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Religious Care by Clergymen at the Patients' Bedsides: Its Impact on Spiritual Health

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Abstract

Background and Objectives: Disease is a matter with which each person may face in his life. If caregivers want to provide real and complete health care services, comprehensive attention to the spiritual needs of a patient is indispensibe. Since many people obtain spirituality through religion, appropriate religious care can promote spiritual health of patients. This research aimed at examining religious care program and determining the impact of religious care on spiritual health of hospitalized patients provided by the clergymen at the patients' bedsides.

Methods: In this clinical trial, 142 patients hospitalized in Qom Nekuoei hospital were selected randomly and divided into experimental and control groups. After completing the questionnaire on demographic information and spiritual health questionnaire by the participants, religious care program was implemented in the experimental group and then the two groups were followed after intervention.

Results: The two groups had no statistically significant difference before intervention in spiritual health score and its domains (religious health and existential health) but after intervention there were statistically significant differences. Spiritual health score and its domains increased after the intervention ($P<0.000$).

Conclusion: Religious care provided by clergymen at the patients' bedsides increases patients' spiritual health and their ability to cope with illness as well as reduce complications of the disease.

Keywords: Clergymen, Randomized Clinical Trial, Religious Care, Spiritual Health.

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Introduction

Disease is a problem which each person may face in his life. As such, the patient needs to enhance his physical and spiritual needs so as to regain the full health and continue his life and activity. Paying heed to spiritual aspects could have a significant role in increasing the patient's ability to confront his disease. It can also leave an impression on increasing the patient's satisfaction with the provided services.

Health care providers have realized that if they want to provide real and complete health care services, comprehensive attention to the spiritual needs of a patient is required (1) There are several perceptions about how to deal with the problems and stresses resulting from the disease. Spiritual health is one of these concepts. Spiritual health as one of the aspects of health results from the integration of other aspects and contains both existential and religious dimensions. Religious health and existential health refer to satisfaction with connection with superior strength and the strife for understanding the meaning and purpose of life, respectively. Spirituality and spiritual growth in human being and their roles in different phases of his life have increasingly attracted the attention of psychologists and mental health experts in recent decades (2). Studies have shown that individuals with spiritual tendencies, when dealing with trauma, have a better response to the situation in which they are. They also manage stressful situations more efficiently and possess better health (3-5). Providing the spiritual care of patients has also been linked to higher levels of welfare, and spiritual skills and values have been increasingly recognized as necessary aspects of clinical care (6). In the last two decades, spirituality has been emphasized as playing a significant part in relation to the process of inspecting the quality of life. Some studies indicate the relationship between spirituality on the one hand and physical and mental health as well as the promotion of compatibility with a disease on the other hand (7).

Many people obtain spirituality through religion. Due to the fact that there is variation among the people, what makes a person feel comfortable may not answer for others. As a result, prayers, reading the book of Revelation or other holy books, or being engaged in religious services are among those resources that some religious people- who possess them- will suffer less in the face of stressful events of life (8). Spirituality and religion overlap, however, sometimes people interpret them as spiritual health and religious practices (9) in the sense that both probably include seeking meaning and aim, connection and values (10). Spiritual health has been considered the central philosophy of life and also the outcome of meeting the need for the purpose, meaning, love, and forgiveness (11). Although certain aspects of religiosity have provided fairly consistent positive findings (12), the exact nature of the relationship between the religious factors and the health aftereffects is unclear(13).

The need for religious care is very important from the patients' point of view. Hospital health-care authorities and planners have been recommended that religious care be embraced as part of their hospital intensive care (14) Hospitals should give patients and their families the opportunity to practice their religious duties and cultural beliefs and hospitals, in turn, should be prepared for providing religious services if requested by patients. The results of the study by Abedi et al. suggested that the barriers to meet the religious needs of the patients were nurses' lack of knowledge, lack of clear guidelines with regard to providing this type of care and the absence of clergymen at all shifts for answering the religious questions of patients (15). In the study by Soleiman Zand et al. it was shown that 80% of patients believed that the presence of a religious expert in the hospital was necessary for them to consult with regarding religious matters (14). When someone is sick, in addition to the need for medication, medical care and nursing, he needs a clergyman who can strengthen his resolve not to give in during the difficult time of his disease. The presence of a clergyman is, thus, of paramount importance while gaining health is not possible and patients are asking about the meaning of life. Clergymen as experts in spirituality can comfort patients conveniently during their very difficult days in hospitals.

Since we live in a country that observes religious laws and values as an integral part of life and even at the moments of death, thus adhering to religious principles and meeting the religious needs of patients are necessary. Many researches need to be conducted so as to identify the best practice in giving religious care, the extension of which could play an important role in faster recovery and contribute to patients' spiritual and mental health. So far, the impact of giving religious care by a clergyman on spiritual

health of patient has not been studied. The aim of this study is to determine the effect of religious care by the presence of a clergyman at the patients' bedsides on spiritual health of hospitalized patients. The impact of giving religious care at the patients' bedsides on spiritual health by a clergyman, who is considered a representative of a religious society and a religious expert in the minds of public, and the relationship between religion and spirituality are also to be examined in this study.

Methods

This study was a controlled clinical trial conducted in 2014. It attempted to determine the effect of giving religious care by a clergyman at the patients' bedsides, who have been traumatized by depression and anxiety and their spiritual health, and hospitalized in Nekouei hospital of Qom. The inclusion criteria of samples set in the study were as follows: 1-Patients being hospitalized at the time of study 2-Participants' willingness to enter the study and obtaining written letter of consent from them 3-The ability of participants to answer the questions 4-Not taking anti-anxiety medicine or antidepressants during the study 5-Being Muslim. The exclusion criteria of samples set in the study were as follows: 1-Having a history of mental problems, active background diseases, or mental retardation 2-The reluctance of the patients to continue the study 3-Causing any difficulty to continue the study for the patients, discharging from hospital, or transferring the patients to other hospitals 4-A history of psychotropic agents and narcotic drugs. The stratified random sampling was chosen in this study. In light of the study by Tahereh Momeni et al (16) and their formula and considering 95% confidence interval and 80% power of test, about 66 participants were assigned to each experimental and control group in which the total sample size reached 132 participants. Taking into account the possible loss of samples, on the whole 142 subjects were finally selected.

At first, among the three hospitals affiliated to Qom University of Medical Sciences, one hospital was chosen and after obtaining the patients' letter of consent for the study, they were given a questionnaire of personal and demographic information. After receiving their initial personal information, if they had the conditions of the study, the participants would take part in the study and then the "spiritual health" questionnaire by Palutzian and Ellison (17) was given to participants in the two groups in order to measure the spiritual health. The questionnaire consisted of 20 questions, 10 of which measured religious health and the other 10 estimated existential health. The range of religious and existential health was from 10-60, separately. There was no level of sub-groups for religious and existential health and evaluation was only based on the scores. The higher the score on one of the tests indicated, the better existential or religious health. The spiritual health was the sum of these two sub-groups with the range of 20 to 120. The questionnaire items are answered on a six-option Likert-type scale, ranging from strongly disagree to strongly agree. And in the end, spiritual health was divided into three groups, lower-level (20-40), medium (41-99) and high (100-120). In the study by Seyyed Fatemi et al. the validity of spiritual health was determined via content validity and its reliability was measured to be 0.82 through Cronbach's alpha (18).

For the sake of making both experimental and control groups equal in the experiment, each participant in the sample had an equal and independent chance of being assigned randomly to the two groups. And the interval was suitable enough to prevent the distortion of results that may be caused by the interaction among the patients.

After that, appropriate intervention regarding religious care was designed and applied to patients in the experimental group. Type, content, method, and the manner of manipulating intervention were thought out after consultation with project partners, including consultations with religious experts and fellow psychologist. Finally, with regard to each patient's condition, the religious factor was introduced by the clergyman at the bedside to meet the patients' religious and spiritual needs.

Practical and informative articles with the following topics were described by the clergyman to the patients:

-The role of afflictions and divine examinations in this mortal worldly life

-The eternal power of God in healing the sick, and reliance on God for healing

-Using the opportunity to communicate with the Creator and remembrance of God

-Thinking about his or her past and future actions and decisions to compensate for the failures of the past and planning for the future

-The wisdom behind pleasant and unpleasant events of life and the hope for the mercy and grace of God at all times

-The place of afflicted and disease-stricken human before God and the role of disease in bestowing a redemption by God

-The manner and quality of carrying out religious duties and prayers

-Responding to the questions and religious doubts of patients

-Providing an environment for worship and religious practices

One to two days after religious intervention, the rate of spiritual health of experimental and control groups was assessed by the questionnaire again. The significance level of less than 0.05 was taken into account in all stages of the study and statistical analysis. The statistical software SPSS was used in order to extract and analyze data

Results

142 patients who were admitted to Nekouei hospital of Qom participated in the study. The participants' age range was from 16 to 80 years (34±14). 41% of them had the history of hospitalization, 52% had never been hospitalized and 7% gave no answer. 78% of patients had injuries which compelled them to have surgery and 5% were not in need of surgery. 17% of them were unspecified. Table 1 indicates the absolute frequency distribution and characteristics of the participants' illness.

Table 1 - The characteristics of the study sample

Variable		Frequency	Percentage
Level of education	Illiterate	4	2.8
	Elementary	28	19.7
	Middle School	54	38
	High School	34	23.9
	The academic	17	12
	No Answer	5	3.5
	Total	142	100
Hospital department	Orthopedics	49	34
	General surgery	52	37
	Neurosurgery	11	8
	Burn	20	14
	Other	10	7
	Total	142	100

Independent-sample t-test revealed that there was no significant difference between the mean scores of spiritual health in both experimental and control groups before the intervention (P=0.87). However, after intervention, there was a

significant statistical difference in the mean scores of the two groups (P=0.001). Paired-samples t-test displayed that there was a significant difference in the spiritual health score of the experimental group, before and after the intervention (P<0.000). However, there was no statistically significant difference in the

Table 2: Comparison of the spiritual, religious and existential health in the two groups before and after intervention

variable	Group	Before intervention M±SD	After intervention M±SD	P-value
Spiritual health	Test	20.24 ±88.20	14.93±98.40	0.000
	Control	19.22 ±88.70	15.44±89.34	0.48
	P-value	0.87	0.001	
Religious health	Test	48.35±8	51.9±6.7	0.000
	Control	47.66±9	47.8±7.2	0.66
	P-value	0.63	0.001	
Existential health	Test	13.9±39.9	9.6±46.4	0.000
	Control	11±41	9.2±41.5	0.41
	P-value	0.55	0.002	

Table 3: Relationship between the religious health score and existential health score

Group	Variable	Before intervention		After intervention	
		existential health score (r)	P-value	existential health score (r)	P-value
Control	religious health score	0.833	(P<0.000)	0.758	(P<0.000)
Test		0.680	(P<0.000)	0.673	(P<0.000)

spiritual health scores of the control group, before and after the intervention (P=0.48). (Table 2).

Independent-sample t-test revealed that there was no significant difference between the mean scores of religious health in both experimental and control groups before the intervention (P=0.63). However, after intervention, there was a statistically significant difference in the mean scores of the two groups (P=0.001). Paired- samples t- test displayed that there was a significant difference in the religious health score of the experimental group, before and after the intervention (P<0.000). However, there was no statistically significant difference in the religious health score of the control group, before and after the intervention (P=0.66). (Table 2).

Independent-sample t-test revealed that there was no significant difference between the mean scores of existential health in both experimental and control groups before the intervention (P=0.55). However, after intervention, there was a significant statistical difference in the mean score of the two groups (P=0.002). Paired-samples t-test displayed that there was a significant difference in the existential health score of the experimental group, before and after the intervention (P<0.000). However, there was no statistically significant difference in the existential health score of the control group, before and after the intervention (P=0.41). (Table 2).

There was a significant relationship between the religious health score and existential health score in the experimental and control groups before intervention, in such a way that by increasing religious health, existential health would increase a too or vice versa (P <0.000), which was statistically significant. Furthermore, after intervention, there was a significant relationship between religious health score and existential health score in the experimental and control groups so that by enhancing religious health, existential health would increase or vice versa, that was statistically significant (P<0.000) (table 3).

Discussion

The results showed that religious intervention by means of a clergyman at the patients' bedsides would improve the mean score of the patients' spiritual health. No significant difference was observed in spiritual health of the two experimental and control groups including religious health and existential health before intervention. Statistical tests suggested that random selection of the two key variables caused the differences not to be significant between the two groups. Warber et al. studied the impact of spiritual isolation on spiritual health in patients with acute coronary syndrome at the University of Michigan. There was no significant difference between two groups before intervention in their research (19). In a study by Moeeni et al. there was also no significant difference between two groups regarding the spiritual health before conducting the spiritual care of patients (20).

The findings showed that there was a significant difference between the experimental and control groups regarding spiritual health and its scope including religious and existential health, after intervention. In other words, these factors made an increase in the range of spiritual health including religious and existential health of the participants. In the study by Moeeni et al., introducing the spiritual care could also increase the total score of spiritual welfare and the spiritual health but there was not any significant difference in religious health score by itself (20). But in this study, both dimensions of spiritual health including religious and existential health increased significantly. In the study by Warber et al., there was also a statistically significant difference between the two groups in terms of their difference in spiritual health, after intervention (19). The findings of Wachholtz and Pargament also

correlated with these results. The aim of their study was to evaluate the effect of religious care, secular care, and relaxation, on spiritual health, mental health, heart disease, and pain in three groups of patients in America. It showed a statistically significant difference in spiritual health of the three groups, after intervention (21).

The results of a quasi-experimental research about evaluating the effect of religious care on anxiety and spirituality of patients with cardiovascular disease in New York by Delaney et al., indicated that there was a significant difference between the spiritual health score of patients before and after intervention. Spiritual health score of experimental group increased from 114 to 119. The difference was statistically significant ($p < 0.05$) (22), which confirmed the findings of this study.

In Islamic countries –e.g. Iran, people have strong religious beliefs and rich cultural heritage. Thus, there is an easy and better way in multi-dimensional human care systems for the societies oriented toward spirituality. It should be mentioned that spirituality has a tremendous influence on different aspects of life and that it is a key factor in creating a sense of hope, boosting morale and compatibility, endurance of suffering from incurable diseases, and confronting with an existential crisis of life-threatening diseases.

The findings of the current study showed that the mean score of the level of spiritual health in patients was (88.44±20), which was at an average level. Moreover, the study done by Moosa Rezaii et al. indicated that the spiritual health of the majority of the participants (58.64%) was in the moderate range and that in the high range it was (41.35%). (23) The results of McCoubrie and Davies's study supported the findings of this study as well. The mean score for the spiritual health of the majority of patients suffering from cancer in their study was reported to be in the mid-range (24) In addition, Nelson et al. in their study showed that the spiritual health of cancer patients was at an intermediate level (25). While in the study by Rezai et al., 54% of cancer patients had high spiritual health (26) Additionally, the findings of Leung et al. displayed that the spiritual health of patients in the final stages of cancer was at a high level (27). Noori et al. in their study stated that more than 90% of the subjects which consisted of patients with Ischemic Heart Disease had high spiritual intelligence (28). Furthermore, the results of Momeni et al. who investigated the relationship between spiritual health and anxiety in patients with coronary artery showed that the religious subscale score of patients' spiritual health was high. Momeni suggested it was probably due to the stressful life situations and the crisis resulting from the disease which led to an increased tendency towards religion (29). Since the diseases, type of treatment and treatment stage were heterogeneous in the various studies, there were slight differences which may be due to the result of accuracy level in conducting the research and its various tools, gender and age of the patients who participated in the study.

In this study, the mean score of religion health was 48±8 and the mean score of existential health was 40±20. These results showed that the score of religion health was higher than the score of existential health among the participants of the study. The results of this study correlate with findings of Mosa Rezaei et al. regarding the superiority of religion health score over the existential health score in patients with cancer. In the study by Mosa Rezaei et al., the mean score of religion health was 52±7.22 and the mean score of spiritual health was 43.19±9.67 (23). However there was an inconsistency in the findings of Allahbakhshian Farsani et al., indicating that the existential health score was higher than religion health score in cancer patients (30). In this study, the religion health score is higher than the existential health score. The main reason for this issue could be due to cultural and religious conditions of the people of Iran (31). This has led to a situation in which the people of this country while facing the crisis often resort to religion (30). Livneh et al (2004) showed that spirituality plays an important role in coping with stressful situations caused by illness (32).

In this study, the relationship between existential health and religion health was significant in the sense that the higher the religion health of a patient, the higher his

existential health. This indicates that religion has an important impact on individual's ideology, finding the meaning and purpose of life, hope, and having a good relationship with God.

Regarding the limitations of the research, this study only selected hospitalized male patients in Nekouei medical- training center, which limited the possibility of participation of women or patients with various diseases in other centers. Hence, it is recommended that such studies be done with regard to the other gender, diseases, and geographic areas.

Conclusion

The results of this study suggest that religious care provided by clergymen at patient's bedsides increases patients' spiritual health and can also increase their ability to cope with illness and reduce complications of the disease.

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Conflict of interest

The authors declare no conflict of interest.

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