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Nurses' Lived Experiences in Providing Spiritual Care to Patients with Chronic Pain At University of Ilorin Teaching Hospital: A Quantitative Study

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ABSTRACT

Patients with chronic pain experience physical, emotional, and spiritual distress, requiring holistic nursing care. This study explored nurses' lived experiences of providing spiritual care to patients with chronic pain at the University of Ilorin Teaching Hospital (UITH), including training received and challenges encountered. With a population size of 128 registered nurses, the descriptive cross-sectional design involved 100 registered nurses from medical, surgical, stroke, renal, and pain and palliative care units, obtained through purposive non-probability sampling technique. Data were collected using self-administered structured questionnaires validated by academic colleagues and other experts in nursing within the institution, with reliability confirmed through the split-half (r), Spearman-Brown (rSB), and Guttman coefficients (Guttman) analyses. Data analysis was done descriptively using frequencies, percentages, means, and standard deviations. About 52% had received some spiritual care training, but only 5.6% had formal training, mainly through workshops. While 64% felt confident providing spiritual care and considered it necessary, major challenges included heavy workload (81%), lack of training and policy support (68%), and concerns about diversity (65%). The study concluded that there is a need for structured spiritual care education, supportive institutional policies, and mechanisms to address workload and cultural challenges, thereby enhancing holistic, patient-centred care in clinical settings. It is recommended that structured spiritual care education using frameworks such as Interprofessional Spiritual Care Education Curriculum (ISPEC) and Faith, Importance, Community, Address (FICA), alongside institutional support and collaborative practice, be implemented to strengthen holistic, patient-centred care in Nigeria.

Keywords*:* Spiritual care, Chronic pain, Nurses, lived experiences, Holistic care

INTRODUCTION

Spiritual care is a critical aspect of health care yet often underemphasized dimension of holistic nursing practice, particularly in the management of patients experiencing chronic pain. Chronic pain, defined as persistent pain lasting longer than three months, not only affects the physiological functioning of individuals but also profoundly impacts their psychological, emotional, social, and spiritual well-being (Driscoll et al., 2021). Patients experiencing chronic pain frequently deal with existential questions such as "What is the point of my life now that I cannot do what I used to do?", "How do I find purpose when everyday tasks cause suffering?", and "Why is this happening to me?", highlighting the essential role of spiritual care as part of comprehensive pain management (De Diego-Cordero et al., 2022). Beyond seeking physical relief, individuals with chronic pain often desire holistic support that addresses their spiritual and emotional needs, making the integration of spiritual care into routine nursing practice a vital aspect of patient-centred care.

The multidimensional nature of chronic pain arises from a variety of etiologies, including nociceptive, neuropathic, musculoskeletal, inflammatory, psychogenic, and mechanical causes (Mailis et al., 2020). Unrelieved chronic pain can result in functional impairment, decreased mobility, psychological distress, and increased utilisation of healthcare services. While pharmacological interventions remain central to pain management, non-pharmacological approaches, such as physical therapy, cognitive-behavioural therapy, multidisciplinary pain management programs, and spiritual care, have demonstrated significant benefits in improving patients' pain perception and overall quality of life (Austin & Lovell, 2024; Van Looveren et al., 2022). In this context, spiritual care emerges not only as a complementary strategy but also as a crucial mechanism for addressing the emotional and existential suffering that often accompanies chronic pain.

The provision of spiritual care involves the recognition of the spiritual needs of people and meeting these needs,

including religion, personal values, or seeking meaning and a sense of life (Harrad et al., 2019). Research suggests that spiritual interventions can lower anxiety and depression, promote psychological well-being, and increase life satisfaction (Hu et al., 2019). Spiritual care is especially important for patients with chronic or life-limiting diseases, as it provides an organized approach for coping with uncertainty, distress, and existential issues. Indeed, spirituality has been defined as a significant coping resource and helps complement conventional treatments for patients with pain syndrome (Ferreira-Valente et al., 2020). Despite the proven importance of spiritual care, it has become one of the most frequently overlooked aspects of patients' needs in clinical practice. There is ample evidence that patients have unmet spiritual needs, as 72% of patients feel that the healthcare system does not properly respond to their spiritual needs, and 67% want spiritual support from their healthcare providers (Büssing et al., 2025). Chaplains and clergy usually address this issue in healthcare settings; however, due to the lack of such specialists, nurses and other healthcare practitioners become responsible for the provision of spiritual care because of the availability of such specialists (Bolarinwa et al., 2023). Being frontline caregivers, nurses are able to show constant care, empathy, and presence and, thus, are able to recognize the spiritual needs of patients.

Research shows that the provision of spiritual care training programs improves the performance of nurses (Hemati et al., 2026; Timmins et al., 2026). Programs such as the Interprofessional Spiritual Care Education Curriculum (ISPEC), as well as tools such as the FICA (Faith, Importance, Community, Address) tool developed by Puchalski, provide evidence-based ways to incorporate the aspect of spiritual care into practice (Szilagyi et al., 2022). Training programs enable nurses to better understand the needs of patients, cooperate with spiritual care specialists, and fight for the development of spiritual care in the institution where they work.

Despite the recognized importance of spiritual care, there remains limited research exploring nurses' lived experiences in providing spiritual support to patients with chronic pain, particularly within Nigerian tertiary healthcare settings. The limited studies (Bolarinwa et al., 2023; Esan et al., 2024) laid a good foundation for the unique additional challenges in providing spiritual care due to the country's diverse cultural and religious composition. However, the studies focused only on cancer patients. This study, therefore, aims to explore the lived experiences of nurses providing spiritual care to patients with all forms of chronic pain at the University of Ilorin Teaching Hospital (UITH). This study will help fill the gap in the existing literature regarding nurses' experience in providing spiritual care to patients with chronic pain.

METHODS

A quantitative survey research design was used, whereby data were collected and analyzed throughout the research process. This type of research design is ideal for investigating complex and multidimensional phenomena such as spiritual care in which objective measurements (quantitative) were needed to define the problem (Goodfellow, 2023). A descriptive cross-sectional survey design was used with the aim of quantifying nurses' experiences in terms of the magnitude and type of spiritual care training received and spiritual care challenges.

The research was conducted at University of Ilorin Teaching Hospital (UITH), a reputable tertiary health institution in Ilorin, Nigeria. UITH was established in 1980 and operated in a temporary location that housed the General Hospital, Ilorin (now Kwara State Teaching Hospital), and another government facility until 2010, when it moved to its current permanent location in Oke-Ose, Ilorin. UITH acts as a teaching, research, and specialized care institution providing a wide range of medical and surgical services, including pain and palliative care for patients with chronic pain. UITH has more than 2,000 workers and state-of-the-art healthcare facilities. It treats people from diverse backgrounds in the region.

The target population for this study was registered nurses working in the Medical, Surgical, Stroke, Renal, and Pain and Palliative care units of UITH, in which nurses have the opportunity to meet patients with chronic pain and carry out spiritual care. The target population had 128 registered nurses in all of the above-mentioned units, with the sample size being taken using a purposive non-probability sampling technique. Table 1 shows the distribution of nurses in the respective units.

Table 1: Population Distribution of Nurses in Selected Units at UITH

Unit	Population	Representative Sample
Medical	44	37
Surgical	52	43
Renal	15	13
Stroke	13	11
Pain and Palliative	4	3
Total	**128**	**107**

Inclusion criteria were limited to nurses who held permanent jobs at UITH and who were actively working with patients with chronic pain conditions. The participating nurses had to be working in wards where managing chronic pain is an integral part of patient care and had at least two years of nursing practice to be adequately acquainted with such patients. In addition, only nurses who agreed voluntarily to take part in the research were selected. For exclusion criteria, only nurses who did not work directly with patients with chronic pain conditions, those nurses who worked on a temporary basis and thus may be

less experienced with patients targeted by this research and those working in other departments were eliminated.

For determination of the sample size, Taro Yamane's formula (Yamane, 1967), given in Equation 1, was used.

$$n = \frac{N}{1+N(e)^2} \quad \text{Equation (1)}$$

Let N be the population size (N = 128), n is the sample size, and e is the confidence interval (e = 0.05). Therefore, the minimum sample size obtained through the use of Equation (1) is n = 97. In view of non-response cases, a 10% increase was considered to obtain a sample size of about 107. Proportional allocation was used to obtain the number of participants per unit with reference to the representative sample per unit given in Table 1.

Non-probability sampling was applied with regard to purposive sampling, which refers to choosing participants who have the knowledge, skills, and insight about the topic under research, nurses delivering spiritual care to patients with chronic pain (Molala & Downing, 2024). This sampling method was the most appropriate because it facilitated the intentional choosing of participants who had experiences related to the topic being researched.

For the purpose of data collection, a structured questionnaire with three sections was administered among participating nurses. Demographic data were collected using Section A. Section B collected information regarding the training participants may or may not have undertaken in the area of spiritual care and involved closed-ended (Yes/No) responses and multiple-choice questions. Section C identified challenges nurses faced in terms of delivering spiritual care among their respondents through a Likert scale and multiple response options (challenges could include time problems, institutional challenges, lack of training, emotional burden, among others).

Validity of the instrument was assessed with the help of academic colleagues and other nurses in the same field (experts in nursing) at the University of Ilorin so that each aspect of it can be evaluated based on the clarity and relevance of the information it intends to collect. Adjustments can be made for each component of the instrument in line with the validity assessment to measure the constructs well. Validity assessment involved a review of literature in addition to valid instruments already used.

Reliability of data collected was confirmed through carrying out a pilot test among nine nurses fitting the inclusion criteria but not the sample. Internal consistency of the test is estimated by use of the split-half (r) method to assess the test's reliability, which involves calculation of Spearman-Brown coefficients (rSB) and Guttman split-half coefficient (Guttman) among demographic variables, training and challenges with reference to major sections of the tool (Table 2). Internal consistency reliability values of r, rSB and the Guttman split-half coefficient are 0.63 -0.86; 0.71-0.93; and 0.68-0.84, respectively.

Table 2: Reliability Analysis of Questionnaire Sections

Scale	No. of Items	r	rSB	Guttman
Demography	6	0.86	0.93	0.79
Training in Spiritual Care	5	0.63	0.71	0.68
Challenges in Providing Spiritual Care	9	0.73	0.84	0.84
Major Challenges Faced	10	0.65	0.71	0.77

Data were collected using self-completed structured questionnaires issued to purposefully sampled nurses who met the inclusion criteria. The authors explained the study, obtained consent, and encouraged completion within a week, followed by a retrieval visit that ensured a high response rate and minimized participant burden.

Data from structured questionnaires were coded and analyzed with the Statistical Package for the Social Sciences (SPSS) version 26. Descriptive statistics such as frequency counts, percentage proportions, means, and standard deviations were used to summarize the characteristics of the subjects and their responses.

These protocols were used in line with the established policies of ethical compliance as set by the institution as well as by the nation in order to maintain high ethical standards during the study. An ethical review committee permit had been approved for the study, and it was obtained through the UITH Ethical Review Committee, permit number ERC/PAN/2025/06/0613, and endorsed by a letter of introduction issued by the Department of Nursing Sciences to give ethical approval for the conduct of the study. Participation was voluntary, with the right to withdraw at any time. Written informed consent was obtained before data collection, and throughout the study, the principles of respect for persons, beneficence, non-maleficence, and justice were strictly upheld to safeguard participants' rights and dignity.

The results, which are given in Tables 3-6, cover the quantitative analysis of the study from the 100 responses retrieved (indicating a 93% retrieval rate) in terms of the socio-demographic data (Table 3), responses on training in spiritual care (Table 4), challenges of providing spiritual care (Table 5) and major challenges confronted by the respondents in the delivery of spiritual care (Table 6). According to Table 3, participants' ages ranged from 20 to over 50 years, with the majority (33%) falling between 20 and 30 years, followed by 50 years and above (24%), followed by 23% between 30 and 39 years, and 20% were between 40 and 49 years old. Regarding gender, only 2(2%) were male nurses, while 98(98%) were female nurses. In terms of marital status, 70(70%) of the participants were married, while 30(30%) were single; Religious, 52(52%) identified as Christians, while 48(48%) were Muslims. Concerning the wards/units of the nurses, 37 (37%) were from the medical ward and surgical ward, 13 (13%) from

the renal ward, 12 (12%) from the stroke unit, and only 1 (1%) from the pain and palliative care unit. As regards years of experience, 48(48%) have 2 to 3 years experiences, 27(27%) 6 to 10 years, 13(13%) above 16 years, and 12(12%) have 11 to 15 years. In terms of current rank/designation, 27(27%) are SNOs, 25(25%) NOs, 16(16%) CNOs, 13(13%) PNOs, 12(12%) ADNs, 5(5%) DDNs, and 2(2%) ACNOs.

Table 3: Socio-demographic Variables of Participants (N = 100)

Socio-demographic Data	Frequency	Percent
Age (years)		
20 – 29	33	33
30 – 39	23	23
40 – 49	20	20
50 and above	24	24
Gender		
Male	2	2
Female	98	98
Marital status		
Single	30	30
Married	70	70
Religious		
Christianity	52	52
Islam	48	48
Ward/unit		
Medical ward	37	37
Surgical ward	37	37
Renal ward	13	13
Stroke unit	12	12
Pain and palliative	1	1
Years of experience in a ward/unit		
2 – 5 years	48	48
6 – 10 years	27	27
11 – 15 years	12	12
Above 16 years	13	13
Current rank/designation		
NO	25	25
SNO	27	27
PNO	13	13
ACNO	2	2
CNO	16	16
ADN	12	12
DDN	5	5

Professional cadre abbreviations include: NO = Nursing Officer, SNO = Senior Nursing Officer, PNO = Principal Nursing Officer, ACNO = Assistant Chief Nursing Officer, CNO = Chief Nursing Officer, ADN = Assistant Director of Nursing, and DDN = Deputy Director of Nursing.

Table 4 revealed responses on training in spiritual care among the participants. The majority of the participants reported having received training in spiritual care (52%), with 79.6% of them receiving in-service training/workshops, 14.8% received religious-based training, and 5.6% received formal education. Regarding how nurses rate the adequacy of the training received, 31% indicated adequate, 19% said very adequate, 48% indicated not applicable because they have never been trained, and 1% each indicated inadequate and very inadequate. On nurses' confidence in their ability to provide spiritual care, 64% indicated that they are confident, 23% of them are not sure, while 13% said they have no confidence. Finally, on nurses' interest in participating in training programmes on spiritual care, a significant majority (86%) are interested, and 5% are not, while 9% are not sure.

Table 4: Training in Spiritual Care among the Participants

Items	Frequency	Percent
Have you ever received any training in spiritual care?		
Yes	52	52
No	48	48
Total	**100**	**100**
If yes, what type of training did you receive?		
Formal education	3	5.6
In-service training/workshop	43	79.6
Religious-based training	8	14.8
Total	**52**	**100**
How would you rate the adequacy of the training you received		

Very adequate	19	19
Adequate	31	31
Inadequate	1	1
Very inadequate	1	1
Not applicable	48	48
Total	**100**	**100**
Are you confident in your ability to provide spiritual care?		
Yes	64	64
No	13	13
Maybe	23	23
Total	**100**	**100**
Are you interested in participating in training programmes on spiritual care?		
Yes	86	86
No	5	5
Maybe	9	9
Total	**100**	**100**

Table 5 shows the challenges of providing spiritual care as perceived by participants. Summing up agreed and strongly agreed as agreed and disagree and strongly disagreed as disagreed, 62% agreed that nurses lack adequate training to provide spiritual care. 48% disagreed with the statement that it is uncertain whether providing spiritual care is part of a nurse's role. 67% agreed that the fear of imposing personal beliefs on patients during spiritual care is a concern. 63% agreed that nurses avoid discussions on spirituality to prevent offending patients. 47% agreed that nurses often experience emotional exhaustion from providing spiritual care; 81% agreed that the hospital does not provide clear guidelines on spiritual care delivery. 80% agreed that there is no structured support system for addressing spiritual needs in the hospital. 77% agreed that nurses struggle to provide spiritual care due to the workload. Finally, 83% agreed that cultural and religious differences make it difficult to provide spiritual care.

Table 5: Challenges in Providing Spiritual care as perceived by Participants

Items	SD	D	N	A	SA	Mean±SD
Nurses lack adequate training to provide spiritual care	11(11%)	28(28%)	7(7%)	42(42%)	12(12%)	3.16±1.27
It is uncertain whether providing spiritual care is part of the role of a nurse	10(10%)	38(38%)	5(5%)	37(37%)	10(10%)	2.99±1.25
Fear of imposing personal beliefs on patients during spiritual care	7(7%)	18(18%)	8(8%)	51(51%)	16(16%)	3.51±1.17
Nurses avoid discussions on spirituality to prevent offending patients	7(7%)	27(27%)	3(3%)	45(45%)	18(18%)	3.40±1.26
Nurses often experience emotional exhaustion from providing spiritual care	5(5%)	35(35%)	13(13%)	27(27%)	20(20%)	3.22±1.26
The hospital does not provide clear guidelines on spiritual care delivery	8(8%)	3(3%)	8(8%)	57(57%)	24(24%)	3.86±1.07
There is no structured support system for addressing spiritual needs in the hospital	6(6%)	5(5%)	9(9%)	54(54%)	26(26%)	3.89±1.04
Nurses struggle to provide spiritual care due to the workload	5(5%)	11(11%)	7(7%)	43(43%)	34(34%)	3.90±1.42

Cultural and religious differences make it difficult to provide spiritual care	5(5%)	11(11%)	1(1%)	54(54%)	29(29%)	3.91±1.09

Table 6 focuses on the major challenges confronted by the participants. 68% of the participants face a lack of formal training, 21% reported a lack of confidence, 81% face time constraints due to workload, and 48% face a lack of institutional support. 68% of the participants face the absence of hospital policies on spiritual care; 58% reported fear of offending patients, 65% reported cultural/religious differences, and 42% reported emotional exhaustion. 33% of the participants reported role confusion (unsure if it's part of their duty), 39% reported unavailability of chaplains/religious leaders, and 48% reported patients' unwillingness to engage in spiritual conversations.

Table 6: Major Challenges Confronted by the Participants

Items	Yes	No	Total
Lack of formal training	68(68%)	32(32%)	100(100%)
Lack of confidence	21(21%)	79(79%)	100(100%)
Time constraints due to workload	81(81%)	19(19%)	100(100%)
Lack of institutional support	48(48%)	52(52%)	100(100%)
Absence of hospital policies on spiritual care	68(68%)	32(32%)	100(100%)
Fear of offending patients	58(58%)	42(42%)	100(100%)
Cultural/religious differences	65(65%)	35(35%)	100(100%)
Emotional exhaustion	42(42%)	58(58%)	100(100%)
Role confusion (unsure if it's part of my duty)	33(33%)	67(67%)	100(100%)
Unavailability of chaplains/religious leaders	39(39%)	61(61%)	100(100%)
Patient's unwillingness to engage in spiritual conversations	48(48%)	52(52%)	100(100%)

DISCUSSION

The findings, as given in Table 4, show that while a slight majority (52%) of nurses had received some form of training in spiritual care, most of this training was informal, primarily through in-service workshops (79.6%) or religious experiences. A minimal share (5.6%) had ever undergone formal education. In particular, around half (48%) indicated a lack of any previous spiritual care training. The same result has been obtained by Adeyemo et al. (2022), reporting that 69.4% of nurses from Osun State showed poor spiritual care knowledge while demonstrating positive attitudes to spiritual care in more than half of cases. In addition, despite lacking formal education, 64% claimed to be confident about providing spiritual care and 86% demonstrated a desire for additional learning. The above results correspond to Yang et al. (2024). It has been found that many nurses' willingness to implement the spiritual care strategy appeared to be driven mainly by their own personal motivation, not structured education. As well, the Biopsychosocial-Spiritual (BPSS) model by Afolayan (2018) allows for introducing spiritual components into the care process, admitting the possibility for spiritual suffering to aggravate chronic pain psychologically and physically.

In addition, nurses viewed spiritual care provision as a key part of their professional duties. Such an opinion is similar to that of Timmins et al. (2022) and Harrad et al. (2019), indicating that nurses are usually considered key providers of spiritual care because of regular contact with their patients. However, some obstacles were mentioned, in particular the lack of proper support systems and guidance in hospitals (the mean scores equaling 3.89 and 3.86, respectively) - see Table 5. This finding also resonates with Murgia et al. (2022), who found that while many nurses perceive spiritual care as part of their duties, institutional culture does not always support this perception. This conflict often leaves nurses improvising spiritual care within their limited time and resources. Engaging in spiritual care was reported to have both emotionally fulfilling and ethically challenging effects. This is because managing spiritual care also involves maintaining boundaries. Nurses identified the fear of imposing personal beliefs on patients during spiritual care (mean of 3.51) and cultural and religious differences (mean of 3.91) as two of the challenges they face in providing spiritual care, as shown in Table 5. This reflects the ethical tension documented by Nibbelink & Brewer (2018), in which nurses must balance authenticity with respect for patient

autonomy. According to the data presented above, interfaith dynamics have an impact on the formation of the psychological strain of nurses if their values differ significantly from the patients' beliefs. It is possible to support the findings by Murgia et al. (2022) because, according to the BPSS framework, the level of emotional distress related to care activities, including spiritual problems, can be rather high both for patients and professionals providing care.

As can be seen from Table 6, among the most common challenges were time pressure caused by overload (81%), the absence of the hospital policy regarding spiritual care provision (68%), lack of the necessary formal training of the staff (68%), as well as cultural/religious diversity (65%). Emotional exhaustion (42%) and fearfulness (21%) can also be included in the list of the most common challenges related to spiritual care provision among nurses. The presented challenges match the data obtained throughout the global literature review, where Farahani et al. (2019) noted that time pressure and lack of education were the main barriers to the process under discussion. At the same time, Harrad et al. (2019) and Momeni et al. (2022) classified challenges as institutional, educational, and personal.

CONCLUSION

According to the research, it can be seen that even though 64% of the nurses feel that they have been able to provide spiritual care to patients having chronic pain confidently, only 5.6 % were trained properly, whereas 79.6% had attained the required knowledge via attending the workshops. The key barriers faced during the provision of spiritual care include workload concerns (81%), lack of policies at hospital level (68%), lack of proper training on the same (68%), difference in culture and religion (65%), and emotional burnout (42%). Despite these barriers, 86% of the respondents showed interest in gaining more knowledge regarding the subject matter.

Recommendations

From the findings of this study, it is important for nursing institutions of learning and training to include curriculum content such as ISPEC and FICA within both undergraduate and postgraduate training programs to achieve basic competency levels among nursing practitioners. The hospital management at UITH and similar hospitals should also ensure that there are in-service training and continuing education programs on spiritual care provided to staff. There is also a need for conducting qualitative research on experiences of nurses regarding spiritual care.

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