendix reports a Pearson chi-square of 11.150 (df = 4, p = 0.025) and a likelihood-ratio p-value of 0.029. Both reported significance values are below 0.05 and indicate an association between the variables. Conclusion: Nurses' spiritual intelligence was statistically associated with the fulfillment of patients' spiritual needs in this ward. Regular evaluation, practical training, and stronger integration of spiritual assessment into routine nursing care are warranted. Because the design was cross-sectional and the sample was limited to 36 nurses at one hospital, causal conclusions and broad generalization are not justified.

INTRODUCTION

Hospital care requires attention not only to physical symptoms but also to patients' psychological, social, cultural, and spiritual concerns. Illness may interrupt usual routines, threaten a person's sense of meaning, and raise questions about hope, relationships, faith, and the future. Spiritual needs can include the search for meaning and purpose, connection with a transcendent reality, reconciliation, hope, and opportunities to maintain personally important practices. These needs vary between individuals and should be explored without assuming that every patient wants the same form of religious support (Hodge et al., 2011; Wardah, 2019; Yusuf et al., 2021).

Spirituality is broader than the performance of religious rituals. It can involve the meanings people attach to life events, their relationships with themselves and others, and their sources of hope. In nursing, spiritual care may therefore include listening attentively, supporting a patient's chosen practices, helping maintain contact with family or spiritual advisers, facilitating prayer or sacred reading when requested, and documenting identified needs (Potter & Perry, 2005; Husaeni & Haris, 2020; Yanis, 2022). Such care should be person-centred, culturally responsive, and consistent with the patient's own beliefs and preferences.

Spiritual intelligence has been described in the literature as a capacity to reflect on existential questions, construct personal meaning, and integrate spiritual perspectives into adaptive decision-making. King's work on the assessment of spiritual intelligence and related conceptual discussions highlight meaning-making and existential reflection as relevant dimensions (King, 2008; Rasyad, 2019; Manurung, 2023). In nursing practice, these capacities may help nurses reflect on their own values, remain present during distress, and recognize that a patient's spiritual concerns may not be expressed directly (Kurniawati, 2021; Sari & Kartini, 2024).

The source thesis describes a practical gap at Prof. Dr. H. Aloei Saboe Regional General Hospital: spiritual-care procedures for prayer and spiritual guidance were available, but implementation was reported as not optimal. The preliminary observations described limited spiritual assessment and documentation, infrequent referral to spiritual-care providers, workload pressures, and reliance on family members for some forms of support. These local observations provide the context for examining whether nurses' spiritual intelligence is associated with the reported fulfillment of patients' spiritual needs.

The study aimed to describe nurses' spiritual intelligence, describe the fulfillment of patients' spiritual needs, and analyze the relationship between these variables in the hospital's internal medicine ward. The study is relevant to nursing management because a clearer understanding of this relationship can inform staff development, routine assessment, documentation, and referral pathways. Spiritual care should complement, rather than replace, clinical treatment and should always respect patient autonomy (Ismaryadi & Utami, 2021; Nadia Aryani Mustar et al., 2023; Arifandi et al., 2023).

METHODS

Study design and setting

This study used a quantitative correlational approach with a cross-sectional design. It was conducted in the internal medicine ward of Prof. Dr. H. Aloei Saboe Regional General Hospital in Gorontalo, Indonesia. The design measured the study variables within the same general period and was intended to identify an association rather than establish causation.

Population and sample

The study population consisted of 36 nurses working in the internal medicine ward. Total sampling was used, and all 36 nurses were included as respondents. The thesis reports that participants provided consent and that confidentiality was maintained. The manuscript source does not provide enough detail in the abstract to reproduce a full participant flow diagram or all eligibility criteria; these details should be checked against the final approved research protocol before journal submission.

Variables and data collection

The independent variable was nurses' spiritual intelligence, categorized in the thesis into levels. The outcome variable was fulfillment of patients' spiritual needs, also categorized into levels. Data were collected using the study questionnaire described in the thesis appendices. The thesis discusses spiritual-intelligence concepts such as self-awareness, flexibility, meaning-making, existential reflection, and the ability to respond constructively to suffering; it discusses spiritual care through assessment, communication, support for patient-preferred religious practices, and referral when appropriate (Fatimah & Nuryaningsih, 2018; Ismuhadi & Putéh, 2022; Qudrotillah Rahman et al., 2024).

Data analysis

Descriptive analysis was used to summarize the categories. The relationship between nurses' spiritual intelligence and fulfillment of patients' spiritual needs was tested using the chi-square test, with statistical significance set at $p < 0.05$. The appendix's SPSS output reports a Pearson chi-square statistic of 11.150 with 4 degrees of freedom and $p = 0.025$; it also reports a likelihood-ratio statistic with $p = 0.029$. The thesis abstract reports $p = 0.029$. These statistics are reported separately here because the source presents both values.

Ethical considerations

The thesis includes informed-consent materials and states that confidentiality was protected. Before publication, the authors should insert the formal ethics committee name, approval number, and approval date if applicable, because these identifiers were not clearly available in the material used to prepare this manuscript. Participation should be voluntary, and patient spiritual preferences should be respected without coercion.

RESULTS

Nurses' spiritual intelligence

Among the 36 nurse respondents, 18 (50.0%) were categorized as having high spiritual intelligence. This was the largest single category reported in the thesis abstract. The finding suggests that half of the respondents were classified in the high category under the study's measurement approach. The full frequency distribution should be checked against the thesis's results tables when the manuscript is finalized.

Fulfillment of patients' spiritual needs

The most frequent category for fulfillment of patients' spiritual needs was high, involving 17 respondents (47.2%). The source thesis describes relevant nursing activities as asking about patients' religious beliefs and current practices, listening to concerns, offering support for prayer or remembrance when wanted, and facilitating spiritual guidance. It also notes that implementation can be affected by workload, limited resources, insufficient training, and the absence of a dedicated spiritual-care unit.

Association between the variables

The thesis reports a statistically significant association between nurses' spiritual intelligence and fulfillment of patients' spiritual needs. The abstract reports $p = 0.029$, while the SPSS appendix reports Pearson $\chi^2 = 11.150$, $df = 4$, $p = 0.025$ and a likelihood-ratio $p = 0.029$. Both p -values are below the prespecified threshold of 0.05. The appendix notes that no expected cell count was below five, supporting use of the chi-square approximation in the displayed analysis.

Variable / test	Result reported in thesis	Interpretation
Nurse spiritual intelligence	High: 18/36 (50.0%)	Largest reported category in abstract
Fulfillment of patients' spiritual needs	High: 17/36 (47.2%)	Largest reported category in abstract
Pearson chi-square	$\chi^2 = 11.150$; $df = 4$; $p = 0.025$	Statistically significant at $p < 0.05$
Likelihood-ratio test	$p = 0.029$	Statistically significant at $p < 0.05$
Valid cases	36	Total-sampling nurse respondents

DISCUSSION

The main finding is an association between nurses' spiritual intelligence and fulfillment of patients' spiritual needs. One plausible interpretation is that nurses who are more comfortable reflecting on meaning, values, and suffering may be better prepared to notice spiritual concerns and respond with empathy. However, the present cross-sectional analysis cannot determine whether spiritual intelligence improves spiritual-care delivery, whether clinical experience and institutional support influence both variables, or whether other factors explain the association. Spiritual intelligence should therefore be considered one potentially relevant factor rather than the sole determinant of care quality (King, 2008; Manurung, 2023; Qudrotillah Rahman et al., 2024).

The proportion categorized as high in spiritual intelligence was 50.0%, while 47.2% of respondents were in the high category for fulfillment of spiritual needs. These figures indicate that high performance was not universal. A ward may have written procedures for prayer or spiritual guidance yet still experience implementation gaps when staff are busy, documentation is inconsistent, or referral pathways are unclear. The source thesis specifically identifies workload, limited supporting resources, and limited awareness or training as practical barriers. These issues point to a need for organizational support rather than relying only on individual nurses' motivation.

Spiritual care should be based on assessment rather than assumptions. Nurses can ask patients whether spiritual, religious, cultural, or existential concerns are important to them; what forms of support they prefer; and whether they would like contact with family, a chaplain, a religious leader, or another trusted person. Patients who do not identify with a religion should receive equally respectful support. This approach is consistent with literature describing spiritual needs in relation to meaning, hope, relationships, and personal belief, not simply ritual participation (Hodge et al., 2011; Wardah, 2019; Yusuf et al., 2021).

The findings also support incorporating spiritual care into routine nursing processes. Brief assessment prompts, documentation fields, staff education, and a clear referral protocol may help translate professional values into consistent practice. Training can include respectful communication, recognition of spiritual distress, boundaries between support and proselytizing, and how to respond when a nurse's own beliefs differ from a patient's. Reflective practice and supervision may further strengthen awareness of personal assumptions and improve the ability to provide nonjudgmental support (Husaeni & Haris, 2020; Ismaryadi & Utami, 2021; Yanis, 2022).

The result is broadly consistent with the conceptual literature cited in the thesis, which frames spiritual intelligence as related to self-awareness, personal meaning, existential reflection, and constructive responses to adversity. These attributes may support therapeutic presence, but the relationship should be tested in larger and more diverse samples using validated measures. Future studies could include patient-reported outcomes, direct observation of spiritual-care practices, and institutional variables such as staffing levels, training exposure, and availability of spiritual-care services.

Limitations

Several limitations should be considered. First, the sample consisted of only 36 nurses from one ward in one hospital, limiting generalizability. Second, the cross-sectional design does not establish temporal order or causality. Third, the abstract and appendix contain slightly different p -values because they report different test outputs; this article preserves the distinction rather than selecting one without explanation. Fourth, detailed psychometric information for the questionnaire, including validity and reliability statistics, was not available in the summary material used here. Finally, the outcome is described as fulfillment of patients' spiritual needs, but the sample is reported as nurses; the exact unit of measurement and whether responses represent nurses' assessments or patient-level data should be clarified from the original methods and dataset before submission.

CONCLUSION

In this study of 36 nurses in the internal medicine ward of Prof. Dr. H. Aloei Saboe Regional General Hospital, 18 nurses (50.0%) were classified as having high spiritual intelligence, and the most frequent category for fulfillment of patients' spiritual needs was high (17; 47.2%). The thesis reports a statistically significant association between the variables (abstract $p = 0.029$; appendix Pearson chi-square $p = 0.025$ and likelihood-ratio $p = 0.029$). The findings support strengthening routine spiritual assessment, staff education, documentation, and referral pathways. Larger studies using clearly validated measures and patient-level outcomes are needed to clarify the nature and direction of this association.

PRACTICE IMPLICATIONS

Nursing managers should consider periodic audits of spiritual-care documentation, short practical training sessions, and accessible referral arrangements for patients who request spiritual guidance. Nurses should ask about individual preferences, protect privacy, and avoid imposing personal beliefs. These measures can support holistic care while maintaining professional boundaries and respect for diversity.

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