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Religious needs of hospitalized patients

Potrzeby religijne u pacjentów hospitalizowanych

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STRESZCZENIE

POTRZEBY RELIGIJNE U PACJENTÓW HOSPITALIZOWANYCH

Wprowadzenie. Zaspokajanie potrzeb religijnych u pacjentów hospitalizowanych jest istotną częścią opieki pielęgniarskiej. Ich wczesna identyfikacja przez pielęgniarki i późniejsze zaspokajanie mogą prowadzić do łatwiejszej adaptacji do środowiska szpitalnego i choroby oraz przyczynić się do ogólnego komfortu pacjentów.

Cel pracy. Celem pracy było określenie religijności wybranych pacjentów hospitalizowanych w okresie przedchorobowym i chorobowym oraz udziału pielęgniarek w zaspokajaniu potrzeb religijnych.

Materiał i metody. Aby osiągnąć założone cele, wybraliśmy metodę jakościową – studium przypadku. Do mapowania religijności wykorzystano kwestionariusz A Spiritual Screening Tool for Older Adults oraz kwestionariusz Canda i Furmana do ukrytej i jawnej oceny duchowości i religijności. Próba respondentów składała się z trzech pacjentów różnej płci, z różnymi objawami i w różnym czasie trwania choroby, hospitalizowanych na oddziałach stacjonarnych placówek medycznych.

Wyniki. Według Spiritual Screening Tool for Older Adults, stwierdziliśmy pozytywne zdrowie duchowe u pacjentów A, M i R. Potrzeby religijne podczas pobytu w szpitalu były częściowo zaspokajane u pacjenta A, u pacjentów M i R były zaspokajane, ale tylko poprzez indywidualne zajęcia (modlitwa, odwiedzanie kaplicy szpitalnej itp.). Pielęgniarki nie zaspokajały potrzeb żadnego z pacjentów.

Wnioski. Rekomendujemy korzystanie z narzędzi służących do oceny religijności pacjentów i w związku z nimi kontynuowanie planowania interwencji pielęgniarskich. Aktywna współpraca z „asystentami duchowymi" jest również zalecana, jak również integrowanie problematyki potrzeb religijnych w treści kształcenia przyszłych pielęgniarek.

Słowa kluczowe: potrzeby religijne, pacjenci, pielęgniarstwo

ABSTRACT

RELIGIOUS NEEDS OF HOSPITALIZED PATIENTS

Introduction. Meeting the religious needs of hospitalized patients is an essential part of nursing care. Their timely identification by nurses and subsequent satisfaction may lead to an easier adaptation to the hospital environment and illness, and contribute to the overall comfort of the patients.

Aim. The aim of the study was to determine the religiosity of selected hospitalized patients in the premorbid and morbid period and the participation of nurses in meeting religious needs.

Material and methods. To achieve the goals, we chose a qualitative method – a case study. A Spiritual Screening Tool for Older Adults and a questionnaire by Canda and Furman were used to assess spirituality and religiosity implicitly and explicitly. The respondent sample consisted of three patients hospitalized in inpatient wards of medical facilities with different gender, diagnoses and duration of the disease.

Results. According to Spiritual Screening Tool for Older Adults, we found positive spiritual health in patients A, M and R. Religious needs during hospitalization were partially satisfied in patient A and fully satisfied in patients M and R, but only through individual activities (prayer, visiting the hospital chapel and others). None of the patients had their needs met by nurses.

Conclusions. We recommend using the tools aimed at assessing patients' religiosity and continue with the planning and implementation of nursing interventions accordingly. Active cooperattion with "spiritual assistants" and integrating the issue of religious needs into the content of education of future nurses are also recommended.

Key words: religious needs, patients, nursing

INTRODUCTION

Holistic nursing is oriented to all areas of patients' needs, including religious ones. They express the need for a relationship with God, a connection with Him and a deeper knowledge of Him. They are usually associated with religious experience and behaviour, religious activities and affiliation with a particular church or religious group. They are related to religious faith, which is represented by a system of beliefs and values that give meaning to life and provide motivation to activities that are compliant with these beliefs [1]. Puchalski [2] also emphasizes the importance of the ultimate meaning, purpose, transcendence and experiencing the relationship to self, family, community, society, nature and all that is sacred. Saroglou et al. [3] describe four religious dimensions in relation to religiosity – believing, bonding, behaving and belonging. The first dimension refers to belief, which is related to transcendence, the ideal of truth and the search for meaning and epistemic certainty. The bonding dimension is related to emotional aspects – a bond with fellow religionists through religious rituals in order to seek unity, respect and inner peace. The behavioural dimension refers to the moral aspect of religion, it implies moral rules, ideals of virtue, purity and moral order, the search for values and their hierarchy. The dimension of belonging refers to the social aspects of religion – inclusion in a community and the search for collective identity and social self-esteem through belonging to a group. Other dimensions of the patient's religiosity are described by Vélez [4]. The sacrament such as confession and reconciliation heals the soul and restores it to a state of grace or friendship with God when it has been lost. He sees the Eucharist as the medicine of immortality and antidote to death that makes it possible to live eternally in Jesus Christ, and the anointing of the sick gives the grace to suffer with Christ with faith and love. Religious faith is most often expressed by believers through values, traditions and various practices [2]. In hospitalized patients, nurses most commonly encounter a prayer, meditations, watching religious services on television, and, if their health permits, attending services in the hospital chapel. Less frequently, nurses meet with the chaplain's visit and their positive impact is noted by several authors [5, 6]. Cervelin, Kruse [7], Ahmadi [8] emphasize that religiosity helps patients in emotional adaptation to the disease and in prophylaxis against depression, anxiety, despair, anger and hopelessness. Faith and truth in God lead them to greater well-being, a sense of belonging, psychological comfort, a better quality of life, dignity and peace.

Despite the confirmed importance of satisfying religious needs in religious patients, practice often shows an underestimation of these needs [9, 10]. Incorporation of the assessment of religious needs into nursing care and their subsequent satisfaction in hospitalized patients is a prerequisite for approaching holistic principles. Canda and Furman [11] have addressed patient's spirituality and religiosity to such an extent that they created a questionnaire to determine their spiritual and religious attitude and interests. Similarly, Stranahan [12] presents the questionnaire Spiritual Screening Tool for Older Adults in order to determine the spiritual level of patients. The issue of spirituality in relation to nursing diagnoses is included in the tenth domain – Life Principles of the classification system NANDA International Nursing Diagnoses 2021-2023 [13], where diagnoses associated with spirituality are listed. This domain consists of values, belief and congruence of values, belief and actions.

AIM

1. To determine religiosity in selected hospitalized patients in the premorbid period.
2. To determine the degree of satisfaction of religious needs in selected hospitalized patients.
3. To map the participation of nurses in meeting the religious needs of selected hospitalized patients.

MATERIALS AND METHODS

In order to achieve the goals, we chose a qualitative research method – a case study. These studies were aimed at collecting data from selected patients, processing the information and highlighting the overlapping of their religious needs in the process of nursing care. The case studies were descriptive in nature. The questionnaires used for the initial interview were – A Spiritual Screening Tool for Older Adults [12] and the implicit and explicit assessment of spirituality and religiosity according to Canda and Furman [11]. The content of the questionnaires is oriented not only to spiritual, but also religious needs, as they include religious practices and religious participation. The algorithm for selecting respondents was predefined. Respondents were selected deliberately. The selection criteria were adult age, need for religiosity and willingness to communicate. The respondent sample consisted of three patients with different gender, diagnoses and duration of illness in order to describe as broad spectrum as possible in the area of these needs (53-year-old woman, 42-year-old woman and 55-year-old man). Consent to obtain empirical data was included in the medical record, which also consisted of patient education and informed consent for the health care provided, which may include questioning. Hospitals are allowed to use medical records for study purposes under Slovak legislation, provided that confidentiality of information is maintained under the legislation in force.

RESULTS

Instead of the initials of the patients' names and surnames, we used the letters A, M, R and labelled the case studies as A, M and R case studies. Spiritual anamnesis (Tab. 1.), Catamnesis – premorbid period (Tab. 2.), Catamnesis – morbid period (Tab. 3.) we presented in tables 1-3.

Tab. 1. Religious anamnesis

patient	age	W/M	diagnosis	religious anamnesis	score according to: A Spiritual Screening Tool for Older Adults [12]	Assessment according to questionnaire by Canda and Furman [11] * (Note: some questions from Canda and Furman's assessment were not answered by the patients.)
A	53	W	carpal tunnel syndrome	• baptism • First Holy Communion • confirmation • regular church attendance with parents • rejection of faith during puberty because of a handicap (haemangioma on face) • renewal of faith from the age of 23	Inner strength to hope and cope – 19 points Transcendence – 24 points Meaning and purpose – 23 points Religious practices – 21 points = Positive spiritual health	• implicitly: the joy of family, husband, children, grandchildren and the feeling of living life to the fullest while helping other people • explicitly: a prayer
M	42	W	cholecystolithiasis	• baptism • regular evening prayer with parents • First Holy Communion • confirmation • regular church attendance • participation in the Christian community • regular evening prayer with husband, later with children	Inner strength to hope and cope – 23 Transcendence – 23 Meaning and purpose – 24 Religious practices – 24 = Positive spiritual health	• implicitly: inspiration, peace and joy, gratitude for God's favour, for children, husband, friends • explicitly: membership in the Christian community
R	55	M	hernia in postoperative scare	• without faith in childhood (atheistic parents) • received the sacraments of baptism, First Holy Communion and confirmation at the age of 25	Inner strength to hope and cope – 25 Transcendence – 25 Meaning and purpose – 24 Religious practices – 25 = Positive spiritual health	• implicitly: God's presence and will, inspiration, gratitude, giving joy, peace to others • explicitly: membership in the community of believers

Tab. 2. Catamnesis – premorbid period

questions /topics	patient	subjective statements (shortened version)	
who/what influenced/ strengthened your faith	A	• dominantly by mother (in childhood) • tragic death of 3-year-old niece – a period without faith • marriage and child ("desires fulfilled thanks to prayers despite the handicap – haemangioma on face")	
	M	• parents from an early age • inability to conceive a child for 6 years even after many examinations (refusal of in vitro fertilization) • a friend uttering a sentence: "Stop telling God how big your problems are and start telling your problems how big your God is." • spontaneous abortion after second child	
	R	• inner restlessness (frequent consumption of alcohol, partying, changing partners) • a religious girl with whom he fell in love, but who rejected him because of his lifestyle and atheism • a religious clock repairman with whom he later had discussions about God and who „showed him the way" (initially ignoring and mocking) • later strengthening of faith after DX colon cancer and due to unfavourable prognosis	
ways of satisfying spiritual needs before illness			Dimensions of religiosity
	A	• regular church attendance • receiving the sacraments • sorrowful rosary	• vertical
	M	• regular church attendance • receiving the sacraments • regular meetings of the Christian community • regular evening prayer with husband and children	• vertical • horizontal
	R	• regular church attendance • regular meetings of the community of believers, but also some of these people at their homes	• vertical • horizontal

As a part of the religious anamnesis, we focused on the use of practices in relation to faith on the ontogenetic axis in each respondent. We used A Spiritual Screening Tool for Older Adults and the questionnaire by Canda and Furman. We noticed faith in the parents of respondents A and M, which was subsequently reflected in the fact that they had been baptised as children, had received First Holy Communion, confirmation and regularly attended religious services with their parents. Respondent R did not come from a religious family, but received the sacraments of baptism, First Holy Communion and confirmation at the age of 25. Respondents M and R were members of the community of believers.

In subjective statements we documented various life events that led to faith and the variability of individual satisfaction of religious needs in premorbid period.

In case of all respondents, we observed some way of satisfying religious needs after the diagnosis of the disease. In respondents A and M, we registered more intensive individual prayers. In respondents M and R, in addition to individual rituals, visiting the community of believers and visiting believers in the home environment played a significant role. All respondents performed religious activities during hospitalization and attended the hospital chapel, but without the participation of nurses.

Tab. 3. Catamnesis – morbid period

questions/ topics	patient	subjective statements (shortened version)	religious needs
spiritual needs after diagnosis of illness	A	• regular church attendance • more intensive individual praying	• need for a vision of the future • need to overcome crisis • need for hope
	M	• meeting of the Christian community • holy confession before hospitalization • praying with husband several times during the day	• degree of satisfaction of spiritual needs fulfilled
	R	• meeting of the community of believers • praying with wife • visits of people from the community of believers at their home – supporting wife, sending SMS to the religious community throughout Slovakia	• need for faith • need for worship • need for piety • needs manifested mainly in the request for the Sacrament of Anointing of the Sick and priestly blessing
meeting spiritual needs during hospitalization	A	• individual prayer (several times a day) • visiting the hospital chapel	• partially satisfied
	M	• individual prayer (evening) • reading and discussing the Holy Scriptures with a friend who is also a ward inpatient • need for the Eucharist • visiting the hospital chapel	• satisfied
	R	• reading the Holy Scriptures on mobile • reading the book of Deuteronomy • visiting other believing hospitalized patients in order to pray for healing • receiving the Eucharist • receiving the priest's blessing • visiting the hospital chapel	• satisfied
assessment of spiritual needs nurses	A	• no (a nurse only asked about spiritual needs on admission)	
	M	• no	
	R	• no (a nurse only asked about spiritual needs on admission)	
meeting the needs by nurse	A	• no	
	M	• no	
	R	• no	

DISCUSSION

People of faith are influenced by spirituality to such an extent that it can induce/support their health or personal well-being [14]. It was also confirmed by our results in patients A and M, in whom we observed psychological balance, willingness to cooperate and communicate, and more intense and frequent prayers during hospitalization. Dein [15] emphasizes beneficial effects of religious involvement on mental health, well-being and relationship between faith and "healing", which was confirmed in patient R, who expressed the conviction that he had not been sick for the last seven years thanks to regular prayers. In this patient, it was also confirmed that the life crisis conditioned by a challenging event can lead some people to faith. Similarly, Koening et al. [16] in the Handbook of Religion and Health summarized the results of more than 3,000 research studies that demonstrated higher or lower correlation of religiosity with various areas of physical and mental health. Results of our survey pointed to the same observation. Positive family relationships resonated in all three case studies. Patients M and R stated that they felt and met their religious needs equally in both home and hospital environment. The fact that the satisfaction of spiritual needs is not influenced by the environment was also indicated by the results of the study by Andrási [14]. However, Santos states that satisfying physical needs of patients is a higher priority for nurses. Crize et al. [17] observed that nurses neglect religious access to patients or limit it to sporadic visits of religious authorities. In all three patients, we registered a positive correlation between prayers and their "fulfilment/answering". Patient A mentioned that her prayer was answered in relation to marriage and children (despite a significant handicap on her face, she "impetrated" husband and children), patient M was blessed with children thanks to prayers and intensive prayers "minimised health problems related to gallstones". Patient R "did not get sick thanks to faith despite his immunodeficiency due to cancer and frequent hospital visits". The correlation between prayers and their "fulfilment/answering" was also pointed out by Andrasi et al. [14]. Thiengo [18] also mentions that spiritual practices, including religious ones, serve as a support to cope with health problems for both the patient and his/her relatives. Religiosity contributed to the interpretation of the illness and its meaning, as shown in our survey by the attitude of patient R. We would also like to bring to attention the comparison of individual case studies. Satisfying patients' religious needs by nurses was mostly absent. Two respondents stated that nurses had asked them about their religious needs as part of the assessment, but that "was it". Lack of saturation of these needs in patients was also reported in the study results by Areshtanab et al. [19]. As a reason for it, nurses stated lack of competence and personal discomfort. In addition to lack of competence, Zakaria et al. [20] considered lack of time, training of nurses in this area of needs and low motivation among the most dominant obstacles in meeting patients' religious needs. Similarly, Austin et al. [21] concluded that although nurses are able to identify patients' religious needs, they do not know how to adequately satisfy them. However, there are also research findings in which nurses were considered competent in meeting this category of needs. At the same time, nurses' religious beliefs correlated with their willingness to provide "religious" care for patients [22]. With these results, it is necessary to emphasize their subjective nature, that is, the nurses evaluated themselves. Results of the study by Deluga, Dobrowolska et al. [23] also confirmed the relationship between the satisfaction of patients' religious needs and the nurses' age, the length of their practice (job seniority), declaration of their attitude

to faith, and positive religious stress management strategies. It can be clearly stated that meeting patients' religious needs is part of a holistic approach. Underestimating the religious side of patients also underestimates its impact on physical and mental health. The secularization of religious needs has created space for studies in which experts confirmed the positive outcomes achieved by implementing nursing interventions focused on religious needs [24].

Recommendations for practice

Based on the analyses and conclusions of the case studies, we formulated recommendations for nursing practice:

- dealing with one's own religiosity and individual religious needs and transcendence,
- actively using tools aimed at religious assessment of patients, e.g. [11, 12],
- following the assessment of patients' religiosity, continuing to plan and implementing the satisfaction of religious needs,
- actively cooperating with "spiritual assistants" (a priest, monk or other spiritual leaders) to saturate the religious needs of patients,
- integrating the issue of meeting the patients' religious needs into the content of education of future nurses,
- providing educational training programmes for nurses in practice focused on religious care.

CONCLUSIONS

In the recent past and also present, several authors have emphasized the importance of religiosity in patients. The World Health Organization also included the domain of religiosity among official instruments for assessing the quality of life – WHOQOL [25]. Religiosity is multidimensional in nature which affects the physical and psychological health and personal well-being of patients. Based on this knowledge, it would be desirable to strengthen the satisfaction of spiritual needs of hospitalized patients by nurses.

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