The impact of diagnosis on the psychosocial and spiritual needs of the patients

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Abstract. *Introduction:* Holistic care focuses on the relationship between the body, mind, and spirit. Spiritual needs are among the basic needs of the individual. From the physical and spiritual dimension and the interaction of these two dimensions, the spiritual needs of the person are developed. *Aim:* The aim of our study was to analyze if the patient's knowledge regarding their diagnosis and possible proximity of death have significant impact on satisfaction of psychological and spiritual needs. *Material and Methods:* In our study we used standardized questionnaire The Spiritual Needs Assessment for Patient – SNAP constructed by Sharma Rashmi, applied for 113 respondents and processed by SPSS statistical program. *Results:* Reliability of questionnaire is given by Cronbach's Alpha 0.945 for the total SNAP. A statistically significant difference at the level $p < 0.01$ has been confirmed in all questions among respondents with fatal diagnosis and respondents with not life-threatening diagnosis. In domain of psychosocial needs, significant difference was not confirmed regarding to gender, age, education, income, religion and place of residency. In domain of spiritual needs, significant difference was partially confirmed regarding religion in 4 questions from 13. *Conclusion:* Faced with chronic or fatal diseases, many patients rely on dealing with spiritual and religious issues. In fact, spirituality/religiosity can be considered an important source of support and management of severe chronic diseases. It is possible to identify the four basic dimensions of spiritual need: interconnection, peace, meaning/purpose, and transcendence. Patients often have the problem addressing their needs for related psychosocial and physical problems such as physical disability, fatigue, sleep disorders, side effects of treatment, etc. Importance of satisfaction of psychosocial and spiritual needs is increased in time of threat, fatal diagnosis.

Key words: diagnosis, psychological needs, spiritual needs, religious needs, patient, holistic approach.

1 Introduction

The behaviour of the patient, acceptance of the diagnosis and coping with reality are important factors during treatment process. Therefore one of the greatest challenges for nursing is to provide the greatest possible comfort for the patient and it is necessary to focus nursing care to the whole personality of the patient. In recent years, scientific advances in health care have evolved to the detriment of the importance of human spirituality, particularly in terms of health and disease. The importance of spiritual needs is declared by authors Best,

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Butow and Olver who state that patients require their doctors to reflect on their spiritual needs and facilitate their access to their satisfaction [1]. Holistic care focuses on the relationship between the body, mind, and spirit. Solutions to emotional, social and existential concerns can be realized through a team of interdisciplinary professionals. Spiritual needs may not always be associated with life satisfaction, but sometimes with anxiety, and can be interpreted as patient's desire for spiritual well-being. The need for peace, health and well-being is universal human need and is particularly important for patients with long-term illnesses [2]. It is possible to identify the four basic dimensions of spiritual need: interconnection, peace, meaning/purpose, and transcendence. Apart from addressing the physical needs of patients healthcare needs to address also emotional, social, existential and spiritual needs. Authors Mesquita et al identified eight groups of spiritual needs: finding the meaning and purpose of life; finding the meaning in experiencing the disease; being connected to other people, God and nature; having access to religious/spiritual practices; physical, psychological, social and spiritual wellbeing; talking about death and the experience of dying; making the best out of their time; being independent and being treated like a normal person [3]. Faced with chronic or fatal diseases, many patients rely on dealing with spiritual and religious issues. The patient in the terminal stage of the disease falls into palliative care, which is currently aimed at ensuring that the patient has a good quality of life during this period. But despite this effort, we are faced with situations when the dying is accompanied by pain, loneliness and loss of human dignity. The spiritual needs of the dying patient are related especially with his/her accompanying spiritual experience. Spiritual care can be perceived by such patient as a need for understanding their own lives, suffering and death [4].

Aim: The study was carried out as a pilot study in the project KEGA no. 007KU-4/2018 focused on professional applied ethics in the teaching process at the Faculty of Health in Ružomberok. The main aim of the study is to identify the psychosocial, spiritual and religious needs of the patients on the basis of a survey carried out in designated health care facilities in Slovakia. Based on our research, we tried to identify the components that affect patients' needs most, especially, how severity of diagnosis is influencing patient's needs.

2 Methods

2.1 Study design and setting

In our survey, we used the standardized questionnaire The Spiritual Needs Assessment for Patient – SNAP constructed by Sharma Rashmi [5]. This questionnaire is divided into three domains: psychological needs, spiritual needs and religious needs. The questionnaire has been filled on the basis of the Likert scale with values: 4 = very, 3 = little, 2 = not very, 1 = not at all. The patient – the respondent tells in the first domain how much help they need with the individual problems, in the second domain they talk about the problems and in the third domain what great benefits the actions for them are giving. Respondents can fill in the questionnaire independently – if their health status allows them, or data collector help them fill out by way of an interview. Responses were analyzed by SPSS statistical program with $p < 0.01$ and $p < 0.05$.

Research was carried out in 2017 and 2018 in several health care facilities and also in homecare agencies in regions of Ružomberok, Banská Bystrica and Liptovský Mikuláš.

2.2 Research sample and limitations

The final research sample consisted of 113 respondents: 44.2% men and 55.8% women. 69 respondents belong to Christian faith, 13 belong to another faith, 7 did not give religion

Table 1. Pearson correlations for questionnaire SNAP – Domain of Psychological Needs.

Q = questions of SNAP		Q 01	Q 02	Q 03	Q 04	Q 05
Gender	Pearson Correlation	.016	-.156	-.134	-.067	-.151
	Sig. (2-tailed)	.865	.098	.159	.478	.109
Age	Pearson Correlation	-.034	-.030	-.039	-.067	-.003
	Sig. (2-tailed)	.720	.753	.680	.483	.978
Education	Pearson Correlation	-.021	-.181	-.068	-.123	-.082
	Sig. (2-tailed)	.824	.055	.475	.196	.388
Income	Pearson Correlation	-.043	-.045	-.009	-.031	.055
	Sig. (2-tailed)	.652	.639	.928	.742	.566
Religion	Pearson Correlation	-.038	-.122	-.091	.007	.006
	Sig. (2-tailed)	.688	.198	.336	.940	.948
Residency	Pearson Correlation	-.023	-.002	.086	-.059	.038
	Sig. (2-tailed)	.813	.985	.364	.534	.689
N		113	113	113	113	113

* Correlation is significant at the level $p < 0.05$ **Correlation is significant at the level $p < 0.01$.

and 24 identified themselves as unbelievers. A fatal (deadly) diagnosis was determined in 49.6% of respondents and not life-threatening in 50.4% of respondents. We addressed to 150 respondents, but 21 were excluded due to unfavourable mental state and 16 questionnaires were excluded due to incomplete filling. Limitation was set up as:

1. The first set of patients, hospitalized in standard hospital departments with not life-threatening diagnoses. The removing criteria are: severe cognitive deficits, sensory deficit, terminal status, and psychiatric illness according to patient's documentation. The age limit is from the age of 18 to 65 years.
2. The second group patients, hospitalized in the oncology department – incurably ill. The defining criteria are: severe cognitive deficits, sensory deficits, and the incidence of psychiatric illnesses as documented. The age limit is from the age of 18 to 65 years.

The division into groups was chosen in order to compare the satisfaction of psychosocial, spiritual and religious needs among groups. We wanted to find out if incurable diagnoses were influencing satisfaction the patient's spiritual needs.

3 Results and discussion

Reliability of questionnaire is given by Cronbach's Alpha 0.945 for the total SNAP. Authors Andradi et al. achieved Cronbach's Alpha 0.921 for the total SNAP on the similar research with the sample of 433 respondents [4]. Authors of the questionnaire in research related to the validation of this instrument achieved Cronbach's alpha for the total SNAP 0.95, with the psychosocial subscale 0.74, the spiritual subscale 0.93, and the religious 0.86 [5]. This means that questionnaire is strongly reliable, valid and consistent.

In domain of psychosocial needs, significant difference was not confirmed in one question regarding to gender, age, education, income, religion and residency. The result can be seen in Table 1.

Table 2. Pearson correlations for questionnaire SNAP – Domain of Spiritual Needs.

Q = questions of SNAP		Q 06	Q 07	Q 08	Q 09	Q 10	Q 11	Q 12	Q 13	Q 14	Q 15	Q 16	Q 17	Q 18
Gender	Pearson Correlation	-.112	-.163	-.045	.017	.009	-.162	-.140	-.054	.223*	.185*	-.130	-.029	.065
	Sig. (2-tailed)	.238	.085	.640	.858	.923	.087	.138	.568	.018	.050	.170	.758	.497
Age	Pearson Correlation	.047	.117	.027	.041	-.091	.116	-.032	-.178	-.095	-.031	-.121	-.104	-.056
	Sig. (2-tailed)	.623	.217	.779	.666	.336	.220	.735	.059	.319	.743	.201	.272	.553
Education	Pearson Correlation	-.095	-.047	-.069	-.165	-.063	-.049	-.066	.259*	-.035	-.157	-.111	-.113	-.064
	Sig. (2-tailed)	.317	.618	.470	.080	.507	.603	.486	.006	.714	.096	.240	.233	.500
Income	Pearson Correlation	.063	.148	.020	.048	.003	.101	-.026	.186*	-.075	-.034	-.107	-.078	-.006
	Sig. (2-tailed)	.506	.118	.831	.610	.976	.289	.788	.049	.428	.723	.261	.409	.946
Religion	Pearson Correlation	-.061	-.036	-.032	.212*	.274*	-.115	-.016	.191*	-.062	-.103	-.136	.219*	-.174
	Sig. (2-tailed)	.518	.708	.738	.024	.003	.224	.867	.042	.513	.278	.150	.020	.066
Residency	Pearson Correlation	.097	.042	.101	.011	-.007	.168	.061	-.014	.078	-.011	.012	.070	-.014
	Sig. (2-tailed)	.308	.662	.286	.908	.943	.076	.522	.882	.411	.905	.901	.458	.887
N		113	113	113	113	113	113	113	113	113	113	113	113	113

* Correlation is significant at the level $p < 0.05$ ** Correlation is significant at the level $p < 0.01$.

This means that there is not a direct dependence between severity of diagnosis and satisfaction of psychological needs of the patient. In contrast, authors Elizabeth Luth at Holly Prigerson in her study focused on the relationship between advance care planning and sadness and anxiety at the end of life. In the study, 315 respondents stated that surely there was some distinction in feelings and ways of coping with advance care planning [6]. After the patient first learns that they have diagnosis of an incurable disease, they are on the way of dealing with this. Their ability to cope with illness depends heavily on themselves, on their inner attitude to life. Often, however, this attitude affects the patient's belief. In many cases, we find that the dying is afraid of death.

In domain of spiritual needs, a significant difference was partially confirmed regarding religion and gender in 6 questions of 13. Detailed results are shown in Table 2.

Spiritual care is an important component of high-quality health care, especially for critically ill patients and their families. In addition, it is common that spiritual care resources that can improve both patient outcomes and family member experiences are underutilized [7]. As to gender, significant correlation at the level of 5% was in the question 14 = death and dying as well as in 15 = finding peace of mind. The difference is quelling from the divergence in attitudes and manifestation of feelings of men and women. Women are usually more willing to talk about their problems and inner feelings. Men are usually closed in time of suffering. They do not like to manifest anything that can be pointing at their weakness.

Table 3. Pearson correlations for questionnaire SNAP – Domain Religious Needs.

Q = questions of SNAP		Q 19	Q 20	Q 21	Q 22	Q 23
Gender	Pearson Correlation	–.143	–.068	–.011	–.203*	–.100
	Sig. (2-tailed)	.130	.476	.911	.031	.290
Age	Pearson Correlation	.073	–.066	–.102	–.035	–.179
	Sig. (2-tailed)	.440	.485	.283	.713	.057
Education	Pearson Correlation	–.038	–.126	–.219*	–.081	–.098
	Sig. (2-tailed)	.686	.185	.020	.393	.304
Income	Pearson Correlation	.098	–.053	–.105	–.032	–.168
	Sig. (2-tailed)	.304	.576	.269	.735	.075
Religion	Pearson Correlation	–.117	–.114	–.026	–.050	–.102
	Sig. (2-tailed)	.216	.231	.784	.600	.280
Residency	Pearson Correlation	.116	.045	.048	.177	.105
	Sig. (2-tailed)	.222	.632	.614	.060	.271
N		113	113	113	113	113

* Correlation is significant at the level $p < 0.05$ **Correlation is significant at the level $p < 0.01$.

In domain of religious needs, significant correlation between gender groups in question 22 and between groups of different education in question 21 at the level 5% was confirmed.

Responses for questions 23: “What great benefits the actions for him/her give religious rituals such as chant, prayer, lighting candles or incense, anointing, or communion?” have emerged from the situation in Slovakia in the last 20 years. Looking into church ceremonies in Slovakia (no matter of a particular belief) you can see the remarkable predominance of the women who take part in them.

Responses for questions 22: “What great benefits the actions for him/her give visits from fellow members of your faith community?” are revealing the situation, when younger patients belong to different religious groups and movements based on strong interpersonal communication and attachment. The generation of people from 20 to 50 at the same time have had better opportunity to complete study at the university level. Nowadays in Slovakia about 45% of young population achieve university level of education. Authors Johnson, Engelberg, Nielsen et al. in their research focused on association of spiritual care provider’s activities with family members’ satisfaction with care. They detected a significant association between the discussions on patients’ wishes for end-of life care and higher overall assessments experience. Possibly, the opportunity for family members to give voice to the patient’s wishes and have this acknowledged by a spiritual care provider ensures some support [8]. Andrási in his research that was conducted among paramedics pointed out that the spiritual needs of a dying person can sometimes be overlooked while dealing with physical care. However, for those experiencing it, spiritual distress is very real [9]. Role of spiritual provider is very important for believers, because the medical staff – doctors, nurses and paramedics are often too busy with medical solutions.

4 Conclusions

Even though it is possible to identify the four basic dimensions of spiritual need: interconnection, peace, meaning/purpose, and transcendence the majority of patients often have a problem addressing their needs related to psychosocial and spiritual domain because of dominant physical problems such as physical disability, fatigue, sleep disorders, side effects of treatment, etc. If we want to provide good and complex nursing care, we need to assess the presence of symptoms and their severity [10]. The importance of satisfaction of psychosocial and spiritual needs is increased in time of threat and fatal diagnosis, especially in women. Generally, we have not confirmed deep interdependence between the seriousness of the diagnosis on the one hand and gender, age, education, income, religion and residence on the other. Despite the benefits of increased longevity, it is widely acknowledged that enough has not been done to adequately address end-of-life care decisions at the crossroads between medical futility and quality of life [11]. The person with their needs remains essentially on the way they are brought up and how they were accustomed to act before the onset of the illness.

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