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Understanding Patients' Spiritual Issues During Hospitalisation: A Qualitative Study

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Abstract

Introduction: A holistic approach to patient care emphasises the need to consider not only physical and mental health but also spiritual well-being. Objective: This study aimed to explore patients' spiritual issues during hospitalisation. Methods: This study employed a qualitative design. Ten participants were recruited through purposive sampling. They participated in in-depth, face-to-face, audio-recorded, one-time interviews using a semi-structured interview guide. All interviews analysed using thematic analysis. Results: Five themes were identified concerning patients' spiritual issues during hospitalisation: 1) physical and emotional suffering, 2) unexpected health diagnoses, 3) loneliness of illness, 4) emotional impact of hospitalisation, and 5) neglected religious practice. Conclusion: Patients require more than just medical interventions; they also need spiritual care to aid their healing process and treatment. These findings highlight the importance of healthcare professionals conducting spiritual assessments of patients and taking necessary actions when they are admitted to hospital.

Keywords: *Spirituality, Patient Participation, Qualitative Research*

INTRODUCTION

Spirituality is defined as "a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred" (Nolan et al., 2011:88]. This broad definition highlights spirituality as a fundamental dimension of human existence, deeply intertwined with how individuals make sense of their lives and connect with the world around them. Despite its profound significance, spirituality has historically received less attention in healthcare compared to the physical, psychological, and psychosocial aspects of patient care (Harrison et al., 2009). This neglect presents a significant concern as being diagnosed with a disease and requiring hospitalisation can impact more than just a patient's physical health; it also deeply affects their spiritual well-being.

Pearce et al. (2012) emphasised the importance of addressing spiritual needs, noting that nearly 91% of patients expressed a need for spiritual care during their medical treatment, and when these needs are unmet, patients are at increased risk of depression, a diminished sense of spiritual meaning, and a loss of inner peace. These findings highlight the critical role that spirituality plays in patient health and well-being, suggesting that neglecting this aspect of care can lead to significant emotional and psychological distress. Moreover, studies have recognised that spiritual distress can occur at any stage of a patient's journey, from diagnosis through treatment and recovery, making it essential for healthcare staff to be fully prepared to provide spiritual care whenever it is needed (Giske & Cone, 2015). Effective spiritual care requires more than just awareness; it demands that healthcare professionals are trained and equipped to respond compassionately and competently to the spiritual concerns of their patients.

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Despite the growing recognition of the importance of holistic healthcare, which aims to treat the whole person rather than just the disease, the integration of spirituality into patient care remains limited. Most existing research has predominantly focused on the psychological and physical dimensions of health (Doan et al., 2023), with spirituality frequently being treated as a secondary consideration. This gap in care can lead to incomplete treatment plans that fail to address the full spectrum of patient needs. Recognising this gap, the current study aimed to explore patients' spiritual issues during hospitalisation as a crucial first step toward developing and refining services that address these concerns. By focusing on spirituality within the context of patient care, this study aligns with a person-centred approach, which emphasises the importance of understanding and responding to each patient's unique needs, values, and experiences. Addressing spiritual issues as part of a comprehensive care plan not only improves patient outcomes but also contributes to a more compassionate and humane healthcare system.

METHODS

This study employed a qualitative design, which is appropriate research design when the researchers need to understand the contexts in which respondents or participants can address the issue or problem (Islam & Aldaihani, 2022). The experience of spirituality during hospitalisation may vary among participants, potentially leading to the construction of multiple perspectives that can be understood through a qualitative design. Qualitative research focuses on "the processes by which people construct meaning and to describe what those meanings are" (Bogdan & Biklen, 2007:43). Therefore, qualitative research attempts to interpret phenomena or events in relation to the meanings that people attribute to them. This study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al., 2007).

Setting and Samples

Participants were approached face-to-face by healthcare staff, who acted as gatekeepers from one teaching hospital through purposive sampling based on specific criteria: male/female, age 18 and above, diagnosed with acute or chronic disease, and admitted for at least three days. The study continued to interview participants until data saturation was reached, meaning the process was stopped once interviews ceased to yield new information or contribute additional codes for analysis (Guest et al., 2006). In this study, data saturation was reached after 9 interviews. One additional interview was conducted to confirm data saturation.

Data Collection

Participants were recruited from May 2023 until November 2023. Prospective participants who met the inclusion criteria were approached by the healthcare staff in the ward and provided a simple explanation of the study. Those who expressed interest in participating received a patient information sheet outlining the study details. After the participants agreed, the healthcare staff introduced the researcher, NAH, to the potential participants. The interview was conducted by NAH, a female master's candidate. Before data collection, NAH had a training session with WHWM, who has extensive experience in qualitative research. Prior to the interviews, the researcher took time to build rapport with the participants. The researcher applied semi-structured interview guide that had been developed with the help of the expert team members and already tested during the pilot study. Examples of the main questions: What are the problems that you faced during hospitalisation? How does these problems affect your emotion, life? Explain the situation or event. Additional questions and clarifications were requested based on the responses of the participants. All interviews were conducted in Malay language. The interviews were conducted in an informal, semi-structured, and face-to-face manner. Voice recorders were used with the participants' consent in addition to taking notes, ensuring comprehensive capture of the conversation for accurate transcription and subsequent data analysis. Most of the interviews took place in the ward at the convenience room between the researcher and the participant. No one else was present during the interview. Each interview lasted between 20 and 40 minutes.

Data Analysis

Thematic analysis was applied to analyse the data. It is a technique that identifies themes within the data, with the themes forming the basis of categorisation (Fereday & Muir-Cochrane, 2006). This method entails a detailed examination of the data, where the researcher meticulously codes the data to uncover meaningful

themes. The codes and themes that are generated serve to integrate data gathered by different methods (Bowen, 2009). Data analysis was conducted in Malay language. The first step involved a thorough transcription of the data from the notes and audio recordings. After completing the transcription process, two researchers (NAH & WHWM) read and re-read the transcripts multiple times to familiarize themselves with and understand the participants' experiences. The researcher then scrutinised the transcripts, actively searching for significant meanings and patterns. The second step involved generating initial codes that represent the meanings and patterns in the data. This phase included discussions within the research team composed of qualitative research experts (NAH, WHWM, NMS, ACA, SM and SNIJ), to identify pertinent text segments and assign appropriate codes. Excerpts that represent the same meaning were grouped under the same code. Any discrepancies among the researchers were resolved by referring to the participants' interview transcripts, audio recordings, reflective diaries, and field notes. The next step was to sift through these codes to identify potential themes, ensuring the cohesiveness and relevance of each theme. Later, the themes were defined and named. The reporting phase included a detailed presentation of the findings, with a quotation example. Finally, the selected quotes were translated into English for publication and verified by a certified translator. The use of NVivo software helped organize the data into specific themes, making the reporting process more efficient.

Trustworthiness

Tobin and Begley (2004) suggest that dependability and confirmability in research can be achieved by maintaining an audit trail. In this study, an audit trail was meticulously kept to record every step and any modifications made during the data collection, analysis, interpretation, and reporting phases. The researcher extensively recorded observations about the research process, interactions with participants, thoughts, emotions, and analytical interpretations in a research diary, which accompanied the audit trail. Additionally, the study's rigorousness was enhanced by engaging in discussions with the research team, comprised of experts in qualitative research. The discussions indirectly provided critical insights and feedback, further ensuring the integrity and reliability of the research findings.

Ethical considerations

Participation in the study was voluntary, and all participants were informed of their rights to withdraw at any time without any repercussions. Before collecting the data, written consent was secured from each participant. The interviews were recorded with the participant's consent, ensuring that their data remained confidential and anonymous. This study was approved by the XX Postgraduate and Research Committee (XXPGRC) and the ZZ Research Ethics Committee (Approval no: IRXX-20XX-0XX).

RESULTS

A total of 20 participants were invited to participate, of whom 10 declined due to health conditions or lack of interest. Therefore, ten participants participated in this study, and their backgrounds are summarised in Table 1.

Table 1. Socio-demographic characteristics of the participants (n=10)

Variables		n
Age (years old)	35-55	
Gender	Male	7
	Female	3
Marital	Married	6
Status	Divorced/widowed	4
Days admitted	11– 45 days	
Diagnosis	Acute	
	Femur fracture	1
	Tibia/fibula fracture	1
	Spinal fracture	2
	Patella fracture	1
	Septic shock	1
	Chronic	
	Pancreatic cancer	1
	Colorectal cancer	1

Chronic kidney disease	1
Chronic meningitis	1

The analysis revealed five themes related to patients' issues during hospitalisation: 1) Physical and emotional suffering, 2) Unexpected health diagnosis, 3) Loneliness of illness, 4) Emotional impact of hospitalisation, and 5) Neglected religious practice.

Theme 1: Physical and emotional suffering of illness

Some participants experienced emotional and physical distress during their illness. They reported persistent crying, significant pain, immobilisation, feelings of sadness, hopelessness, and being engulfed by negative emotions that sometimes lead to considerations of psychiatric referrals.

> "… I could say that I cry most of the time. I am in pain and could not walk until, at one point, the doctor wanted to refer me to [a] psychiatrist. I [was] really depressed at that moment. It is really hard to go to the toilet…" (P7)

> "… When I am sick, I feel sad and hopeless. I feel all the negativity feelings surround me…" (P6)

> "… I feel down and feel sad, I am in pain, I could not walk…" (P10)

Theme 2: Unexpected health diagnoses

One participant reflected on her initial shock and profound sadness upon receiving a cancer diagnosis. This emotional turmoil is often expressed through days of crying, illustrating the intense personal struggle and the initial phase of coping with the diagnosis.

> "… At first, when I knew I got cancer, I was really sad. I ask God, 'why me?' My family members have no history of cancer. I cried for a few days…" (P8)

Theme 3: Loneliness of illness

Some participants expressed deep sadness and a feeling of isolation, indicating the lack of listeners or supporters who fully understand their struggles.

"… I truly feel sad, I have no one to listen to me…" (P10).

> "… I need a companion. I feel sad and afraid to be here alone. Only my children understand me well…" (P4)

> "… Honestly, having no companion affects me. As a father, I feel sad when my children do not come and visit me. But it is okay, I know it is my fault. I failed to teach my children…" (P8)

Theme 4: Emotional impact of hospitalisation

Two participants expressed their desire to go home, indicating a need to escape from the clinical environment that affected their emotions.

"… I don't want to think too much about hospital. I want to go back home…" (P6)

> … I have mixed feelings. I don't like hospitals. I have never been warded. I have been forced by my children and doctors here. I have to obey. I would escape from this hospital if I could… (P9)

Theme 5: Neglected religious practice

Two participants highlight about their challenges when trying to practice their religious rituals, such as prayer in a hospital setting.

> … On my early admission, there is no one taking care of me, if I able to take ablution, then I will pray, but if I can't, then I do not perform my prayer… (P1)

> … I feel not comfortable to perform prayer, the floor is dirty, and the ward environment is quite noisy when I want to perform prayer… (P8)

DISCUSSION

This study was conducted to explore the perspectives on spiritual issues held by patients during hospitalisation, recognising that the experience of illness often extends beyond physical symptoms. Hospitalisation can be a particularly challenging period for patients, as they face not only the physical discomforts associated with their disease but also the psychological burden of sadness, stress, and hopelessness. These emotional states are frequently exacerbated by spiritual distress, a condition that is deeply interconnected with depression. When individuals encounter spiritual distress, they may experience a range of debilitating symptoms, including insomnia, pain, fatigue, feelings of guilt, fear, anger, anxiety, loneliness, alienation, and a profound lack of hope, meaning, and serenity in their lives (Caldeira et al., 2013). In this study, for example, the overwhelming nature of pain and the restrictions on patients' physical movement lead to a sense of helplessness and depression. even during basic daily activities, such as using the toilet. This sense of dependency and loss of control can deepen their feelings of isolation and exacerbate their spiritual struggles. As De-Diego-Cordero et al. (2024) have reported, effectively managing pain should involve not only pharmacological interventions but also therapies that incorporate spiritual care, as the acceptance of pain through spiritual means can directly reduce its perceived intensity.

This study revealed that patients often experience profound shock and emotional turmoil upon receiving a serious diagnosis, such as cancer. The unexpected nature of the diagnosis, especially in the absence of any family history of the disease, compounds the confusion and despair, prompting existential questions like, "Why me?" This poignant question reflects a deep inner struggle as patients grapple with the reality of their illness and its implications for their lives. Velosa (2023) stated that questions such as "Why me?" and "What is the meaning of my suffering?" which often arise during times of illness, illuminate a person's search for meaning and connection with themselves, others, or the sacred, and are indicative of the complex process of spiritual coping that can manifest in both positive and negative ways. Spirituality plays a significant role in helping patients cope with the worsening of physical symptoms (Buck & Meghani, 2012) and the psychological distress that often accompanies serious illnesses (King et al., 2013) aiding them in finding value and meaning in life even in the face of debilitating conditions (Shi et al., 2023). Given the profound impact of spirituality on patients' well-being, it is essential for healthcare professionals to be attuned to the spiritual needs of their patients, which requires not only clinical expertise but also a deep sensitivity to the underlying purposes and meanings in a patient's words and actions (Melis et al., 2020).

This study revealed that participants experienced a profound sense of loneliness and an intense need for companionship during their illness. The fear of being alone while in such a vulnerable state was a significant concern for many, highlighting the emotional and psychological challenges that accompany physical illness. This sense of isolation emphasised the critical importance of empathetic support during hospitalisation. The study by Pearce et al. (2012) supports these findings, revealing that some patients sought to make sense of what had happened to them during their hospital stay. Furthermore, the value of empathetic listening cannot be overstated. Research has shown that patients greatly appreciate having their concerns acknowledged and having someone who listens to them without judgment (Fitch et al., 2019). Despite the clear need for spiritual and emotional support, there is evidence that these aspects of care are often neglected in practice. Selman et al. (2018) reported that, although spiritual care is recognised as both necessary and important, it is frequently overlooked by healthcare professionals.

This study also revealed that physical limitations and the hospital environment significantly impacted patients' ability to engage in their usual religious practices. Many patients found it challenging to maintain their religious routines due to the physical constraints imposed by their illness. Abbasi et al. (2018) reported that several factors, including physical conditioning, lack of knowledge among healthcare providers, and the absence of requests for religious care, serve as barriers to fulfilling the spiritual and religious needs of hospitalised patients. These barriers can prevent patients from accessing the spiritual support they need, which is especially important during times of illness when their reliance on religious practices for comfort and strength often increases. When patients are hospitalised, their need for spiritual and religious practices often

becomes more increase, as these practices provide a sense of peace, hope, and connection to their faith, leading them to rely on the support of healthcare team members to assist in maintaining these practices during their hospital stay (Abbasi et al., 2016). Despite the critical importance of religious care for hospitalised patients, research indicates that this aspect of care is often insufficiently addressed, and the religious needs of patients are frequently overlooked (Basiri et al., 2015). This neglect can exacerbate the emotional and spiritual distress experienced by patients, as they may feel disconnected from their faith and deprived of the spiritual resources that are vital to their well-being.

Another significant finding in this study that contributes to the existing knowledge base is the patients' aversion to hospitalisation and their strong longing for the familiarity and comfort of home. Many participants expressed a clear and straightforward desire to return home, highlighting their need to escape the impersonal environment of the clinical setting. This yearning for home highlights not just a preference for physical comfort but also a deeper emotional and psychological need for the safety, security, and spiritual solace that home represents. The hospital environment, while designed to treat physical ailments, can sometimes exacerbate feelings of isolation, fear, and spiritual disconnection, contributing to patients' discomfort and distress. Supporting this finding, Ellis et al. (2013) found that nearly 30% of respondents in their study reported spiritual issues directly associated with their hospitalisation. When confronted with spiritual doubts or questions, especially within the healthcare setting, patients often face the challenge of not knowing where to turn for assistance (Fitch & Bartlett, 2019). According to Yousefi and Abedi (2011), patients enter an unfamiliar environment. Hence, the hospital should assign a person for this purpose and provide them with essential training, such as physical engagement, that may remarkably cause spiritual changes in patients' past and future attitudes and behaviours (O'Brien, 2003).

A significant limitation of this study is its reliance on participants from only one hospital, which inherently restricts the diversity of the patient population and the generalizability of the findings. Despite this limitation, the study's use of in-depth, face-to-face interviews provided a robust method for gathering detailed and nuanced data. These interviews allowed for a deep exploration of participants' experiences and perspectives, thereby enriching the study's findings. Another limitation of the study is the exclusive recruitment of Malay participants. This focus on a single ethnic group means that the findings may not fully capture the spiritual issues and needs of patients from other ethnic backgrounds, such as Chinese and Indian communities, who may have different religious beliefs, spiritual practices, and cultural perspectives. This lack of ethnic diversity in the sample limits the study's applicability to Malaysia's multicultural population, where spirituality and religious practices are deeply intertwined with cultural identity. To address these limitations, future studies should aim to include a more diverse sample of participants by recruiting patients from various types of hospitals across Malaysia, including public, private, and teaching hospitals. By expanding the scope of the research to encompass a broader range of healthcare settings and a more diverse patient population, future studies could improve the representativeness and generalizability of the findings.

CONCLUSION

In conclusion, the findings of this study emphasize the critical importance of recognizing and addressing the spiritual needs of patients within healthcare settings. Spiritual issues, which can manifest in various forms such as physical and emotional suffering, feelings of loneliness, serious diagnosis, admitted to the hospital and neglected religious practice, are often intertwined with patients' overall well-being. The ability of healthcare professionals to identify these issues plays a pivotal role in the comprehensive care of patients. It is highly beneficial for patients if healthcare providers not only recognise when an individual is grappling with spiritual concerns but also take proactive steps to connect them with appropriate resources. This may include referring the patient to a hospital chaplain, contacting the patient's religious leader, or involving another staff member who shares similar beliefs and can offer spiritual support. Moreover, there was a paucity of assessment instruments with validity evidence to guide healthcare professionals in identifying spiritual distress in patients within the inpatient setting (des Ordons et al., 2018). Moreover, healthcare professionals should be equipped with a deep understanding of the diverse spiritual beliefs, faiths, and practices that their patients may hold. This cultural and religious competence is essential for delivering personalized spiritual care that respects and

aligns with the patient's values and needs. It is not merely about acknowledging these beliefs but also about integrating this understanding into the care plan in a way that is sensitive and supportive.

These findings further highlight the necessity for healthcare professionals to adopt a holistic approach to patient care—one that integrates physical, mental, and spiritual health into a unified framework. By viewing spirituality as a fundamental human need and an inherent right, healthcare professionals can foster environments that promote healing not just of the body and mind, but of the spirit as well. Such an environment is characterised by empathy, respect, and a commitment to addressing the full spectrum of patient needs. Ultimately, recognising and addressing spiritual well-being is a crucial component of comprehensive patient care, and it contributes to the overall effectiveness of the healthcare system in providing compassionate, patient-centred care.

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Conflict of Interest

The authors have no conflicts of interest to disclose.

Data Statement

The research data are confidential.

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