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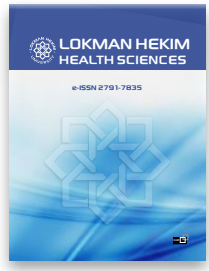

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ORIGINAL ARTICLE

Clinical Assessment of Spiritual Care Needs: A Cross-sectional Study Focusing on Patient Experiences

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Abstract

Introduction: Spirituality encompasses a person's interaction with themselves and others, their place in the universe, and their efforts to understand the meaning of life. This study aims to identify the spiritual care needs of patients receiving professional healthcare services.

Methods: This cross-sectional study was conducted with 273 patients treated at a research hospital in Istanbul between April 2025 and May 2025. Data were collected using an Information Form and the Patient Spiritual Needs Assessment Scale (PSNAS). Mann–Whitney U test, Kruskal–Wallis test, and Dunn–Bonferroni tests were used to analyze the data.

Results: There were 49.4% (n=134) female and 51.6% (139) male, with a mean age of 48.29±12.95. The mean PSNAS score was 64.16±16.10. The mean PSNAS scores were as follows: "Divine" subdimension 11.24±3.86, "Appreciation of Art and Beauty" subdimension 8.24±2.86, "Meaning and Purpose" subdimension 7.30±2.48 the "Love and Belonging" subscale was 14.67±3.97, the "Death and Resolve" subscale was 10.09±3.25, and the "Positivity/Gratitude/Hope/Peace" subscale was 12.52±3.52 points. Spiritual needs levels differed according to gender, chronic illness, and expectations of spiritual support from nurses.

Discussion and Conclusion: Hospitalized patients have high spiritual care needs. Participants who were female, participants with chronic illnesses, and expected spiritual support from nurses had significantly higher spiritual care needs. These research findings will guide the development of spiritual care practices and spiritual care training content for healthcare professionals.

Keywords: Needs assessment; Nursing care; Patient beliefs; Spirituality

Spirituality in healthcare services is an important component of a holistic care approach that addresses not only an individual's physical symptoms but also their social, psychological, and existential needs. It also focuses on faith, rituals, culture, values, perceptions, traditions, intrinsic motivation, well-being, security, experiences, expectations, and ways of resolving internal conflicts. Therefore, spirituality is characterized as the process of understanding the meaning of life.[1–4] The spiritual dimension must also be considered in healthcare, and individuals' spiritual needs must be identified and incorporated into healthcare.[1,5]

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Spiritual needs express the desire to understand the importance of life. They also aim to comprehend the relationship between oneself and other people, the Creator, or nature. Spiritual care needs vary for each patient and family. Descriptive studies planned for the spiritual needs of patients will enable healthcare professionals to select personalized spiritual care interventions based on individuals' spiritual needs and cultural backgrounds. Furthermore, they will provide important evidence for public health policies and clinical care practices by yielding significant results regarding the quantitative aspects of spiritual needs.[3,6,7]

Most studies on patient-centered spiritual care need to focus on palliative care and oncology patients.[7–9] A Taiwan-based study argued that spiritual care practices are an effective component in controlling post-traumatic stress disorder in cancer patients.[4] Another Nigeria-based study determined that cancer patients have high levels of spiritual care needs. It was also recommended that healthcare workers meet the spiritual needs of cancer patients to improve their quality of life.[10]

The fact that this study did not differentiate between types of illness is important in terms of the heterogeneity of the study results. Therefore, understanding the spiritual care needs of patients and the factors that influence them will help support their physical and mental health.[11] This study, which aims to determine the spiritual care needs of patients, seeks to answer the following research questions.

1. Is the level of spiritual care needs of sick individuals high?
2. Which sociodemographic variables affect the spiritual care needs of sick individuals?

Materials and Methods

Study Design

This study was designed as a descriptive cross-sectional study. The STROBE checklist was used in reporting this study.

Place and Time of the Study

The study was conducted in the inpatient clinics of a research hospital in Istanbul between April 2025 and May 2025.

Sample

A power analysis was performed using a purposive sampling method to determine the number of participants to include in the study. The study population consists of patients receiving treatment in relevant clinics who meet the inclusion criteria. Since the population size is not precisely known, a sample size calculation method for an unknown population was used. The total sample size was calculated as n=132 using G*Power 3.1.3 (Heinrich-Heine Universität Düsseldorf, Düsseldorf, Germany) with an effect size of 0.5, 80% power, and a 0.5% margin of error based on the percentage measurement values for the methods to be studied.[10,12] The study was completed with 273 patients who met the inclusion criteria and agreed to participate in the study. After the study was completed, a post-hoc power analysis was performed using G*Power 3.1 software. The results obtained indicate that the current sample size is sufficient to detect a statistically significant difference.

Inclusion Criteria

Individuals who agreed to participate in the study by signing the informed consent form, who did not have visual or hearing impairment, who were literate, who were over 18 years of age, and who were treated in the inpatient clinics of the research hospital, was obtained between April 2025 and May 2025, were included in the study.

Ethical Approval

This study was approved by the University of Health Sciences Hamidiye Scientific Research Ethics Committee (Date: 14.11.2024, Decision no: 13/4). The ethical rules in the Declaration of Helsinki were followed at all stages of the study. The purpose, duration, plan, how and where the data would be used, and what was expected from them were explained to the individuals included in the study through the Informed consent form prepared in accordance with the Declaration of Helsinki. Their written consent was obtained for their inclusion in the study in accordance with the principle of voluntarism.

Data Collection

The research data were collected using the "Introductory Information Form" and the "Patient Spiritual Needs Assessment Scale." Data collection tools were administered by researchers to patients face-to-face in the patient room. The data collection process took approximately 4–5 min.

Introductory Information Form

It consists of a total of 16 questions created by the researcher in line with the literature and aims to examine the sociodemographic characteristics of the participants.

Patients' Spiritual Needs Assessment Scale (PSNAS)

Developed by Galek in 2005.[13] Dedeli et al.[14] adapted it to Turkish society by conducting validity and reliability studies.[14] The Turkish version of the scale consists of 23 items and 6 subscales. The subscales are: "Appreciation of art and beauty" (1), "Meaning and purpose"(2), "Love and belonging" (3), "Death/resolve" (4), "Positivity/gratitude/hope/peace" (5), and "Divine" (6). The questions on the scale can be answered with "yes" or "no." To determine the extent to which those who answer "yes" need this requirement, they are asked to rate their level of need by selecting "Never," "Rarely," "Often," or "Very often." Responses are scored between 0 and 3. The lowest possible score on the scale is "0," and the highest is "69." Needs are evaluated according to descriptive statistical analysis showing numbers and percentages. In this study, the total and sub-dimension mean scores of the scale were also calculated. The factor loadings of the items on the scale range from 0.41 to 0.78, and the Cronbach's Alpha internal consistency coefficient is 0.89. In this study, the Cronbach's Alpha value of the scale was determined to be 0.93. When we examined the Cronbach's alpha of the scale's sub-dimensions, we determined that the "Divine" sub-dimension had a value of 0.91, the "Appreciation of art and beauty" sub-dimension had a value of 0.80, the "Meaning and purpose" sub-dimension had a value of 0.60, the "Love and belonging" sub-dimension had a value of 0.81, the "Death/resolve" sub-dimension had a value of 0.77, and the "Positivity/gratitude/hope/peace" sub-dimension had a value of 0.90.

Analysis of Data

Statistical analyses were performed using Statistical Package for the Social Sciences (SPSS) Statistics 25 (Published 2017. IBM SPSS Statistics for Windows, Version 25.0. Armonk, NY: IBM Corp). Descriptive statistics included mean±standard deviation, median (min-max), frequency, and percentage values. The internal consistency of the scale and its sub-dimensions was evaluated using the Cronbach's Alpha coefficient. For intergroup comparisons, the assumption of normal distribution was assessed using the Shapiro–Wilk test. When the normality assumption was not met, appropriate nonparametric tests were applied; the Mann–Whitney U test was used for comparisons between two groups. The Kruskal–Wallis test was used for comparisons involving three or more groups. For variables with statistically significant differences following the Kruskal–Wallis test, Dunn–Bonferroni correction was applied for multiple comparisons. The confidence level in the analyses was set at 95%. The significance level was determined as $p<0.05$ in pairwise comparisons.

Table 1. Findings related to socio-demographic and disease characteristics of individuals (n=273)

Variable	n	%
Gender		
Female	134	49.4
Male	139	50.6
Marital status		
Married	188	69.4
Single	95	30.6
Educational background		
Illiterate	32	11.5
Primary school graduate	118	43.7
High school graduate	77	28.5
University graduate	46	16.3
Chronic disease		
No	140	50.9
Yes	133	49.1
Clinic where treatment is given		
Internal medicine clinics	165	62.4
Surgical clinics	108	37.6
Hospitalization experience		
Yes	171	63.1
No	102	36.9
Expectation of moral support from nurses		
No	94	33.9
Yes	179	66.1
Relaxation methods*		
Praying, reading the Quran	177	21.40
Praying	187	22.60
Watching television and listening to music	73	8.90
Working on the computer	39	4.70
Reading books, newspapers, magazines, etc.	55	6.70
Traveling, picnicking, etc.	122	14.80
Chatting with loved ones	153	18.60
Illiterate	18	2.30
Age, median (min-max)	48 (19–80)	

*: Multiple options were selected. SD: Standard deviation.

Results

The findings regarding the socio-demographic and disease characteristics of the individuals included in the study are given in Table 1. The mean age of the participants was 48.29±12.95; 139 (50.6%) were male, 188 (69.4%) were

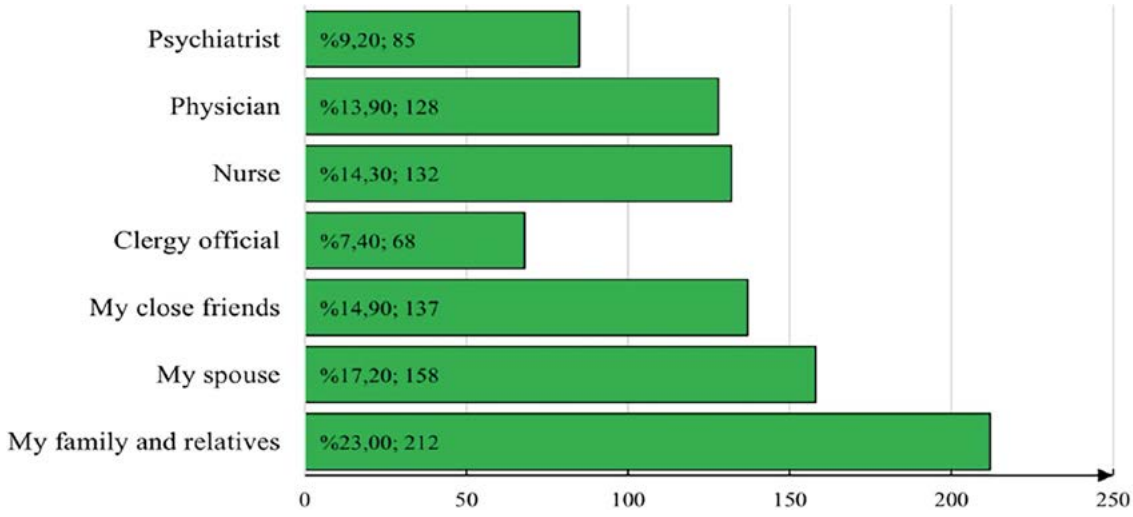

Figure 1. Expectations for spiritual support providers (n=273*).

*: Multiple options were selected.

married, and 118 (43.7%) were primary school graduates. When the disease characteristics of the participants were examined, it was determined that 133 (49.1%) had a chronic disease, 165 (62.4%) received treatment and care services in the internal clinic, and 171 (63.1%) had previous hospitalization experience. In this study, 179 (66.1%) of the patients expected moral support from nurses.

The findings of the patients regarding their expectations from spiritual support providers are given in Figure 1. Accordingly, 212 (23%) of the participants expected spiritual support from family and relatives, 137 (14.90%) from close friends, 132 (14.30%) from nurses, 128 (13.90%) from physicians, and 68 (7.40%) from religious officials.

The findings of the participants regarding the spiritual support practices they expect from nurses are given in Figure 2. 199 (57.20%) of the participants expected nurses to talk to them and listen to their problems, 86 (27.70%) expected them to prepare a suitable environment for them to worship, 24 (6.90%) expected them to listen to music and do relaxing exercises, and 10 (2.90%) expected them to call a religious official to chat.

The mean scores of the PSNAS total and sub-dimensions of the participants are given in Figure 3. The mean total score of PSNAS was 64.16±16.10. The mean score of the "Godly" sub-dimension of the scale was 11.24±3.86, the "Appreciation of Art and Beauty" sub-dimension was 8.24±2.86, the "Meaning and Purpose" sub-dimension was 7.30±2.48, the "Love and Belonging" sub-dimension was 14.67±3.97, the "Death and Determination" sub-dimension was 10.09±3.25, and the "Positivity/Gratitude/Hope/Peace" sub-dimension was 12.52±3.52.

The answers of the patients regarding the propositions of spiritual needs are analyzed in detail in Table 2. When the spiritual needs of the patients in the "Godly" dimension were analyzed, 29.2% (n=79) of patients needed to be able to participate in religious or spiritual services, 32.8% (n=89) needed to read religious or spiritual materials, 50.9% (n=139) needed to pray with someone or have someone pray for them and 40.2% (n=110) needed guidance from a higher power.

When the spiritual needs of the patients in the dimension of "Knowing the Value of Art and Beauty" were analyzed, 39.5% (n=108) of patients had a strong need to experience or value beauty. However, 37.3% (n=102) of the patients rarely needed to experience or appreciate nature, and 31% (n=85) of the patients never needed to enjoy or experience music.

According to "Meaning and Purpose" dimension, 32.5% (n=88) of patients rarely needed to find the meaning and purpose of life, 37.6% (n=102) never needed to find the meaning in suffering, and 41.3% (n=113) needed a lot to understand why this disease/medical condition occurred. The dimension of "Love and Belonging" was also evaluated. 47.6% (n=130) of patients needed to love and be loved, 36.9% (n=101) needed to be accepted as an individual, 42.1% (n=115) needed friendship, 46.5% (n=127) needed compassion and kindness very much, and 32.5% (n=88) rarely needed to feel a meaningful connection with the world. In terms of "Death and Determination," 33.6% (n=91) of patients rarely needed to talk about unresolved problems before death, and 35.8% (n=97) rarely needed to express their concerns about life after death. It was determined that 31.4% (n=86) of the participants needed

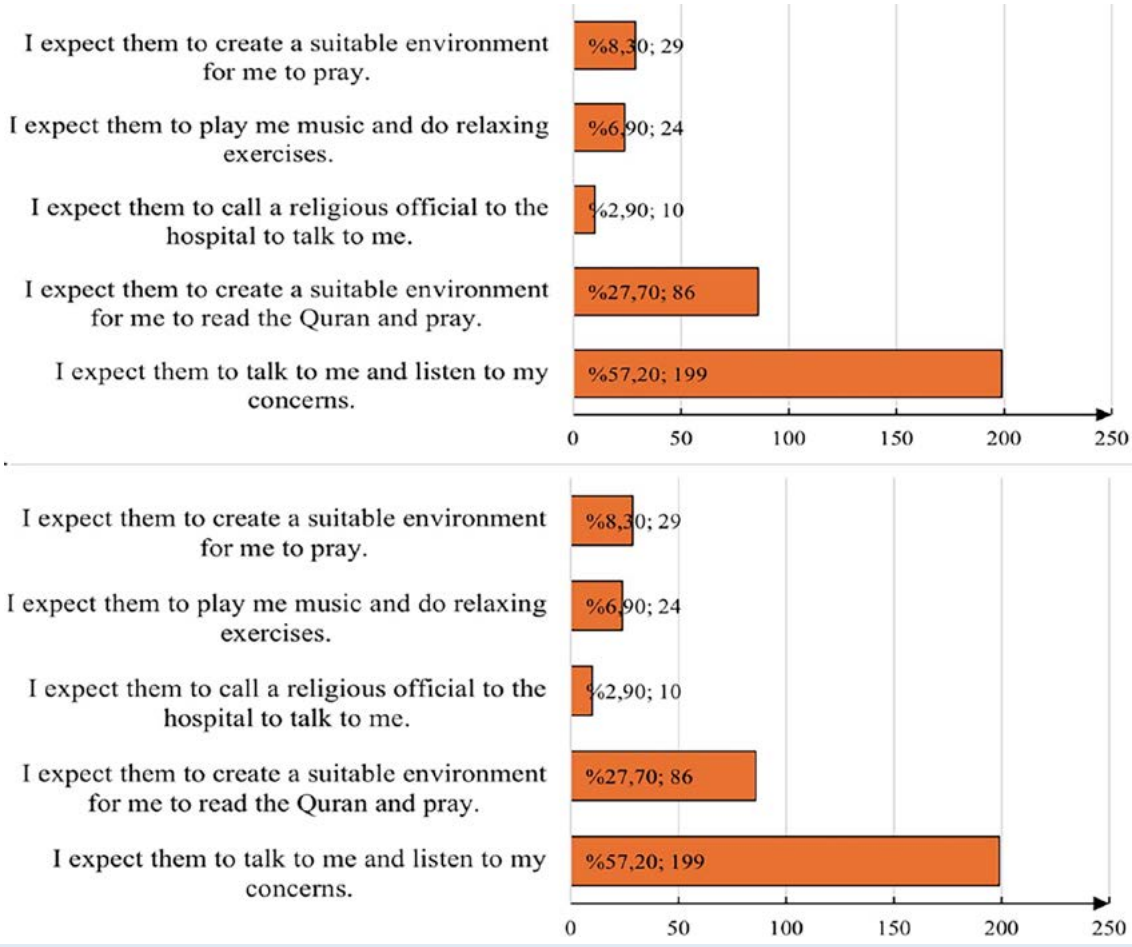

Figure 2. Spiritual support practices expected from nurses (n=273*).

*: Multiple options were selected.

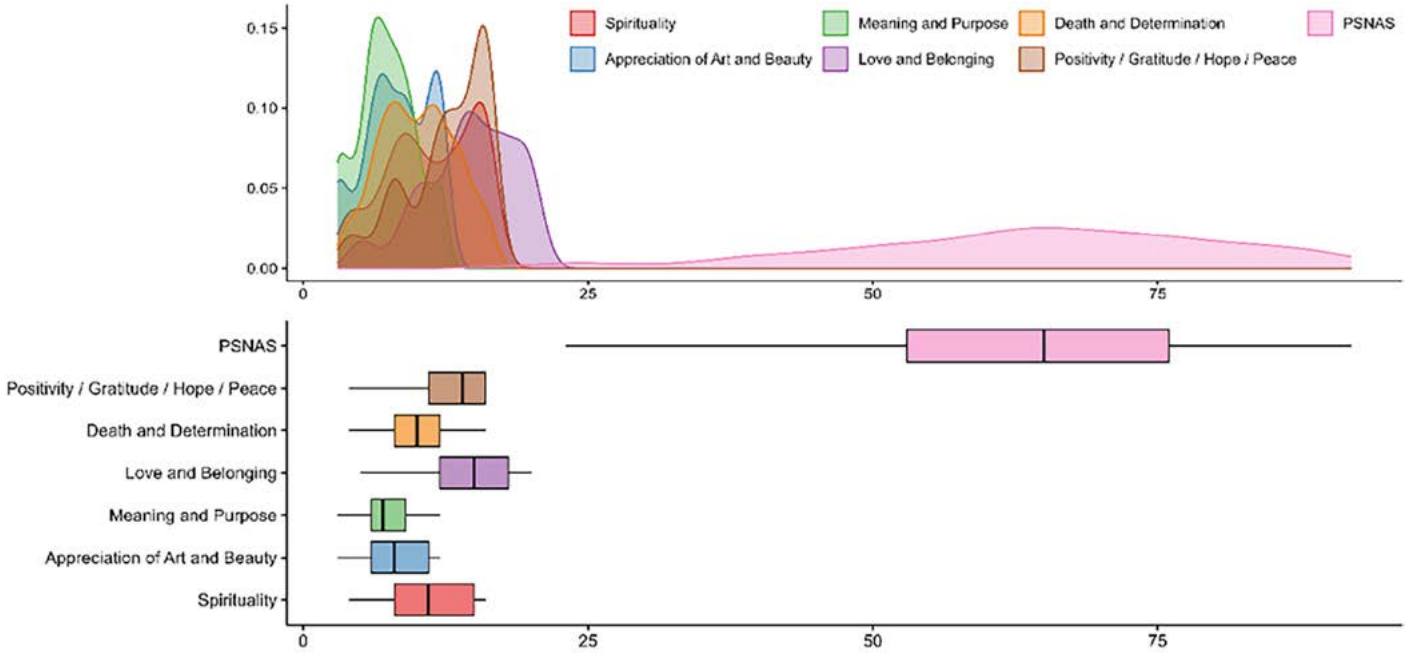

Figure 3. Patient spiritual needs assessment scale total and sub-dimension score averages (n=273).

Table 2. Spiritual care needs of patients (n=273)

Dimension	Item	Never (%)	Rarely (%)	Much (%)	Too much (%)	Total (%)
Spirituality	Attending religious or spiritual services	55 (19.9)	73 (26.6)	66 (24.4)	79 (29.2)	273 (100)
	Storing religious or spiritual materials	57 (20.7)	65 (23.6)	62 (22.9)	89 (32.8)	273 (100)
	Praying with someone or having someone pray for you	30 (11.1)	49 (18.1)	55 (19.9)	139 (50.9)	273 (100)
	Receiving guidance from a higher power	44 (16.2)	69 (25.5)	50 (18.1)	110 (40.2)	273 (100)
Appreciation of art and beauty	Experiencing beauty or practicing values	36 (13.3)	41 (15.1)	88 (32.1)	108 (39.5)	273 (100)
	Experiencing or appreciating nature	48 (17.7)	51 (18.8)	72 (26.2)	102 (37.3)	273 (100)
	Enjoying or experiencing music	85 (31)	69 (25.5)	36 (12.9)	83 (30.6)	273 (100)
Meaning and purpose	Keeping the meaning and purpose of life	78 (28.8)	88 (32.5)	46 (16.6)	61 (22.1)	273 (100)
	Meaning in suffering	102 (37.6)	78 (28.8)	44 (15.9)	49 (17.7)	273 (100)
	Understanding the full manifestation of this illness/medical event	51 (18.8)	52 (19.2)	57 (20.7)	113 (41.3)	273 (100)
Love and belonging	Loving and being loved	27 (10)	39 (14.4)	77 (28)	130 (47.6)	273 (100)
	Being accepted as an individual	47 (17.3)	57 (21)	68 (24.7)	101 (36.9)	273 (100)
	Friendship	35 (12.9)	57 (21)	66 (24)	115 (42.1)	273 (100)
	Compassion and kindness	31 (11.4)	41 (15.1)	74 (26.9)	127 (46.5)	273 (100)
	Feeling a meaningful connection to the world	38 (14)	88 (32.5)	65 (23.6)	82 (29.9)	273 (100)
Death and determination	Recognizing unresolved issues before death	72 (26.6)	91 (33.6)	66 (24)	44 (15.9)	273 (100)
	Not expressing concerns about the afterlife	84 (31)	97 (35.8)	46 (16.6)	46 (16.6)	273 (100)
	Reviewing your life	45 (16.6)	76 (28)	66 (24)	86 (31.4)	273 (100)
	Influencing yourself and others	41 (15.1)	58 (21.4)	56 (20.3)	118 (43.2)	273 (100)
Positivity/gratitude/hope/peace	Expressing gratitude and appreciation	23 (8.5)	52 (19.2)	61 (22.1)	137 (50.2)	273 (100)
	Feeling hopeful	25 (9.2)	45 (16.6)	68 (24.7)	135 (49.4)	273 (100)
	A mutual perspective	21 (7.7)	48 (17.7)	63 (22.9)	141 (51.7)	273 (100)
	Feeling a sense of peace and relief	19 (7)	53 (19.6)	66 (24)	135 (49.4)	273 (100)

Response variations are given as frequencies (%).

to review their lives and 43.2% (n=118) needed to forgive themselves and others a lot. "Positivity/Gratitude/Hope/Peace" evaluation showed 50.2% (n=137) of the patients participating in the study needed to feel gratitude, 49.4% (n=135) needed to feel hopeful, 51.7% (n=141) needed to provide a positive perspective, and 49.4% (n=135) needed to feel a sense of peace and refreshment.

The comparison of participants' PSNAS total and subscale mean scores according to certain sociodemographic characteristics is presented in Table 3. Statistically significant differences were found in the PSNAS total mean score with respect to the variables "gender," "chronic illness", and "expectation of spiritual support from nurses." In the subgroup analysis, it was determined that female participants, participants with chronic illness, and participants expecting spiritual support from nurses had higher PSNAS total score averages ($p<0.05$). The pairwise comparison results of the sub-dimensions that differ according to gender and education are given in Table 4.

Discussion

The findings regarding the socio-demographic and disease characteristics of the individuals included in this study, in which the spiritual care needs of sick individuals and the factors affecting them were examined, are given in Table 1. Accordingly, it was determined that more than half of the participants were male, married, and had graduated from primary school. These results are associated with the fact that the participants are predominantly middle-aged and older adults. Some studies examining the need for spiritual care are similar to the findings of this study in terms of sociodemographic characteristics.[9,11,13]

The findings regarding the participants' expectations for spiritual support providers are given in Figure 1.

Table 3. Comparison of PSNAS total and sub-dimension score averages according to some sociodemographic characteristics (n=273)

	Divine	Appreciation of art and beauty	Meaning and purpose	Love and belonging	Death and resolve	Positivity/ gratitude/hope/ peace	PSNAS
Gender							
Male	9 (4–16)	7 (3–12)	7 (3–12)	14 (5–20)	9 (4–16)	13 (4–16)	60 (23–89)
Female	12 (4–16)	9 (3–12)	8 (3–12)	16 (5–20)	11 (4–16)	14 (4–16)	67 (23–92)
p†	0.004*	0.069	0.020*	<0.001*	0.045*	0.110	0.010*
Marital status							
Married	12 (4–16)	8 (3–12)[a]	7 (3–12)	14 (5–20)[a]	10 (4–16)	14 (4–16)	63 (23–89)
Single	11 (4–16)	9 (3–12)[b]	7 (3–12)	17 (5–20)[b]	10 (4–16)	15 (4–16)	66 (23–92)
Divorced	11.5 (10–16)	10 (6–12)[b]	7.5 (6–10)	15.5 (12–19)[a,b]	11.5 (7–12)	12.5 (12–14)	69 (54–77)
p‡	0.667	0.001*	0.588	0.007*	0.672	0.147	0.08
Educational background							
Illiterate	10 (4–16)	8 (3–11)	7 (3–11)	15 (5–20)[a,b]	10 (4–16)	13 (4–16)	63 (23–89)
Primary school graduate	11.5 (4–16)	7 (3–12)	7 (3–12)	14 (5–20)[a]	10 (4–16)	13 (4–16)	63 (23–89)
High school graduate	12 (4–16)	9 (3–12)	7 (3–12)	16 (10–20)[b]	10 (4–16)	14 (5–16)	67 (44–92)
University graduate	11 (4–16)	9 (3–12)	8 (3–12)	15.5 (5–20)[a,b]	11 (4–16)	13 (4–16)	66 (23–92)
p‡	0.331	0.148	0.162	0.006*	0.830	0.628	0.259
Hospitalization experience							
Yes	12 (4–16)	9 (3–12)	7 (3–12)	15 (5–20)	10 (4–16)	13 (4–16)	66 (23–92)
No	10 (4–16)	8 (3–12)	7 (3–12)	15 (5–20)	9 (4–16)	14 (4–16)	63 (23–92)
p†	0.147	0.316	0.016*	0.771	0.151	0.9	0.214
Chronic disease							
Yes	13 (4–16)	9 (3–12)	8 (3–12)	15 (5–20)	11 (4–16)	14 (4–16)	67 (23–89)
No	10 (4–16)	8 (3–12)	7 (3–12)	15 (5–20)	9 (4–16)	13 (4–16)	63 (23–92)
p†	0	0.169	0.112	0.040*	0.008*	0.043*	0.008*
Expectation of moral support from nurses							
Yes	13 (4–16)	9 (3–12)	8 (3–12)	16 (8–20)	11 (4–16)	14 (4–16)	71 (35–92)
No	8.5 (4–16)	6 (3–12)	6 (3–10)	13 (5–20)	8 (4–15)	12 (4–16)	58.5 (23–82)
p†	0	<0.001*	<0.001*	<0.001*	<0.001*	<0.001*	<0.001*

†: Mann Whitney U; ‡: Kruskal Wallis H; a-b: a-b represent group memberships in Bonferroni results; Statistic are presented as median (minimum maximum); *: p<0.05. PSNAS: Patient spiritual needs assessment scale.

Table 4. Post hoc pairwise comparisons of appreciation of art and beauty and love and belonging according to marital status and educational background

Pairwise	Test statistic	p_{Adj}
MaritalStatus (Appreciation of Art and Beauty)		
Married versus Single	-36.485	0.004
Married versus Divorce	-43.923	0.049
Single versus Divorce	-7.438	1.000
Marital Status (Love and Belonging)		
Married versus Single	-35.109	0.006
Married versus Divorce	-18.961	0.905
Divorce versus Single	16.148	1.000
Educational background (Love and Belonging)		
Primary school graduate versus Illiterate	17.967	1.000
Primary school graduate versus University graduate	-27.581	0.267
Primary school graduate versus High school graduate	-38.934	0.004
Illiterate versus University graduate	-9.614	1.000
Illiterate versus High school graduate	-20.966	1.000
University graduate versus High school graduate	11.352	1.000

p_{Adj}: Adjusted p-values were calculated using the Bonferroni correction.

Accordingly, the participants expected the most spiritual support from family and relatives, followed by close friends, nurses, physicians, and religious officials, respectively. This result, as supported by the literature, shows that individuals tend to meet their spiritual support needs primarily from their close social environment.[9,15]

Figure 2 presents the findings regarding the emotional support practices that participants expected from nurses. Accordingly, it was determined that the participants mostly expected nurses to talk to them and listen to their problems. This was followed by preparing a suitable environment for worship, listening to music and relaxing exercises, and calling a religious official for a chat. In a study examining the spiritual care needs of caregivers, it was reported that the participants requested regular priest visits and prayer support. In addition, the importance of efforts to strengthen the trust and connection that support the communication of religious officials with patients and caregivers was emphasized.[7,15] The results obtained prove that health care services should be handled with a holistic approach that includes not only physiological but also psychological and spiritual aspects. As supported by the literature, it is understood that nurses' ability to provide emotional support is an important element of the care process.[10,16]

The mean scores of PSNAS total and sub-dimensions of the participants are given in Figure 3. The findings obtained show that the spiritual care needs of the patients are at a high level. When the PSNAS sub-dimensions were analyzed, it was found that the highest mean score belonged to the sub-dimension of "Love and Belonging," followed by the sub-dimension of "Positivity/Gratitude/Hope/Peace," "Godly," "Death and Determination," "Appreciation of Art and Beauty" and "Meaning and Purpose." The higher level of spiritual care needs for the "Love and Belonging" sub-dimension shows that the needs for love, bonding and feeling of belonging come to the forefront in coping with feelings of loneliness, uncertainty and fear during periods of illness. In a study that assessed the spiritual care needs of oncology patients from a multicultural perspective, the vast majority of participants stated that they had high levels of unmet spiritual needs, particularly 6 months after diagnosis, and requested assistance in this regard. It was noted that the spiritual care needs expressed by more than half of the participants were related to "sharing thoughts or feelings", "finding hope", and "concerns about family".[9,17] The literature indicates that regularly assessing spiritual health and integrating spiritual care into clinical care reduces post-traumatic stress levels in cancer patients.[4] Furthermore, patients who discuss their spiritual concerns while hospitalized report higher levels of satisfaction with treatment and care services, and it has been recommended that an early intervention plan for spiritual care needs be developed and clinical guidelines be established.[7,17] A study conducted in Denmark also indicated that the vast majority of participants had very strong spiritual care needs,

with these needs most frequently related to inner peace, productivity, existential, and religious needs, respectively.[12] The results obtained from all these studies prove that spiritual care services are in high demand among patients.

Patients' responses to the propositions in the Spiritual Needs Scale are analysed in detail in Table 2. When the spiritual needs of the patients in the "Godly" dimension were analyzed, it was found that the patients most needed to be able to participate in religious or spiritual services, followed by reading religious or spiritual materials, praying with someone or having someone pray for them, and needing guidance from a higher power. This suggests that patients' spiritual orientations function as a supportive coping mechanism in the process of health care services, but these needs are often ignored in clinical practice. In a study examining the level of spiritual care needs of oncology patients, similar to the results of this study, it was determined that the participants most needed "personal meditation or prayer practices," followed by "visit from clergy" and "visit from hospital chaplain."[9] In the literature, it has been reported that practices such as reading the Bible, praying, and other religion-specific practices are practical non-pharmacological spiritual care interventions. These interventions have positive physiological and psychological effects on the health outcomes of patients and improve the quality of life.[6,18]

In studies, it has been stated that alpha waves in the brain increase significantly after reading or listening to the Holy Qur'an, which provides calmness, relaxation, and hemodynamic stability.[18,19] In addition, it was determined that reading the Holy Qur'an decreased blood pressure, heart and respiratory rate, increased oxygen saturation, increased level of consciousness, and improved pain control. The results obtained support that spiritual care practices improve mental and emotional processes and increase the satisfaction levels of patients and their families with care.[18,20] The fact that the results obtained from this study are similar to the findings of the literature shows that spiritual needs in the disease experience are a universal need regardless of cultural and religious structure.[21,22]

When the spiritual needs of the patients in the dimension of "Knowing the Value of Art and Beauty" were analyzed, it was determined that most participants had a strong need to experience or value beauty; it was found that they had a limited need to experience nature, appreciate its value, and enjoy music or engage in musical activities. The literature indicates that practices such as art therapy, music therapy, and dance are drug-free, practical spiritual care interventions.[6,23] Nevertheless, some studies indicate that the artistic and esthetic dimensions of spiritual needs in disease and care processes are often secondary, and individuals tend to turn to more concrete sources of spiritual support.[24] This result, which supports the findings of the current study, draws attention to the importance of using music, art, and nature-based approaches more effectively in spiritual care practices.

This study shows that patients' spiritual needs related to the "Meaning and Purpose" dimension are perceived at different levels. The findings suggest that some patients attach limited importance to questions about the meaning and purpose of life and the reasons for their suffering, whereas for many patients, the search for an explanation for the cause of their illness or medical condition emerges as a distinct spiritual need. This situation shows that a significant portion of the participants are not seeking the general meaning of life or the meaning of suffering, but rather have a strong search for meaning regarding the cause of their illness. It suggests that individuals' spiritual inquiries focus on cause-and-effect relationships directly related to the illness experience rather than abstract existential themes. In the literature, studies conclude that spiritual needs in the "Meaning and Purpose" dimension are at a lower level compared to other dimensions.[9,25] In a study of oncology patients, unlike the results of this study, it was reported that more than half of the participants needed spiritual care practices in the "Meaning and Purpose" dimension.[26]

When examining participants' spiritual needs in the dimension of "Love and Belonging," it is evident that needs related to human contact, such as loving and being loved, acceptance, friendship, compassion, and kindness, are paramount for many patients. In contrast, the need to establish a meaningful connection with the world, a more abstract concept, is felt to a more limited extent by some patients. This indicates that individuals may tend to turn primarily to close and concrete sources of social support primarily during the illness process.

The analysis of participants" spiritual needs in the "Love and Belonging" dimension revealed that needs related to human contact, such as loving and being loved, acceptance, friendship, compassion, and kindness, are highly significant for many patients. In contrast, the need to establish a meaningful connection with the world, a more abstract concept, appears less prominent for some individuals. These findings suggest that, during the illness process, patients tend to rely primarily on close and tangible sources of social support rather than on more abstract forms of connection. In similar studies conducted in the literature, it was reported that the spiritual needs

of the patients in the dimension of "Love and Belonging" were higher than the other dimensions, and this need emphasized the importance of emotional bonding especially in care relationships.[26,27]

In the "Death and Resolve" dimension, some patients report a limited need to discuss issues related to death and the afterlife, whereas needs related to evaluating life and forgiving oneself or others are more pronounced. These results are consistent with the literature, suggesting that during the illness process, individuals may tend to focus on making sense of life, confronting the past, and achieving inner peace rather than death. This suggests that individuals approach the phenomenon of death indirectly through emotional acceptance and the search for inner peace, rather than directly.[26,28]

The analysis of participants" spiritual needs in the "Death and Resolve" dimension revealed that some patients report a limited need to discuss issues related to death and the afterlife, whereas needs related to evaluating life and forgiving oneself or others are more pronounced. These results are consistent with the literature, suggesting that during the illness process, individuals may tend to focus on making sense of life, confronting the past, and achieving inner peace rather than death. This suggests that individuals approach the phenomenon of death indirectly through emotional acceptance and the search for inner peace, rather than directly.[26,28]

When examining participants' spiritual needs in terms of "Positivity/Gratitude/Hope/Peace," patients have a strong need to feel grateful, to feel hopeful, to maintain a positive outlook, and to feel a sense of peace and serenity. The high level of need for the dimension of "Positivity/Gratitude/Hope/Peace" shows that patients tend to find meaning in life, provide inner peace, and maintain a sense of hope despite difficulties. In studies conducted with patients diagnosed with chronic disease, pain, and cancer, it was determined that the "Positivity/Gratitude/Hope/Peace" dimension was the highest spiritual need dimension.[26,29] The results obtained emphasise the importance of approaches that strengthen the positive emotional resources of individuals in spiritual care practices.

The comparison of participants' PSNAS total and subscale mean scores according to certain sociodemographic characteristics is presented in Table 3. According to this, statistically significant differences were found in the PSNAS total mean score with respect to the variables "gender," "chronic illness," and "expectation of spiritual support from nurses." In the advanced analysis, female participants, participants with chronic diseases, and participants expecting spiritual support from nurses had higher PSNAS total score averages. The higher level of spiritual care needs among female participants can be explained by women's more pronounced tendencies toward empathy, emotional awareness, and forming meaningful bonds with others. This finding, supported by the literature, suggests that spiritual needs are closely related not only to religious beliefs but also to forms of emotional expression, gender, and social roles. Studies examining spiritual needs in patients with terminal cancer have also reported that, as in this study, spiritual care needs are stronger in female patients than in male patients.[13,30]

The high level of spiritual care needs among individuals with chronic illnesses suggests that chronic illness may increase individuals' need for support in areas such as meaning of life, spiritual resilience, and death awareness. Although spiritual care practices are more frequently requested by individuals with chronic illnesses, these needs are often not addressed within the scope of healthcare services.[12,31]

The literature reports a strong relationship between spiritual support received from healthcare professionals, primarily nurses, and the fulfillment of individuals' spiritual care needs. This study found that patients expect spiritual support more from nurses.[32,33] These results emphasize the importance of nurses' role in spiritual care services and highlight the necessity of nurses' active participation in the planning of spiritual care.

One of the strengths of the study is that the results provide a multifaceted perspective on patient expectations regarding spiritual care practices, which are described as unmet care in the literature. The results obtained due to limited sample representation cannot be generalized to the whole society.

Conclusion

Participants mostly expected spiritual support from relatives and nurses to listen to their concerns. Patients' spiritual care needs were high, and their spiritual care needs related to the "Love and Belonging" sub-dimension were greater. Female participants, participants with chronic illnesses, and participants who expected spiritual support from nurses had higher levels of spiritual care needs. The findings will shed light on how the identified spiritual care needs can be met in accordance with individuals' cultural and religious beliefs, as well as on the clinical effectiveness of such spiritual care interventions, informing future research and public policy. Future research should focus on the link between the needs reported by patients and test spiritual care practices.

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