

The Lived Experiences of Psychospiritual Care Practices of Indonesian Nurses in Promoting End-of-Life Acceptance Among Patients Undergoing Hemodialysis

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Abstract: Patients undergoing long-term hemodialysis frequently experience profound emotional, existential, and spiritual distress, making end-of-life acceptance an important yet often insufficiently addressed dimension of nursing care. Although nurses are uniquely positioned to provide sustained psychospiritual support across repeated dialysis encounters, limited evidence exists regarding how such care is enacted in routine hemodialysis practice. This study aimed to explore psychospiritual care practices among Indonesian nurses to promote patients' acceptance of end-of-life care among those receiving long-term hemodialysis. A qualitative descriptive study, guided by Husserlian phenomenology, was conducted at two referral hospitals in Indonesia. Ten purposively selected hemodialysis nurses participated as primary informants, while five patients were included solely as triangulation informants to corroborate contextual interpretations. Data were collected through semi-structured in-depth interviews between October and December 2025, transcribed verbatim, and analyzed using Colaizzi's method.

Three themes were identified: Facilitating spiritual meaning-making and existential acceptance in end-of-life care; Supporting patients in recognizing, managing, and reflecting on anger; and Strengthening connectedness, contribution, and spiritual purpose. These themes indicate that nurses promoted end-of-life acceptance by helping patients interpret illness within a spiritual-existential framework, transforming their anger into emotional insight, and reconstructing meaning in life through relationships, contributions, and a spiritually grounded purpose. Psychospiritual care thus emerged not as an additional task, but as a meaning-centered, relational, and nursing practice embedded in routine hemodialysis care. The findings highlight nurses' strategic role in integrating culturally sensitive psychospiritual support into everyday practice to foster dignity, inner peace, and acceptance at the end of life.

Keywords: End-of-life care, Hemodialysis, Indonesia, Nursing, Phenomenology, Psychospiritual care, Spirituality

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Introduction

End-stage renal disease remains a growing global health challenge, with the burden of advanced kidney disease continuing to rise worldwide.¹ In Indonesia, recent national health data also indicate an increasing burden, with a reported prevalence of 4.2 per 1,000 population, alongside other reports showing a prevalence of 0.18% among individuals

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aged 14 years or older, particularly among older adults.² These estimates likely reflect differences in population coverage and case definitions, but consistently highlight end-stage renal disease as an important and growing public health concern. As the main life-sustaining therapy for this condition, long-term hemodialysis extends survival but also exposes patients to ongoing physical burden, treatment dependence, and profound emotional, existential, and spiritual distress. Repeated exposure to symptom fluctuations, uncertainty, functional limitations, and awareness of mortality often places these patients in a prolonged process of psychological and existential confrontation.³ In this context, end-of-life acceptance is a dynamic process in which patients acknowledge the reality of life-limiting illness while maintaining dignity, emotional balance, spiritual meaning, and relational connection.

Nurses are uniquely positioned to support this process because they maintain continuous, repeated contact with patients throughout dialysis sessions.⁴ Through these sustained encounters, nurses are often the first health professionals to witness subtle expressions of fear, anger, hopelessness, spiritual struggle, or shifting life perspectives.⁵ This places nursing practice at the center of psychospiritual care and refers to nursing care that integrates emotional support, spiritual sensitivity, meaning-oriented communication, and relational presence to help patients cope with suffering and reconstruct meaning in illness.⁶ In hemodialysis settings, psychospiritual care is therefore not peripheral to nursing practice, but integral to holistic and person-centered care.

Existing literature has acknowledged the importance of psychospiritual care in chronic and life-limiting illness. However, much of the available evidence remains broadly focused on psychosocial burden, symptom distress, coping outcomes, or general spiritual support, with less attention to how nurses actually enact psychospiritual care in everyday clinical interactions.⁷ More specifically, limited research has examined how nurses facilitate spiritual

meaning-making, help patients process anger as part of emotional adaptation, and foster self-transcendence through social connectedness, meaningful contribution, and spiritually grounded life purpose. These dimensions are especially important because end-of-life acceptance is not achieved through information alone, but through relational, emotional, and existential processes that unfold over time.⁸

This gap is particularly relevant in the Indonesian context, where religious beliefs, family connectedness, communal values, and spiritual interpretations of illness strongly shape how patients understand suffering, life purpose, and mortality. In such settings, psychospiritual care may extend beyond emotional reassurance to include support for existential reflection, faith-congruent meaning reconstruction, and socially embedded forms of acceptance. Yet evidence remains limited on how Indonesian nurses operationalize these practices amid the procedural intensity of hemodialysis care.⁵ As a result, psychospiritual care may be delivered variably, insufficiently articulated, or underrecognized as a core nursing function in promoting end-of-life acceptance.⁹

A qualitative approach is needed to understand these practices from nurses' lived clinical experiences. Exploring such experiences may generate a more context-sensitive understanding of how end-of-life acceptance is supported in routine hemodialysis care.¹⁰ Therefore, this study aimed to explore the psychospiritual care practices of Indonesian nurses to promote end-of-life acceptance among patients undergoing long-term hemodialysis. By focusing on nurses' lived experiences, this study seeks to illuminate how psychospiritual care is enacted through spiritual reflection, emotional adaptation, relational support, and meaning reconstruction in everyday nursing practice.

Review of Literature

Psychospiritual care has become increasingly important in the care of patients living with chronic and life-limiting illness, particularly those undergoing

long-term hemodialysis.^{3,11} The hemodialysis trajectory is characterized not only by physiological instability and treatment dependence, but also by recurring emotional exhaustion, existential uncertainty, and spiritual struggle. For many patients, repeated exposure to symptoms, bodily decline, and the awareness of mortality creates a persistent confrontation with questions about suffering, purpose, hope, and the meaning of continued life.^{12,13} Within this context, end-of-life acceptance is not a sudden endpoint, but a gradual process through which patients seek to emotionally, spiritually, and existentially reconcile themselves with life-limiting illness.

Studies have consistently shown that patients receiving hemodialysis often experience fear, hopelessness, anxiety, anger, and psychological distress that extend beyond biomedical symptoms. Such distress can disrupt emotional adaptation, weaken treatment engagement, and intensify existential suffering.^{6,14} As a result, holistic nursing care in hemodialysis settings requires attention not only to clinical and procedural needs, but also to the psychospiritual dimensions of patient experience. This broader view positions psychospiritual care as an essential component of supportive nursing practice rather than an optional or supplementary intervention.

Nurses play a particularly important role in psychospiritual care because they engage with patients repeatedly throughout dialysis sessions and often develop sustained therapeutic relationships.¹⁵ Through these recurring interactions, nurses can observe subtle changes in mood, listen to expressions of distress, and respond to patients' emotional and spiritual concerns in ways embedded in routine care. Previous studies have emphasized the value of empathy, presence, and spiritual sensitivity in strengthening adaptation among individuals with chronic illness.¹⁶ However, much of this literature remains conceptually broad and gives limited attention to the concrete processes through which nurses help patients move toward end-of-life acceptance in everyday practice.

One important dimension of psychospiritual care involves spiritual meaning-making. Spirituality in serious illness is not limited to formal religious practices. Still, it includes the ways individuals seek peace, interpret suffering, connect with transcendent beliefs, and construct beliefs to understand illness as part of divine will, a test of faith, or a meaningful life passage.⁵ Meaning-making of this kind can help reduce despair, preserve dignity, and support existential acceptance. Nevertheless, the literature remains limited in explaining how nurses facilitate such processes in ethically appropriate and culturally sensitive ways, particularly in contexts where faith and spirituality are central to patients' worldview.¹⁷

Another important but less explored dimension concerns emotional adaptation, especially anger. Anger is a common response in chronic and life-limiting illness and may emerge in relation to bodily decline, dependence, perceived injustice, uncertainty, or fear of death.^{14,18} Yet anger is often insufficiently addressed within clinical care, where emotional expression may be interpreted as resistance or noncooperation rather than as part of existential suffering. From a psychospiritual perspective, helping patients acknowledge anger as a natural emotional process and gradually transform it into reflection, patience, and personal insight may represent an important pathway toward acceptance.^{19,20} However, empirical literature has paid relatively little attention to how nurses support this emotional transformation in hemodialysis settings.

A further dimension relevant to end-of-life acceptance is self-transcendence. Self-transcendence refers to the expansion of personal boundaries through deeper connection with others, greater integration of past and present experience, and a stronger orientation toward meaning, contribution, and spiritual purpose.^{21,22} In the context of serious illness, self-transcendence may be expressed through strengthened family bonds, concern for others, a desire to remain useful, and a reorientation of life purpose in spiritually meaningful ways. These processes enable patients to move beyond

immediate suffering and reconnect with broader sources of value and identity. Although the concept of self-transcendence has been widely discussed in nursing and palliative care literature, there remains a limited understanding of how nurses foster these experiences in routine hemodialysis practice.

These gaps are especially significant in Indonesia, where spiritual beliefs, communal relationships, and family-centered values strongly shape the meanings attached to illness, care, and mortality.^{7,21} In such a sociocultural context, psychospiritual care may involve more than emotional comfort or generic support. Psychospiritual care may require nurses to engage in faith-congruent communication, facilitate existential reflection, respond sensitively to emotional struggle, and strengthen patients' connection to family, community, and spiritual purpose. Despite this relevance, current evidence remains insufficient in explaining how Indonesian nurses operationalize these psychospiritual practices within the high-demand, procedure-intensive environment of hemodialysis care.^{5,22,23}

This study was intentionally exploratory and was not designed to test a predetermined theoretical framework. Instead, it adopted descriptive phenomenology to understand the essence of nurses' lived experiences in providing psychospiritual care. Although previous studies have emphasized spiritual care, psychosocial support, and palliative care in chronic illness, there is limited evidence on how nurses experience and enact psychospiritual care within routine hemodialysis encounters. Existing studies have also focused more on patient outcomes than on nurses' lived experiences in accompanying patients through emotional, existential, and spiritual struggles during long-term hemodialysis. Therefore, a qualitative exploration of nurses' experiences was needed to deepen understanding of how psychospiritual care is enacted in routine practice. Examining these experiences may clarify how nurses facilitate spiritual reflection, emotional adaptation, connectedness, and reconstruction of life meaning as pathways toward end-of-life

acceptance among patients undergoing long-term hemodialysis.

Study Aim and Research Question

To explore the lived experiences of Indonesian nurses in providing psychospiritual care to promote end-of-life acceptance among patients undergoing long-term hemodialysis. The guiding research question was: "What are the lived experiences of Indonesian nurses in providing psychospiritual care to promote end-of-life acceptance among patients undergoing long-term hemodialysis?"

Methods

Design: This study was grounded in descriptive phenomenology, a tradition associated with Husserlian philosophy that focuses on understanding participants' lived experiences while minimizing researcher preconceptions through bracketing. Descriptive phenomenology was selected to describe the essence of nurses' lived experiences in providing psychospiritual care to support end-of-life acceptance among patients undergoing long-term hemodialysis. The study was conducted and reported in accordance with the Standards for Reporting Qualitative Research to ensure methodological rigor.²⁴

Setting and Participants: The study was conducted in the hemodialysis units of two referral hospitals in Indonesia. Both units provided high-volume, long-term hemodialysis services and were procedure-intensive clinical environments in which nurses maintained continuous, repeated contact with patients. Purposive sampling was used to recruit participants with direct experience of providing or receiving long-term hemodialysis care. Potential participants were identified in coordination with the nurse managers and clinical staff of the participating units.

Nurses were eligible to participate if they:
1) were registered nurses assigned to a hemodialysis

unit; 2) had at least two years of clinical experience in hemodialysis care; 3) were actively involved in direct patient care during the study period; and 4) were able to articulate their experiences during an in-depth interview. Nurses who were on extended leave or assigned exclusively to non-clinical administrative roles were excluded.

Ten hemodialysis nurses were recruited as the primary participants because the study focused on nurses' lived experiences of providing psychospiritual care. Five patients undergoing long-term hemodialysis were additionally recruited as source-triangulation informants. Patients were eligible if they had experience receiving ongoing hemodialysis care and were able to reflect on their interactions with nurses. Their accounts were used to corroborate and contextualize the interpretations derived from the nurses' experiences rather than to generate the primary thematic structure.

Ethical Considerations: This study obtained ethical approval from the Research Ethics Committee, Faculty of Nursing, Universitas Indonesia (Approval No. KET-324/UN2.F12.D1.2.1/PPM.00.02/2025). Institutional permission to conduct the study was also obtained from the participating hospitals and the heads of the hemodialysis units before participant recruitment and data collection began. All participants received written and verbal explanations regarding the study purpose, procedures, potential benefits and risks, voluntary participation, confidentiality, and the right to withdraw at any time without penalty. Written informed consent was obtained from all participants before the interviews were conducted. Participants were informed of their right to decline to participate or withdraw from the study at any time, without penalty or consequences to their professional role or care relationship. Participant confidentiality was maintained through coded identifiers, secure password-protected storage, restricted access to files, and removal of identifying information from transcripts and data excerpts. Given the sensitive nature of discussing end-of-life concerns, participants were reminded

that they could pause, skip questions, or stop the interview at any time, and that supportive referral information would be made available if distress occurred. The ethical principles of respect for persons, beneficence, nonmaleficence, and justice were upheld throughout the study.

Data Collection: Data were collected between October and December 2025 through semi-structured, in-depth interviews. An interview guide was developed based on the study aim and relevant literature. Before the main data collection, the guide was pilot-tested with two hemodialysis nurses who met the eligibility criteria but were not included in the final sample. The pilot interviews assessed the clarity, wording, sequence, cultural appropriateness, and feasibility of the questions. Feedback was used to refine the wording and probing strategies without changing the central focus of the interviews.

The primary investigator (PI), a doctoral nursing student with formal training in qualitative research and previous experience in procedure-intensive nursing settings, conducted all interviews. A non-evaluative interviewing approach and neutral, non-leading prompts were used to encourage participants to describe their experiences freely. The primary interview question for nurse participants was: *"Can you describe your experiences of providing psychospiritual care to support end-of-life acceptance among patients undergoing long-term hemodialysis?"* Flexible follow-up prompts encouraged nurses to elaborate on the situations they encountered, their feelings and responses, the meanings they attached to those experiences, and the perceived effects of their interactions with patients. Additional questions explored nurses' experiences of responding to patients' emotional distress, spiritual concerns, family-related needs, and reflections on illness and mortality during routine hemodialysis care.

For patient triangulation informants, the primary interview question was: *"Can you describe your experiences of receiving psychospiritual support from*

nurses during long-term hemodialysis care?” Open-ended follow-up prompts encouraged patients to describe specific interactions with nurses, the support they perceived, and the meaning of those interactions during their illness experience. Additional questions explored patients’ experiences of emotional support, spiritual concerns, family relationships, and reflections on illness and mortality. These interviews were conducted solely to corroborate and contextualize the nurse-derived findings.

All interviews were conducted in Bahasa Indonesia, lasted approximately 45–95 minutes, and were audio-recorded with participants’ permission. Recordings were transcribed verbatim. Field notes were completed immediately after each interview to document the interview context, relevant nonverbal expressions, and preliminary reflections that could inform the analysis.

Data Analysis: Data were analyzed manually and iteratively using Colaizzi’s seven-step descriptive phenomenological method.²⁵ First, the PI repeatedly read all nurse interview transcripts to obtain a comprehensive understanding of the participants’ experiences. Second, significant statements related to psychospiritual care were identified and extracted verbatim. Third, formulated meanings were developed from each significant statement while remaining close to the participants’ original narratives. Fourth, related formulated meanings were grouped into sub-themes and broader themes. Fifth, the themes were integrated into an exhaustive description of the phenomenon. Sixth, the exhaustive description was condensed into a fundamental structure representing the essence of nurses’ lived experiences. Seventh, a plain-language summary of the thematic structure and fundamental description was returned to the nurse participants for confirmation and clarification. Patient interview transcripts were reviewed only after the nurse-derived themes had stabilized and were used solely to corroborate and contextualize the interpretations; they did not contribute to primary coding, theme development, theme hierarchy, or theme naming.²⁵

Rigor and Trustworthiness: Trustworthiness was ensured through strategies addressing credibility, dependability, confirmability, and transferability. Credibility was strengthened through member

checking, source triangulation, peer debriefing, and negative case analysis. Member checking involved returning a plain-language summary of the findings to nurse participants to confirm whether the interpretations reflected their experiences, while source triangulation involved comparing the nurse-derived findings with the accounts of patient informants. Peer debriefing was conducted with members of the supervisory research team who reviewed coding decisions, theme development, and interpretive claims. Negative or deviant accounts, including procedure-focused communication and limited psychospiritual engagement, were retained to refine theme boundaries. Dependability and confirmability were supported by an audit trail that documented analytical decisions, theme mapping, and revisions. Bracketing was maintained through reflexive journaling and analytic memo writing to identify and manage the PI’s prior assumptions, clinical knowledge, and potential influence on data interpretation. Transferability was enhanced through detailed descriptions of the clinical setting, participant characteristics, recruitment procedures, and hemodialysis care context.²⁶

Findings

The demographic characteristics of participants are summarized in **Table 1**. A total of 15 participants were included: ten hemodialysis nurses as the primary analytic participants and 5 patients as triangulation informants. These triangulation data provided contextual support for understanding the relational impact of nurses’ psychospiritual care. Among the nurses, 60% were female, and 40% were male. Most nurses held a bachelor’s degree, with one participant holding a diploma. The nurses had a mean age of 33 years and an average of 4.1 years of experience in hemodialysis care. Among the patient informants, 60% were female, and 40% were male. Most held a bachelor’s degree, while the remainder had completed high school education. The patients had a mean age of 48 years and an average illness duration of 3.4 years.

Table 1. Demographic characteristics of participants

Participant code	Age (years)	Sex	Educational attainment	Years of work experience (Nurses)
N1	30	Female	Bachelor	4
N2	41	Female	Bachelor	6
N3	28	Male	Bachelor	3
N4	37	Female	Bachelor	4
N5	30	Female	Bachelor	3
N6	35	Male	Bachelor	6
N7	27	Female	Diploma	3
N8	33	Male	Bachelor	4
N9	38	Male	Bachelor	5
N10	31	Female	Bachelor	3
Duration of illness (Patients)				
P1	53	Male	High School	2
P2	44	Female	Bachelor	4
P3	49	Female	High School	6
P4	48	Male	Bachelor	3
P5	46	Female	Bachelor	2

Note. N = nurse, P = patient

Following Colaizzi's seven-step descriptive phenomenological method, the analysis progressed from repeated reading of transcripts to the extraction of significant statements, the formulation of meanings, the clustering of themes, the development of an exhaustive

description, the identification of the fundamental structure, and the validation through member checking.²⁵

The analytical progression from significant statements to formulated meanings, theme clusters, and final themes is presented in **Table 2**.

Table 2. Examples of Colaizzi's analytical process used in analysis

Significant statements	Formulated meanings	Theme clusters	Final themes
"Sometimes they ask, 'Why me?'... I don't answer directly. I ask what they believe about this situation. From there, they start to reflect." (N3)	Nurses facilitated a reflective exploration of patients' beliefs in response to existential questions.	Encouraging reflection on religious and spiritual beliefs	Facilitating Spiritual Meaning-Making and Existential Acceptance in End-of-Life Care
"There are patients who don't want to talk about faith at first.... We just stay present, and slowly they open up." (N7)	Nurses used presence and patience to support gradual spiritual openness.	Being present without forcing spiritual discussion	Facilitating Spiritual Meaning-Making and Existential Acceptance in End-of-Life Care
"We cannot impose anything. If they talk about prayer, we stay there.... If not, we don't force it." (N6)	Nurses respected individual beliefs and followed patients' spiritual preferences.	Providing faith-congruent spiritual support	Facilitating Spiritual Meaning-Making and Existential Acceptance in End-of-Life Care
"At first they complain a lot... but later they say maybe this is part of their path." (N8)	Nurses observed patients gradually reframing illness as part of their life journey.	Reframing illness experiences	Facilitating Spiritual Meaning-Making and Existential Acceptance in End-of-Life Care

Table 2. Examples of Colaizzi's analytical process used in analysis (Cont.)

Significant statements	Formulated meanings	Theme clusters	Final themes
"Some patients get angry easily... sometimes at us, sometimes at the situation." (N1)	Nurses recognized anger as a common emotional response to chronic illness and treatment burden.	Recognizing anger as part of illness experience	Supporting Patients in Recognizing, Managing, and Reflecting on Anger
"We tell them it's okay to feel that way... it's not wrong to be angry." (N2)	Nurses normalized anger and validated emotional reactions.	Normalizing emotional responses	Supporting Patients in Recognizing, Managing, and Reflecting on Anger
"We do not simply say, 'Do not be angry.' We guide them slowly to become more patient." (N5)	Nurses supported emotional regulation through repeated reassurance and presence.	Supporting emotional control through repeated reassurance	Supporting Patients in Recognizing, Managing, and Reflecting on Anger
"After some time, they say they understand themselves more... why they felt angry before." (N10)	Nurses observed that emotional struggles could become opportunities for self-reflection and learning.	Linking anger to life learning	Supporting Patients in Recognizing, Managing, and Reflecting on Anger
"We remind them they can still do something, even small things for their family." (N4)	Nurses encouraged patients to recognize remaining roles and contributions.	Recognizing remaining roles and usefulness	Strengthening Connectedness, Contribution, and Spiritual Purpose
"When family is present, patients become more motivated." (N7)	Nurses viewed family relationships as a source of motivation and strength.	Strengthening family connectedness	Strengthening Connectedness, Contribution, and Spiritual Purpose
"They say maybe their purpose now is to be closer to God." (N10)	Nurses observed patients reconstructing life purpose through spiritual values.	Linking life purpose to spiritual values	Strengthening Connectedness, Contribution, and Spiritual Purpose

Table 2 demonstrates the traceability of the analytical process by showing how selected participant statements were transformed into formulated meanings, grouped into theme clusters, and developed into the final thematic structure.

The analysis generated three interconnected themes and nine sub-themes describing how nurses experienced psychospiritual care in promoting end-of-life acceptance. The final themes and sub-themes are summarized in **Table 3**.

Table 3. Themes and sub-themes

Theme	Sub-theme
1. Facilitating Spiritual Meaning-Making and Existential Acceptance in End-of-Life Care	1.1 Reconnecting with religious and spiritual beliefs through reflective awareness 1.2 Providing faith-congruent spiritual support 1.3 Helping patients reframe illness as part of their life journey
2. Supporting Patients in Recognizing, Managing, and Reflecting on Anger	2.1 Helping patients recognize anger as a natural emotional process 2.2 Emphatic in routine workflow 2.3 Linking the experience of anger to life learning

Table 3. Themes and sub-themes (Cont.)

Theme	Sub-theme
3. Strengthening Connectedness, Contribution, and Spiritual Purpose	3.1 Helping patients construct meaning in life through social contributions
	3.2 Strengthening relationship with family and community
	3.3 Linking life purpose to spiritual values

Exhaustive description of the phenomena indicated that nurses experienced psychospiritual care as a gradual, relational, and meaning-centered practice embedded within repeated hemodialysis encounters. Rather than perceiving psychospiritual care as a separate intervention, nurses described it as an ongoing process of presence, listening, emotional support, spiritual sensitivity, and family-oriented encouragement. Through repeated encounters, nurses accompanied patients as they questioned illness, expressed anger, sought spiritual meaning, reconnected with family members, and attempted to preserve dignity and purpose while living with long-term hemodialysis.

Nurses described psychospiritual care as extending beyond symptom management. They experienced their role as helping patients make sense of suffering, normalize emotional struggles, maintain meaningful relationships, and reconnect with spiritual values. These experiences revealed that psychospiritual care was not delivered through isolated interventions but through cumulative interactions that gradually supported acceptance of the end of life. Patient triangulation data supported these interpretations by showing that patients perceived nurses' presence, listening, and encouragement as meaningful sources of calmness, acceptance, and hope.

The fundamental structure of the phenomena was that nurses supported end-of-life acceptance through sustained relational presence within routine hemodialysis care. By facilitating spiritual reflection, validating emotional experiences, strengthening connectedness with family and others, and supporting

reconstruction of life meaning, nurses accompanied patients in their gradual movement toward acceptance despite ongoing illness and treatment burden. Psychospiritual care was therefore experienced as a sustained relational practice in which ordinary clinical encounters became opportunities to accompany patients through existential questioning, emotional fluctuation, spiritual reflection, and efforts to preserve dignity and purpose.

Theme 1: Facilitating Spiritual Meaning-Making and Existential Acceptance in End-of-Life Care

This theme refers to nurses engaging patients in processes of meaning-making, where illness is gradually understood beyond its physical burden. Rather than directly teaching or directing, nurses described "walking alongside" patients as they reinterpret their condition within spiritual and existential frames. This process was often subtle, unfolding across repeated interactions rather than in a single conversation.

Sub-theme 1.1: Reconnecting with religious and spiritual beliefs through reflective awareness

Nurses described that patients often raised existential questions during routine hemodialysis care, especially when they felt tired, afraid, or uncertain about their illness. In these moments, nurses did not provide direct answers or impose specific religious interpretations. Instead, they invited patients to reflect on their own religious and spiritual beliefs as sources of strength.

"Sometimes they ask, 'Why me?'... I don't answer directly. I ask what they believe about this situation. From there, they start to reflect."
(N3)

Nurses also experienced that spiritual reflection could not be forced. Some patients were initially silent, resistant, or unwilling to discuss faith. In such situations, nurses described remaining present, listening patiently, and allowing patients to open up gradually when they felt ready.

“There are patients who don’t want to talk about faith at first.... We just stay present, and slowly they open up.” (N7)

Patient accounts supported this interpretation by showing that nurses’ reflective prompts helped them reconnect with personal beliefs during moments of uncertainty.

“At first I only complained and asked why this happened to me, but the nurse asked me to remember what usually gives me strength. That made me think again about my faith and helped me calm down.” (P2)

Sub-theme 1.2: Providing faith-congruent spiritual support

Spiritual care was described as effective only when aligned with patients’ own beliefs. Nurses emphasized the importance of following rather than leading in spiritual conversations.

“We cannot impose anything. If they talk about prayer, we stay there.... If not, we don’t force it.” (N6)

At times, nurses experienced uncertainty, especially when patients held different beliefs or expressed spiritual doubt:

“Sometimes I feel unsure... what if I say the wrong thing? So, I choose to listen more.” (N2)

This highlights that spiritual support was not always straightforward, but required sensitivity and restraint. Patients likewise described feeling more comfortable when nurses respected their beliefs

rather than imposing specific spiritual messages, for example:

“I felt helped because the nurse did not force me. When I talked about praying, she followed my way, so I felt understood and not judged.” (P4)

Sub-theme 1.3: Helping patients reframe illness as part of their life journey

Over time, nurses observed shifts in how patients understood their illness. Patients who initially expressed frustration or despair began to reinterpret their condition as part of a broader life narrative.

“At first they complain a lot... but later they say maybe this is part of their path.” (N8)

This reframing was not immediate and did not occur in all patients. Some continued to struggle, reflecting the non-linear nature of acceptance:

“Not everyone reaches that point... some still feel it is unfair, even after a long time.” (N5)

Patient narratives further supported this finding by showing that some gradually came to view illness not only as suffering, but also as part of their personal and spiritual journey.

“Now I still feel tired, but I no longer see this illness only as a burden. I try to see it as part of my journey in life, and that makes me accept it.” (P1)

Theme 2: Supporting Patients in Recognizing, Managing, and Reflecting on Anger

This theme captures how nurses encountered and responded to anger as a central emotional expression among patients facing chronic illness and mortality. Rather than suppressing anger, nurses described working through it as part of the pathway toward acceptance.

Sub-theme 2.1: Helping patients recognize anger as a natural emotional process

Nurses frequently encountered anger expressed through irritability, withdrawal, or frustration toward treatment.

"Some patients get angry easily... sometimes at us, sometimes at the situation." (N1)

Instead of correcting or minimizing these reactions, nurses normalized them as part of the illness experience.

"We tell them it's okay to feel that way... it's not wrong to be angry." (N2)

However, this was not always easy. Some nurses admitted feeling challenged when anger was directed toward them.

"Sometimes it's hard when they are angry at us, but we have to stay calm." (N4)

Patients also described anger as a common response to the burden of illness and treatment, and some felt relieved when nurses did not judge these emotions.

"Sometimes I felt angry with my condition and even with the treatment, but the nurse told me that it was normal to feel that way. I felt relieved because I was not blamed for my emotions." (P3)

Sub-theme 2.2: Emphatic in routine workflow

Over time, nurses supported patients in gradually developing emotional control. This was not achieved through instruction alone, but through repeated reassurance and presence.

"We do not simply say, 'Do not be angry.' We guide them slowly to become more patient." (N5)

Patients' progress varied. Some showed increased calmness, while others fluctuated between acceptance and frustration, for example:

"Some days they are calm, other days they go back to being upset." (N9)

This reflects emotional adaptation as a fluctuating, rather than linear, process. Patient narratives similarly suggested that emotional control developed gradually through repeated support rather than a single conversation.

"I did not become calm immediately, but little by little the nurse kept reminding me and listening to me. Over time, I learned to hold my emotions better." (P5)

Sub-theme 2.3: Linking the experience of anger to life learning

In some cases, anger became a starting point for deeper reflection. Nurses described moments when patients began to derive insight from their emotional struggles.

"After some time, they say they understand themselves more... why they felt angry before." (N10)

However, such transformation did not occur in all patients, indicating variability in emotional processing.

"Not everyone can reach that stage... some stay in that feeling for a long time." (N3)

Patient accounts also indicated that anger could become a point of reflection, helping them better understand themselves and their illness experience.

"Before, I only felt angry, but after going through this for a long time, I started to understand myself more. I realized my anger came from fear and disappointment." (P2)

Theme 3: Strengthening Connectedness, Contribution, and Spiritual Purpose

This theme described how nurses supported patients in reconnecting with others, recognizing their remaining roles, and rediscovering purpose despite illness. This process was described as a gradual shift from "why me" toward "what still matters."

Sub-theme 3.1: Helping patients construct meaning through social contributions

Even within physical limitations, nurses encouraged patients to see themselves as still having value and roles.

"We remind them they can still do something, even small things for their family." (N4)

For some patients, this restored a sense of identity and usefulness.

“They feel better when they know they are still needed.” (N6)

However, patients with severe limitations sometimes struggled to see their contribution.

“Some say they cannot do anything anymore... that’s the hardest part.” (N8)

Patient narratives corroborated this finding by showing that being reminded of their ongoing value and role helped them feel less helpless.

“I used to feel useless because I was sick, but the nurse reminded me that I could still do small things for my family. That made me feel that I still had value.” (P4)

Sub-theme 3.2: Strengthening relationships with family and community

Family relationships emerged as a central source of strength. Nurses often encouraged patients to reconnect with loved ones.

“When family is present, patients become more motivated.” (N7)

At the same time, strained relationships sometimes became barriers.

“There are patients who feel abandoned... it affects their acceptance.” (N2)

This highlights that connectedness can both support and complicate acceptance. Patients likewise described family presence as an important source of motivation and emotional strength.

“When my family accompanied me, I felt stronger. The nurse also encouraged me to keep talking with them, and that made me feel I was not alone.” (P1)

Sub-theme 3.3: Linking life purpose to spiritual values

Nurses described how some patients began to redefine their life purpose through spiritual perspectives.

“They say maybe their purpose now is to be closer to God.” (N10)

This shift was often associated with greater peace.

“When they find that meaning, they become calmer.” (N5)

However, not all patients were able to articulate such purpose, reflecting diversity in spiritual processing. Patients’ narratives also suggested that spiritual values could help them reinterpret their remaining life in a more peaceful and purposeful way.

“Now I feel my purpose is not only to recover physically, but also to become closer to God and live more meaningfully. That thought makes me feel more peaceful.” (P3)

Discussion

This study explored the lived experience of how nurses enact psychospiritual care to promote end-of-life acceptance among patients undergoing long-term hemodialysis. The findings show that psychospiritual care is not merely an additional supportive activity, but a relational and meaning-oriented nursing practice through which patients are accompanied in navigating spiritual reflection, emotional struggle, and the reconstruction of life meaning. Across the three themes, end-of-life acceptance emerged not as passive resignation but as a gradual process shaped by spiritual reflection, emotional support, family connectedness, social contribution, and reconstruction of life meaning. These findings extend the understanding of psychospiritual care in hemodialysis by showing that acceptance is facilitated not only through support and presence but also through deeper existential and relational processes.

From a descriptive phenomenological perspective, the findings suggest that nurses experienced psychospiritual care as a relational practice rather than a separate clinical task. This practice was expressed through

repeated presence, sensitive listening, emotional validation, spiritual support, and family-oriented encouragement within routine hemodialysis encounters. Nurses' lived experiences were explained as involving psychospiritual care: remaining present with patients amid uncertainty, listening to emotional struggles, facilitating spiritual reflection, and supporting patients' gradual movement toward end-of-life acceptance.

The first theme, facilitating spiritual meaning-making and existential acceptance in end-of-life care, indicates that nurses play an important role in helping patients interpret illness within a broader spiritual and existential framework. In this study, spiritual care was not described as doctrinal instruction or ritual prescription, but as a sensitive process of following patients' own religious and spiritual language, encouraging reflection, and helping them reinterpret suffering as part of life's journey. This finding shows that nurses supported spiritual reflection not by imposing religious instruction, but by listening, responding sensitively to patients' beliefs, and creating space for patients to interpret illness in ways that preserved dignity and inner peace. Rather than simply "providing spiritual support," nurses appeared to facilitate meaning reconstruction through brief but repeated interactions that respected patient autonomy and belief congruence. In this sense, end-of-life acceptance was supported through existential reframing, where illness became less of an isolated burden and more of a personally meaningful life reality.¹⁴ This process was reflected in the sub-themes of encouraging patients to reflect on their religious and spiritual beliefs, providing faith-congruent spiritual support, and helping them reframe illness as part of their life journey.

This finding is important because it suggests that psychospiritual care in hemodialysis should not be narrowly understood as the provision of comfort or prayer-related support. Instead, it involves assisting patients in reconnecting suffering with meaning. In the Indonesian context, where religious belief often shapes interpretations of illness, fate, and mortality, such meaning-making may be especially influential

in supporting acceptance.^{7,21,27} The present findings further show that faith-congruent care can function as a pathway toward existential acceptance, not merely emotional reassurance. This also highlights that nurses' spiritual sensitivity requires ethical restraint: they must remain responsive to patients' beliefs without imposing their own values, which reinforces the importance of culturally attuned and relationally safe communication. In this regard, spiritual meaning-making becomes a pathway through which patients gradually move toward acceptance while retaining spiritual identity and inner peace.

The second theme, supporting patients in recognizing, managing, and reflecting on anger, shows how nurses responded to anger as a meaningful emotional response within long-term hemodialysis care. Anger is often underexplored in hemodialysis care, despite being a common emotional response to prolonged dependence, disrupted identity, and awareness of bodily decline.^{3,11,28} In this study, nurses did not treat anger simply as problematic behavior to be controlled, but as a natural emotional expression that required recognition, patience, and gradual support. This finding suggests that anger should not be viewed only as disruptive behavior, but also as an emotional expression that nurses can acknowledge, normalize, and support through repeated presence and therapeutic communication.^{14,29,30} Nurses supported patients not by suppressing anger, but by normalizing it, staying emotionally present, and helping patients gradually reflect on its meaning.³¹⁻³³ This was reflected in the sub-themes of helping patients recognize anger as a natural emotional process, strengthening patience and emotional self-control, and linking the experience of anger to life learning.

Conceptually, this finding suggests that end-of-life acceptance is not achieved through calmness alone, but often through engagement with emotionally difficult states. Acceptance may therefore include the capacity to move through anger rather than bypass it.¹⁵ This is where the theme becomes especially

valuable: it shows that emotional regulation in psychospiritual care is not merely behavioral management, but an interpretive and relational process through which anger may evolve into insight, patience, and self-understanding.^{17,31,34} The patient narratives that corroborated the nurse accounts further strengthened this interpretation, showing that some patients experienced relief when their anger was acknowledged rather than judged.

At the same time, the findings show that this transformation is neither immediate nor universal. Some patients remained in prolonged frustration, while others moved gradually toward calmness and reflection. This non-linearity is theoretically important. It suggests that emotional transcendence should not be understood as complete emotional resolution, but as an ongoing process in which patients gradually gain distance, understanding, and control over intense emotional responses.^{14,35} For nursing practice, this implies that supporting anger requires continuity, emotional containment, and a willingness to remain present without forcing premature acceptance. In this regard, the nurses' role resembles accompaniment rather than correction.^{5,22}

The third theme, strengthening connectedness, contribution, and spiritual purpose, shows that nurses supported acceptance by helping patients recognize remaining roles, maintain family relationships, and reconnect life purpose with spiritual values. The findings suggest that patients moved toward greater acceptance when they were helped to reconnect with others, recognize their continued value, and reinterpret life purpose through spiritual values. This is highly consistent with the broader nursing view that serious illness can prompt not only loss, but also an expansion of perspective beyond the self.^{11,27,28} In the present study, self-transcendence was not presented as an abstract philosophical ideal, but as a lived shift from self-focused suffering toward relational belonging, usefulness, and spiritually grounded meaning. This theme was reflected in the sub-themes of helping patients construct meaning through social contribution, strengthening relation-

ships with family and community, and linking life purpose to spiritual values.^{14,35}

This finding is especially significant because it moves the discussion beyond the individual interior world of the patients. End-of-life acceptance was shown to be socially and spiritually embedded. Family relationships, community ties, and perceived contribution were not peripheral influences, but central resources through which patients sustained dignity and purpose. This aligns with the relational nature of Indonesian sociocultural life, in which identity is often closely tied to family responsibility, communal connection, and spiritual orientation.^{18,36} The findings therefore suggest that psychospiritual care in this setting cannot be reduced to intrapersonal counseling alone. It must also include support for relational restoration, social usefulness, and spiritually meaningful purpose. Evidence from chronic disease management also shows that family-centered care can improve health outcomes.³⁷

The self-transcendence theme also makes an important conceptual contribution by showing that acceptance is strengthened when patients can still see themselves as valuable persons rather than passive recipients of care. Even small acts of contribution or relational presence appeared to support continuity of identity.^{32,33} This is crucial in hemodialysis, where repeated treatment can easily reinforce dependency and helplessness.³⁸ By helping patients recognize remaining purpose and contribution, nurses supported a form of acceptance that preserves agency and dignity. In this sense, the revised findings deepen the original manuscript's emphasis on relational and acceptance-oriented care by demonstrating that end-of-life acceptance may be fostered not only by reducing distress but also by reawakening meaning beyond illness.

Taken together, the findings suggest that psychospiritual care in long-term hemodialysis is a relational and meaning-centered nursing practice grounded in listening, emotional support, spiritual sensitivity, and family-oriented care.^{17,33} The findings

indicate that acceptance develops through interconnected pathways: patients seek meaning in suffering, negotiate difficult emotional states, and gradually reconnect with broader sources of identity and purpose. This understanding moves beyond narrow views of psychospiritual care that focus primarily on symptom distress, empathy, or spiritual support in isolation. Instead, it shows that nurses contribute to end-of-life acceptance by facilitating a deeper process of existential adaptation through everyday relational care.

These findings extend previous studies on spiritual care, supportive care, and palliative care in hemodialysis by showing how nurses translate psychospiritual care into everyday relational practices, including listening, emotional validation, spiritual reflection, and family support. Evidence from other study also suggests that interprofessional collaboration and program integration can strengthen service delivery and professional relationships.^{39,40} Rather than locating acceptance solely within the patient, the study shows that acceptance is co-facilitated through nursing relationships that help patients reinterpret illness, regulate emotional struggle, and recover a broader sense of meaning and purpose. This contribution is particularly relevant for settings where procedural intensity risks overshadowing existential and spiritual dimensions of care. In such environments, the findings affirm that even within routine clinical workflow, nurses remain central to sustaining the human, spiritual, and meaning-oriented dimensions of end-of-life care.

Limitations

This study has several limitations. It relied primarily on nurses' self-reported accounts, which may be subject to recall and social desirability bias. Although patient informants were included for triangulation, their narratives were used only to corroborate contextual interpretations and were not included in primary thematic analysis. The study was conducted in two referral hospitals in Indonesia, which

may limit transferability to other dialysis settings. As a qualitative phenomenological study, the findings are contextually situated and are intended for contextual transferability rather than statistical generalization. Although patient informants were included for triangulation, their narratives were used only to corroborate contextual interpretations and were not included in primary coding, theme generation, theme naming, or primary thematic analysis. In addition, the findings were based on participants' narrated experiences rather than direct observation of psychospiritual care practices; therefore, observational or longitudinal approaches may provide deeper insight into how psychospiritual care and end-of-life acceptance evolve over time. Although the study generated nuanced findings concerning spiritual reflection, emotional support, connectedness, contribution, and reconstruction of life meaning, these interpretations remain in the implications for nursing research section that observing care practices would add to knowledge about psychospiritual care. Finally, the sociocultural and spiritual context of Indonesian hemodialysis care likely shaped participants' experiences and the meanings attached to illness, care, and end-of-life acceptance; while this strengthens contextual relevance, it may also shape the transferability of findings to settings with different cultural and spiritual orientations.

Conclusions

Psychospiritual care in hemodialysis is a relational and meaning-centered practice through which nurses facilitate end-of-life acceptance. Acceptance is shaped by spiritual reflection, emotional support, family connectedness, social contribution, and the reconstruction of life meaning, and it develops dynamically over time. In this study, these processes were reflected in nurses' efforts to help patients reinterpret illness within a spiritual-existential framework, acknowledge and transform anger as part of emotional

adaptation, and reconstruct meaning through family connectedness, social contribution, and spiritually grounded purpose. Integrating psychospiritual competencies into routine nursing care is essential to support patients' dignity, meaning, and adaptation in life-limiting illness. This study contributes to nursing knowledge by describing the essence of nurses' lived experiences in supporting end-of-life acceptance within long-term hemodialysis care. This study contributes to nursing knowledge by describing the essence of nurses' lived experiences in supporting end-of-life acceptance within long-term hemodialysis care. These findings underscore that end-of-life acceptance is not a passive outcome but a gradual, relational process co-facilitated by everyday nurse-patient interactions in long-term hemodialysis care.

Implications for Nursing Practice and Research

Psychospiritual care should be integrated into routine hemodialysis nursing practice through practical competencies in brief psychospiritual assessment, meaning-oriented communication, therapeutic responses to anger, family involvement, and culturally sensitive spiritual support. Nurses should be equipped to help patients reflect on religious and spiritual beliefs, reframe illness as part of their life journey, recognize and regulate emotional responses, maintain meaningful family relationships, preserve a sense of usefulness, and reconnect life purpose with spiritual values. At the organizational level, these competencies should be incorporated into nursing education, clinical guidelines, staff training, and interdisciplinary care pathways to strengthen continuity of relational care and support patients' dignity, adaptation, and end-of-life acceptance. Future research should examine psychospiritual care using observational, longitudinal, and intervention-based designs to clarify how it is enacted in real-time

clinical practice, how acceptance develops across the dialysis trajectory, and how culturally responsive psychospiritual interventions can be developed, tested, and integrated into hemodialysis nursing education and practice.

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Author Contributions

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Declaration of Use of AI in Scientific Writing

During the revision of this manuscript, the authors used a generative artificial intelligence tool (ChatGPT) to assist with English-language editing, grammatical correction, and improvement of sentence clarity.

Declaration Regarding Conflict of Interest

We declare we have no conflict of interest related to this study or publication.

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ประสบการณ์ชีวิตในการปฏิบัติการพยาบาลด้านจิตวิญญาณของพยาบาลชาวอินโดนีเซียในการส่งเสริมการยอมรับการดูแลในระยะสุดท้ายของผู้ป่วยที่ได้รับการฟอกเลือดด้วยเครื่องไตเทียม

La Rakhmat Wabula,* Krisna Yetti, Masfuri, Widyatuti, Ika Yuni Widyawati, Cahyu Septiwi

บทคัดย่อ: ผู้ป่วยที่ได้รับการฟอกเลือดด้วยเครื่องไตเทียมเป็นระยะเวลานาน มักต้องเผชิญกับความทุกข์ทรมานอย่างรุนแรงทางอารมณ์ การมีชีวิตอยู่ และจิตวิญญาณ ส่งผลให้การยอมรับการดูแลในระยะสุดท้ายกลายเป็นมิติของการพยาบาลที่มีความสำคัญ แต่บ่อยครั้งกลับไม่ได้รับการตอบสนองอย่างเพียงพอ แม้ว่าพยาบาลจะอยู่ในฐานะที่เหมาะสมอย่างยิ่งในการให้การสนับสนุนทางจิตวิญญาณอย่างต่อเนื่องตลอดการเผชิญหน้ากับการฟอกเลือดซ้ำ ๆ แต่หลักฐานเชิงประจักษ์เกี่ยวกับการนำการดูแลดังกล่าวไปปฏิบัติจริงในการพยาบาลฟอกเลือดเป็นประจำยังมีอยู่จำกัด การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อสำรวจการปฏิบัติการพยาบาลด้านจิตวิญญาณของพยาบาลชาวอินโดนีเซียในการส่งเสริมการยอมรับการดูแลในระยะสุดท้ายท่ามกลางผู้ป่วยที่ได้รับการฟอกเลือดด้วยเครื่องไตเทียมเป็นระยะเวลานาน การศึกษานี้ใช้รูปแบบการวิจัยพรรณนาเชิงคุณภาพ โดยอาศัยแนวคิดปรากฏการณ์วิทยาตามแนวคิดของฮัสเซิร์ล ดำเนินการในโรงพยาบาลระดับสองแห่งในประเทศอินโดนีเซีย กลุ่มตัวอย่างคัดเลือกแบบเจาะจงเป็นพยาบาลไตเทียมจำนวน 10 ราย ซึ่งเข้าร่วมในฐานะผู้ให้ข้อมูลหลัก และมีผู้ป่วยจำนวน 5 ราย เข้าร่วมในฐานะผู้ให้ข้อมูลเพื่อตรวจสอบข้อมูลแบบสามเส้าเพื่อยืนยันความถูกต้องของการตีความเชิงบริบทเท่านั้น เก็บรวบรวมข้อมูลผ่านการสัมภาษณ์เชิงลึกแบบกึ่งโครงสร้างระหว่างเดือนตุลาคมถึงธันวาคม พ.ศ. 2568 ถอดเทปแบบคำต่อคำ และวิเคราะห์ข้อมูลด้วยวิธีการของโคไลชี

ผลการวิจัยพบ 3 ประเด็นหลัก ได้แก่ 1) การส่งเสริมการสร้างความหมายทางจิตวิญญาณและการยอมรับการมีชีวิตอยู่ในระยะสุดท้ายของการดูแล 2) การสนับสนุนผู้ป่วยในการรับรู้ จัดการ และสะท้อนคิดเกี่ยวกับความโกรธ 3) การเสริมสร้างความผูกพัน การอุทิศตน และเป้าหมายทางจิตวิญญาณ ประเด็นหลักเหล่านี้ชี้ให้เห็นว่า พยาบาลช่วยส่งเสริมการยอมรับการดูแลในระยะสุดท้ายโดยการช่วยผู้ป่วยตีความความเจ็บป่วยภายในกรอบแนวคิดด้านจิตวิญญาณและการมีชีวิตอยู่ การเปลี่ยนความโกรธให้กลายเป็นความเข้าใจเชิงอารมณ์ และการสร้างความหมายในชีวิตขึ้นมาใหม่ผ่านความสัมพันธ์ การอุทิศตน และเป้าหมายที่มีพื้นฐานทางจิตวิญญาณ สรุปผลการดูแลด้านจิตวิญญาณจึงไม่ได้ปรากฏเป็นเพียงงานที่เพิ่มขึ้นมา แต่เป็นการปฏิบัติการพยาบาลที่มีความสัมพันธ์และเน้นความหมาย ซึ่งได้รับการบูรณาการอยู่ในการดูแลผู้ป่วยฟอกเลือดเป็นประจำ ผลลัพธ์ที่ได้เน้นย้ำถึงบทบาทเชิงยุทธศาสตร์ของพยาบาลในการบูรณาการการสนับสนุนทางจิตวิญญาณที่อ่อนไหวต่อวัฒนธรรมเข้าสู่การปฏิบัติงานประจำวันเพื่อส่งเสริมศักดิ์ศรีความเป็นมนุษย์ ความสงบภายในใจ และการยอมรับในช่วงสุดท้ายของชีวิต

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คำสำคัญ: การดูแลในระยะสุดท้าย การฟอกเลือดด้วยเครื่องไตเทียม ประเทศอินโดนีเซีย การพยาบาล ปรากฏการณ์วิทยา การดูแลด้านจิตวิญญาณ จิตวิญญาณ

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