ORIGINAL ARTICLE OPEN ACCESS

Faith and Care: Insights from Christian Family Caregivers on Spiritual Support in Palliative Care

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ABSTRACT

Background: Spiritual care is a crucial component of palliative care, contributing to patients' quality of life and offering emotional and spiritual support. Despite its significance, spiritual care remains underexplored, particularly from the perspectives of family caregivers. This study investigates Christian family caregivers' understanding, roles, and challenges in providing spiritual care to palliative patients, emphasising implications for healthcare professionals, including Muslim nurses. The objective of this study is to explore Christian family caregivers' perspectives on spiritual care, their roles in delivering spiritual support, and the challenges they face in palliative care settings, providing insights to improve healthcare practices.
Methods: A qualitative research design was employed to capture the lived experiences of ten Christian family caregivers recruited through purposive and snowball sampling. Data were collected through semi-structured interviews in Kuantan, Pahang over three months. Deductive thematic analysis was used to analyse the data, ensuring credibility, dependability, confirmability, and transferability throughout the research process.
Results: Three themes emerged from the study: a) Understanding Spiritual Care: Participants associated spiritual care with religious practices such as prayer and emotional support, highlighting its role in providing hope and fostering peace. b) Role of Family Caregivers: Caregivers facilitated spiritual practices, provided emotional support, and shared caregiving responsibilities to enhance the patient's well-being. c) Challenges in Delivering Spiritual Care: Emotional burdens, limited access to spiritual resources, and patients' unstable emotions posed significant barriers to effective caregiving.
Conclusion: The study highlights Christian family caregivers' multifaceted roles and challenges in delivering spiritual care. For healthcare professionals, particularly Muslim nurses, these findings offer critical insights into culturally and religiously sensitive caregiving practices. Addressing patients' spiritual needs fosters trust, enhances care quality, and aligns with Islamic values of compassion and holistic well-being. Future research should focus on developing practical strategies to support family caregivers and improve the integration of spiritual care into palliative care.

Keywords: Spiritual care; Family caregivers; Palliative care; Qualitative research; Muslim nurses

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Article History:
Submitted: 3 December 2024
Revised: 10 February 2025
Accepted: 14 February 2025
Published: 31 March 2025

DOI: 10.31436/ijcs.v8i1.419
ISSN: 2600-898X

INTRODUCTION

Spiritual care, defined as the provision of support that addresses a patient's spiritual or religious needs to enhance their well-being, is a fundamental aspect of palliative care. Palliative care, which focuses on improving the quality of life for patients facing life-limiting illnesses through holistic support, encompasses spiritual care as a crucial component. By integrating spiritual care into palliative care, patients experience enhanced emotional resilience, comfort, and meaning in their journey, aiding them in managing their illnesses more effectively. Evidence suggests that spirituality and religiosity are crucial in alleviating the disease burden. Higher levels of spirituality have been associated with slower disease progression, enhanced coping mechanisms, and accelerated healing processes (1, 2). Patients who receive spiritual support, especially from family members, often have enhance well-being and a more peaceful end-of-life experience.

However, spirituality is not universally beneficial. Certain spiritual or religious beliefs can sometimes result in emotional distress or worsen a patient's condition (3). For example, harmful religious coping mechanisms, such as interpreting illness as divine punishment, may lead to significant declines in spiritual, psychological, and physical well-being, increasing the risk of adverse outcomes. These challenges highlight the critical role of family caregivers in identifying and addressing these issues. As the closest individuals to the patient, caregivers must address these complex spiritual needs and work alongside healthcare professionals to provide comprehensive and effective spiritual care.

According to previous study, despite the recognised importance of spiritual care in palliative care and the extensive literature on the subject, it remains an area that requires further exploration, particularly about the perspectives of Christian patients and their family caregivers (4). Many healthcare providers, including nurses, report insufficient preparation and understanding of religious and spiritual issues, limiting their ability to provide such care (5). This gap underscores the urgent need for targeted education and training for healthcare professionals.

This study is particularly relevant for Muslim nurses who may encounter diverse spiritual needs, including those of Christian patients. Understanding the perspectives of Christian family caregivers on spiritual care provides invaluable insights into culturally and religiously sensitive caregiving practices. For Muslim nurses, these findings emphasise the universal principles of compassion, respect for religious diversity, and integrating spiritual care into clinical practice, as Islamic ethical frameworks encourage. By addressing the spiritual needs of patients, Muslim nurses not only enhance the quality of care but also embody the Islamic values of mercy and holistic well-being (rahmah and shifa'). This approach promotes a deeper connection with patients and families, fostering trust and collaboration across cultural and religious contexts.

In conclusion, this research addresses a critical gap by exploring Christian family caregivers' understanding, roles, and challenges in delivering spiritual care. It provides practical implications for healthcare professionals, especially Muslim nurses, to support and collaborate with family caregivers in offering comprehensive spiritual care tailored to palliative patients' needs.

METHODS

Study Design

The study utilized a qualitative research design to thoroughly explore and understand Christian family caregivers' lived experiences and perspectives within palliative care settings. This methodological approach was chosen for its ability to capture the nuanced and multifaceted experiences of caregivers, which often cannot be effectively understood through standardised tools such as questionnaires or closed-ended surveys. By employing qualitative methods, the study sought to provide a rich, in-depth understanding of the caregivers' roles, challenges, and insights, offering valuable context, and meaning to their experiences that are critical for informing practice and policy.

Study Setting and Sample

The study was conducted in Kuantan, Pahang, with participants drawn from the Sultan Ahmad Shah Medical Centre (SASMEC) and

the public. Purposive and snowball sampling methods were employed to ensure the selection of participants with relevant characteristics for the study. These approaches allowed the researchers to identify and recruit individuals whose experiences aligned closely with the study's objectives.

The inclusion criteria required participants to be family caregivers of Christian patients undergoing palliative care, at least 18 years old, and capable of communicating effectively in Malay or English. Additionally, participants had to consent to participate in the study willingly. Exclusion criteria were established to maintain data quality and relevance, specifically excluding family caregivers who were unable to communicate verbally, had cognitive impairments that could hinder their ability to provide meaningful insights into their caregiving experiences, or were non-Christian, as the study focused exclusively on Christian family caregivers' perspectives in palliative care.

Data Collection

Data collection for this study was conducted over three months, from April to July 2024. A total of ten female participants were recruited, with four participants sourced from the Sultan Ahmad Shah Medical Centre (SASMEC) and six from the public. The inclusion and exclusion criteria guided recruitment to ensure the collection of relevant, high-quality data aligned with the study's objectives.

Before the interviews, all participants were provided with an Information and Informed Consent Form. This document provided detailed information about the study's purpose, procedures, and the voluntary nature of participation. Participants were explicitly informed of their right to withdraw from the study or decline to answer any questions without facing any repercussions. Furthermore, consent was obtained for audio recording of the interviews, assuring that these recordings would be securely stored to maintain confidentiality and protect participant privacy.

The data collection process involved semi-structured interviews guided by nine primary questions. This format provided a structured yet flexible framework, enabling participants to share their experiences and perspectives comprehensively. Open-ended questions allowed participants to elaborate freely, ensuring rich and detailed responses. This approach facilitated an in-depth exploration of the nuanced experiences of Christian family caregivers in palliative care settings.

Data Analysis

The data were analysed using a deductive thematic analysis approach. The process began with an initial exploration to identify critical features of the data relevant to addressing the research questions and objectives. Categories were then determined from the dataset, considering the information holistically and contextual relationships among themes. Each theme was organised and refined based on the meanings derived from the data, with detailed analyses culminating in the naming of themes. In the final phase, the interpreted data were contextualized and integrated with existing literature, ensuring a robust and scholarly discussion of the findings.

The study ensured trustworthiness by adhering to key principles of qualitative research: credibility, dependability, confirmability, and transferability. These principles were rigorously applied to maintain the study's quality and reliability.

1. Credibility: The study's credibility was upheld through careful documentation of all processes, from initial planning to the final stages. All activities, documents, and progress were systematically recorded and reported, with supplementary information in the appendices. Purposive sampling was employed to ensure participants met the inclusion and exclusion criteria aligned with the study's objectives. Semi-structured interviews with open-ended questions allowed participants to express their perspectives freely, enhancing the depth and accuracy of the data.
2. Dependability: The research's dependability was demonstrated through a consistent and comprehensive methodology, ensuring a coherent and logical research flow. This approach enabled the study to produce replicable and reliable findings.
3. Confirmability: Confirmability was ensured through meticulous documentation of all data-related activities, including transcription and thematic

analysis. The researcher cross-verified the findings and subjected them to expert review, confirming the validity of the identified themes and interpretations.

4. Transferability: The study's findings are transferable to other settings with similar contexts. The methodology and processes were designed to allow replication, ensuring the broader applicability of the research outcomes.
5. Reflexivity: The researcher actively reflected on potential biases that could influence the study's findings. Efforts were made to minimise bias through a structured approach to data collection and analysis, ensuring objectivity and integrity in the research process.

This rigorous approach to analysis and trustworthiness underscores the reliability and academic rigor of the study, contributing meaningful insights into the experiences of Christian family caregivers in palliative care settings.

ETHICAL CONSIDERATIONS

Ethical approval for this study was secured from the Kulliyyah of Nursing Postgraduate Research Committee (KNPGRC), the IIUM Research Ethics Committee (IREC) (IREC 2024-118), and the Sultan Ahmad Shah Medical Centre (SASMEC) (IIR24-61). To uphold ethical standards, informed consent was obtained from all participants before their involvement. Participants were made fully aware of the study's purpose, procedures, and right to withdraw without repercussions. Confidentiality was maintained by anonymising participants' identities throughout the research process, ensuring their privacy, and safeguarding their personal information. These measures ensured compliance with ethical guidelines and reinforced the study's integrity.

RESULTS

The sociodemographic background of participants is shown in **Table 1**. The analysis revealed three key themes that encapsulate the participants' experiences and perspectives:

1. Understanding Spiritual Care: This theme explores how participants conceptualise spiritual care, encompassing their definitions, interpretations, and the significance they attribute to it in the context of palliative care.
2. The Role of Family Caregivers: This theme highlights family caregivers' specific roles and responsibilities in spiritual care. It delves into their contributions to supporting patients' spiritual and emotional needs and their integration into the caregiving process.
3. Challenges in Delivering Spiritual Care: This theme examines the obstacles faced by family caregivers in fulfilling their spiritual caregiving roles. It addresses practical, emotional, and systemic barriers that impact their ability to provide comprehensive spiritual care.

Table 1: Sociodemographic background of participants

Participant	Age	Gender	Marital status	Occupation	Relationship with patient	Diagnosis
P1	40	Female	Married	Nurses	Daughter	Chronic kidney disease
P2	24	Female	Single	Student	Granddaughter	Osteoporosis
P3	27	Female	Married	Housewife	Sister	Teratoma
P4	30	Female	Single	Nurses	Niece	Lung Cancer
P5	23	Female	Single	Student	Granddaughter	Kidney disease
P6	37	Female	Single	Doctor	Daughter-in-law	Tonsillar Carcinoma
P7	32	Female	Married	Housewife	Daughter	Heart disease
P8	26	Female	Single	Teacher	Granddaughter	Stroke
P9	25	Female	Married	Businesswoman	Granddaughter	Stroke
P10	50	Female	Single	Unemployed	Daughter	Cancer

Understanding Spiritual Care

Participants' understanding of spiritual care primarily centered around its association with religion. They emphasised that spiritual care is deeply rooted in their religious beliefs, which provide hope and strength during challenging times. This perspective highlights the importance of faith as a coping mechanism and a means to navigate significant life transitions. For example, one participant explained,

"In my perspective, spiritual care is how my religion or any religion supports a person when he or she is going through some turning points in life."

(P2)

Another participant added,

"For spiritual care, what I understand, it's about praying for them. Basically, it's just to pray for them, to make them feel at peace."

(P9)

These responses underscore the role of prayer and religious practices in providing comfort to patients.

Beyond its religious dimensions, participants also viewed spiritual care as a form of emotional support critical to patient well-being. They noted that spiritual care fosters hope strengthens faith, and promotes peace, helping patients to accept their circumstances and find meaning in their experiences. One participant stated,

"It's emotional support for the patient. In terms of emotional, it promotes the patient's well-being and wellness."

(P4)

Similarly, another participant shared,

"Spiritual care is my way of taking care of her emotional and mental health."

(P7)

These insights highlight the dual nature of spiritual care, which encompasses religious practices and emotional support, and its vital role in enhancing the holistic well-being of palliative care patients.

Role of Family Caregiver

The participants identified several key roles they undertake as family caregivers in providing spiritual care, emphasising the multifaceted nature of their responsibilities.

Facilitating Spiritual Practices

One of the primary roles described was the organisation and facilitation of spiritual practices. These included arranging prayer sessions, engaging in religious activities, and incorporating faith-based resources to provide comfort and hope to patients. For instance, a participant shared,

"I play spiritual music, like Christian music. And then, I also brought him, like a rosary, books, spiritual books to read. And then, I play spiritual movies to make sure he can feel like he still has hopes."

(P2)

Another added,

"We let him listen to worship songs, encourage him to read the Bible, and do rosary prayer together."

(P5)

These actions reflect the caregivers' dedication to reinforcing spiritual connection and emotional resilience in patients through religious engagement.

Providing Emotional Support

The participants also highlighted the critical role of emotional support in their caregiving responsibilities. This involved offering encouragement, being physically present, listening to patients' feelings, and addressing their emotional needs.

One participant stated,

"Basically, we just always be there for him, to listen to his feelings."

(P5)

Another remarked,

"Maybe through prayer and words of encouragement. Like we always pray together and bring her to church."

(P6)

These expressions illustrate how caregivers use emotional support to foster a sense of peace, connection, and understanding, which are integral to holistic care.

Sharing Caregiving Responsibilities

Participants emphasised the importance of shared caregiving roles within families to distribute the physical and emotional workload more effectively. Rotating tasks and involving extended family members were identified as strategies to enhance caregiving quality while preventing burnout. A participant explained,

"I will include my other siblings, my cousins, and someone she knows she trusts to constantly visit her and say some nice words."

(P2)

Similarly, another noted,

"Our family, sometimes we switch. If they have work, I will take care of them. So, we switch. But most of the time, it's me and my mum."

(P9)

Significance of Family Visits

Regular family visits were also essential in maintaining emotional support and promoting patients' well-being. These visits foster a sense of community and reassurance, reinforcing the importance of familial bonds during palliative care.

These insights underscore the multifaceted roles of family caregivers in spiritual care, encompassing religious facilitation, emotional support, and collaborative caregiving efforts. Together, these practices contribute significantly to the holistic well-being of palliative care patients.

Challenges in Delivering Spiritual Care

Participants identified several challenges that hinder their ability to provide spiritual care, highlighting both structural and emotional barriers.

Limited Access to Spiritual Services

A common issue raised by participants was the restricted access to spiritual services in hospitals and healthcare centers, where limited availability of chaplains, religious leaders, or designated spaces for spiritual practices posed challenges in meeting patients' spiritual needs. This limitation stemmed from the unavailability of spiritual leaders and the lack of individual knowledge or resources to facilitate spiritual care. For instance, one participant shared,

"The pastor comes to the house maybe every two or three weeks to pray for my grandpa. Even though I hope that the pastor can come every week to give blessings for us, I also understand that the pastor also needs to visit other patients who also need his blessing."

(P8)

This highlights the difficulty in receiving regular pastoral visits, a crucial component of spiritual care. Given the diverse religious backgrounds in Malaysia, this suggests the need for designated spaces in hospitals and healthcare centers that accommodate various spiritual and religious practices. Practically, this could be implemented by establishing multi-faith prayer rooms, engaging chaplains or spiritual care providers from different religious backgrounds, and integrating culturally sensitive spiritual support services to ensure inclusivity in palliative care.

Another participant remarked on the challenges posed by interfaith family dynamics:

"My father and I are Christians, but my brother is Buddha. So, if we want to organise a prayer session, it's me who needs to handle it because my brother didn't know much about our religion."

(P10)

This example underscores how differences in religious understanding within families can create additional challenges and strain on caregivers.

Emotional Challenges

In addition to logistical barriers, participants reported significant emotional challenges during their caregiving journey. Feelings of denial and anger towards God were prevalent, reflecting the psychological toll of caregiving. One participant recounted,

"The one who affected a lot is us. Because we keep denying that he can survive. And then, we also blame God. Why did He do this to him?"

(P3)

Another shared,

"For me, when sick, my grandma can't accept it; she blames God."

(P8)

These emotional responses illustrate caregivers' struggle to reconcile their faith with the realities of the patient's condition.

DISCUSSION

Understanding Spiritual Care

Christian family caregivers view spiritual care as a vital component of caregiving, supporting illness management, fostering peace, and reducing the fear of death (7). Their perceptions reveal a broad spectrum of understanding, with some focusing on the religious dimensions of spiritual care, such as organised practices and rituals. In contrast, some take a more inclusive approach, integrating personal beliefs and values. This diversity underscores the personalised and context-dependent nature of spiritual care among caregivers.

Participants in this study primarily linked spirituality with religion and belief in God, specifically Christianity, interpreting spiritual care as a source of strength and support during significant life challenges. For them, spiritual care often entails a profound connection with God, providing love and hope that enhances spiritual well-being during illness and crises (8). This connection is particularly vital for individuals facing the end of life or the loss of a loved one, as spirituality and religion offer essential coping mechanisms to navigate these transitions (9).

Prayer emerged as a key element of spiritual care, regarded as a personal and collective practice providing strength and hope. Participants emphasised the role of worship in alleviating emotional stress, creating a sense of calm, and strengthening resilience for both patients and their caregivers. One participant noted that prayer fosters a shared understanding of faith and hope, enabling patients to better cope with their conditions. This personal perspective aligns with existing literature (10), highlighting the dual role of worship as both a source of comfort and a means to maintain spiritual connectedness. This practice highlights the dual role of worship as both a source of comfort and a way to sustain spiritual connectedness.

Beyond its religious aspects, participants highlighted the emotional dimensions of spiritual care, viewing it as a tool to help patients find meaning, peace, and acceptance. Spiritual care, as described by the caregivers, addresses the holistic needs of patients, alleviating not only physical suffering but also emotional and social challenges. It fosters psychological and spiritual well-being, critical in palliative care settings (11). Participants observed that patients receiving emotional support often appeared calmer, more accepting of their circumstances, and enjoyed an improved quality of life (12).

The findings emphasise the importance of integrating spiritual and emotional care to provide holistic support for palliative patients. By addressing spiritual and emotional needs, caregivers can create an environment that promotes peace, resilience, and dignity for patients during their final stages of life. This holistic approach improves patient well-being while helping family caregivers fulfil their roles effectively and with compassion.

In conclusion, Christian family caregivers have different understandings and practices of spiritual care, making it a complex but essential part of palliative care. However, these differences also present challenges. Key findings include:

- Different Views on Spiritual Care: Some see it as religious practices like prayer, while others focus on emotional support.
- Challenges in Providing Spiritual Care: Caregivers struggle with emotional stress, limited access to religious leaders, and patients' changing spiritual needs.
- Need for Better Support: Effective spiritual care requires combining religious and emotional support while addressing caregivers' difficulties.

Role of Family Caregivers In Delivering Spiritual Care

Family caregivers in this study identified themselves as pivotal in providing spiritual

care to patients, highlighting their unique closeness, and understanding of their needs. This proximity enables them to integrate spiritual care effectively into daily life, supporting the patient's religious and emotional well-being.

A key role of family caregivers involves organising and facilitating spiritual practices. These include daily rosary prayers, which Christian caregivers believe bring comfort and strength to patients. This aligns with existing research indicating that rosary prayers foster acceptance and calmness, helping patients manage their illness more effectively (13). Beyond prayers, caregivers enhance the spiritual experience by playing worship songs, sharing spiritual literature, and engaging in faith-based activities like watching spiritual movies.

Additionally, caregivers often facilitate chaplain or pastoral visits, which they view as essential for providing patients with spiritual support and reassurance. McCurry's findings support this perspective, highlighting the significant role of chaplains in addressing the spiritual needs of both patients and their families, offering comfort and guidance during challenging times (14).

Participants emphasised that spiritual care extends beyond religious practices to encompass patients' emotional needs. Caregivers noted the importance of offering encouragement, being present, and actively listening to patients. These actions help patients feel valued and understood, fostering a sense of connection and emotional comfort. Active listening, in particular, was highlighted as a tool that improves communication between patients and caregivers, facilitating a deeper understanding of patients' needs and contributing to their overall well-being (15).

The study also underscored the importance of shared caregiving responsibilities among family members. Participants acknowledged the challenges of balancing caregiving with other commitments, such as work and personal life, which often lead to stress and fatigue. By involving other family members in caregiving duties, caregivers reported reduced individual burdens and improved overall quality of care. Regular family visits and shared tasks provide practical assistance and emotional support, reinforcing a collective sense of care for the patient (16).

The findings highlight the multifaceted role of family caregivers in delivering spiritual care. Their efforts in facilitating spiritual practices, providing emotional support, and sharing caregiving responsibilities demonstrate a holistic approach to meeting patients' needs. By addressing spiritual and emotional dimensions, caregivers contribute significantly to the patient's well-being, creating a supportive environment that promotes comfort, resilience, and dignity in palliative care settings.

Challenges In Delivering Spiritual Care

Family caregivers in palliative care settings face numerous challenges in providing spiritual care to their loved ones. These challenges span emotional, interpersonal, and systemic barriers, collectively impacting the caregivers' ability to deliver adequate support.

Caregivers often experience a range of emotional difficulties, including sadness, fatigue, stress, helplessness, anger, and depression, which can interfere with their caregiving roles (17). Participants highlighted the burden of balancing their emotional well-being with caregiving responsibilities, many of whom admitted to feelings of denial and anger toward God due to their loved one's condition. One participant reflected,

"*The one who affected a lot is us. Because we keep denying that he can survive. And then, we also blame God. Why did He do this to him?*"

These emotional struggles may hinder caregivers' ability to provide consistent and compassionate spiritual care (18).

The unstable emotions of terminally ill patients further complicate the provision of spiritual care. Following a terminal diagnosis, patients may experience denial, anger toward God, or reluctance to communicate, which strains their interactions with caregivers. Additionally, patients often worry about becoming a burden to their families, leading to heightened stress for both parties. In some cases, this distress can manifest in patients expressing a wish to end their lives to relieve their caregivers' suffering (19). These dynamics require caregivers to manage not only their own emotions but also

the complex emotional states of their loved ones.

A significant barrier reported by participants was the limited access to spiritual resources and services. Many caregivers cited a lack of awareness about available spiritual resources, which hindered their ability to meet the spiritual needs of patients (20). Furthermore, the limited availability of spiritual leaders, such as pastors or chaplains, posed additional challenges. One participant noted,

"*The pastor comes to the house maybe every two or three weeks to pray for my grandpa. Even though I hope that the pastor can come every week to give blessings for us, I also understand that the pastor also needs to visit other patients who also need his blessing.*"

Without regular pastoral visits, patients may experience a weakened sense of faith and heightened emotional distress, as they miss the comfort and spiritual reinforcement these visits provide (7,21).

These challenges highlight the need for systemic improvements in spiritual care resources and support. Healthcare providers must prioritise the integration of accessible spiritual services into palliative care. This involves raising caregiver awareness of available resources, enhancing access to spiritual leaders, and providing training to help caregivers effectively manage emotional challenges. By addressing these barriers, healthcare systems can empower caregivers to deliver comprehensive spiritual care, ultimately enhancing the well-being of both patients and their families.

CONCLUSION

This study effectively explored the perspectives of Christian family caregivers on spiritual care within palliative settings, providing valuable insights into their roles, challenges, and the impact of spiritual care on both patients and caregivers. Participants emphasised the essential role of spirituality, particularly its connection to religious practices and personal relationships with God. Spiritual care was noted to motivate patients, strengthen their faith, and foster peace during times of illness and crisis. Family caregivers played a significant role by facilitating prayer sessions and pastoral visits, which provided both comfort and emotional support to patients and themselves. However, participants also highlighted considerable challenges, including managing their emotional burdens, addressing patients' fluctuating emotions, and dealing with limited access to spiritual support resources.

Implications for Healthcare Professionals

The findings underscore the importance of integrating spiritual care into palliative care plans. For healthcare professionals, understanding the challenges and perspectives of family caregivers is crucial for developing effective support strategies. Enhancing patients' emotional and spiritual well-being requires direct care and empowering caregivers to fulfil their roles effectively. Prioritising caregiver self-care is also essential; addressing their emotional and psychological burdens can improve their resilience and overall caregiving effectiveness. By offering caregivers appropriate resources and support, healthcare professionals can improve patient's quality of care while helping caregivers maintain their well-being.

Benefits for Muslim Nurses

For Muslim nurses, this study provides critical insights into the universal principles of spiritual care that transcend religious boundaries. In Malaysia's multireligious society, developing these principles requires further research on various religious perspectives in palliative care to uncover shared spiritual care practices. Future studies could explore how different faiths approach spiritual needs to establish inclusive guidelines for healthcare providers. Some universal principles include compassion (rahmah), which emphasizes kindness and empathy in caregiving; holistic well-being (shifa'), which integrates physical, emotional, and spiritual support; dignity and respect, which ensures recognition of patients' religious and cultural values in care decisions; hope and meaning-making, which helps patients find comfort and purpose in their final moments; and family and community support, which highlights the importance of involving family members and accessing spiritual caregivers from diverse backgrounds. These principles can serve as a foundation for future research and practical applications to ensure that spiritual care is inclusive, meaningful, and respectful in

palliative settings. Furthermore, Muslim nurses can use these insights to reflect on their practices and enhance their skills in spiritual caregiving, ensuring that care delivery aligns with professional and Islamic ethical standards (22,23).

Future Directions

Future research should focus on developing practical strategies to support family caregivers in managing their emotional burdens while delivering effective spiritual care. Additionally, studies should explore ways to enhance the interactive relationship and integration between professional healthcare providers and palliative spiritual care, ensuring a more holistic approach to patient well-being. Research should also address challenges in palliative spiritual care from the Christian perspective, as highlighted in this study, and examine solutions to mitigate these issues. Furthermore, future studies should aim to uncover common and universal principles of spiritual care that transcend religious differences, fostering an inclusive and culturally sensitive framework for spiritual care in multireligious societies like Malaysia.

LIMITATIONS

This study has some limitations that should be acknowledged.

1. Small Sample Size: The limited number of participants, with only ten Christian family caregivers, restricts the study's ability to generalize the findings. Additionally, as the research focuses solely on one religious group in Malaysia's multireligious society, it may not fully capture the diverse experiences and perspectives of family caregivers from other faith traditions in palliative care settings. This limitation highlights the need for future studies to include a broader and more diverse sample to enhance the applicability of the findings across different religious and cultural backgrounds.
2. Short Study Duration: The relatively brief data collection period may not have captured caregivers' longer-term trends and evolving needs. The dynamic nature of caregiving, particularly in palliative settings, requires a longitudinal approach to understand the complexities of caregivers' experiences over time fully.
3. Geographical Restriction: Conducting the study in Kuantan, Pahang, limits the generalizability of the findings to other regions. Differences in cultural, social, and healthcare systems across areas may lead to distinct caregiving experiences, which are not reflected in this study.

CONFLICT OF INTEREST

The authors acknowledge that publishing this paper has no conflict of interest.

FUNDINGS

The research received no external funding.

ACKNOWLEDGEMENTS

Thanks and gratitude are extended to all participants who generously shared their experiences and insights, contributing significantly to the understanding of spiritual care in palliative settings.

AUTHOR CONTRIBUTIONS

MFMI: drafted the manuscript and played a role in developing and designing the article by gathering, analysing and interpreting data.
NFNS: data collection and revised the manuscript critically with intellectual contents.
SZS: revised the manuscript critically for important intellectual content.

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