Original Article

Assessment of spiritual needs in cancer patients: A cross-sectional study

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Abstract

Introduction: Addressing the spiritual needs of patients is an essential component of holistic care in nursing. Acknowledging the spiritual needs of cancer patients enhances the performance of clinical caregivers in providing quality services to such patients. Therefore, caregivers successfully fulfill or decrease the patients' needs and thus increase their adaptation to crises. **Methods:** The present cross-sectional study was conducted to determine the spiritual needs of cancer patients. In this study, 96 cancer patients were selected from Ayatollah Khansari Hospital in Arak, Iran. The required data were collected through a demographic information form and the Persian version of the Spiritual Needs Questionnaire. **Ethical Considerations:** Participants' verbal consent to participate in the study was obtained, and they were assured of anonymity and confidentiality. **Results:** In the present study, the mean age of the participants was 47.82 ± 14.34 years. The frequency distribution of respondents by gender was 36 males (37.5%) and 60 females (62.5%). The mean scores of spiritual needs in the domains of religious needs, need for inner peace, existential needs, and need for giving/generativity were 12.03 ± 3.18, 7.26 ± 3.26, 4.61 ± 2.96, and 4.06 ± 2.32, respectively. The highest and lowest mean values were associated with religious needs and need for giving/generativity, respectively. Religious needs showed a significantly positive relationship with gender, occupation, and the type of treatment ($P < 0.05$). Moreover, a significant relationship was observed between the need for peace and level of education ($P < 0.05$). **Conclusion:** The recognition of the spiritual needs of cancer patients is the first step in prioritizing and planning to provide spiritual care to these patients and supporting them in adapting to and coping with the disease. Therefore, nurses need to acquire the fundamental knowledge and skills required to identify these needs.

Keywords: Cancer, patients, spiritual needs, spirituality

Introduction

Nowadays, cancer is considered as one of the most serious health issues all over the globe,and it is the second most life-threatening factor in developing countries.[1] In Iran, cancer is ranked second among chronic non-communicable diseases (NCDs). It is also the third leading cause of death following cardiovascular diseases and disasters and other natural phenomena.[2] Nearly

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3,000 Iranians pass away due to this disease annually. The rapid expansion of cancer in recent decades and its fatal impacts on all physical, emotional, psychological, and social aspects of life have prompted experts to attend to this disease and introduce cancer as a major health complication in the twenty-first century.[3] Being diagnosed with cancer provokes several crises in an individual, imperils the patient's self-confidence and religious faith, and causes conventional preliminary adaptation mechanisms to seem inadequate.[4] The experience of living with cancer indicates that spiritual health is a significant aspect of a healthy life, and spirituality leads to having a sense of purpose in patients. Religion enables a person to comprehend the meaning behind life events, especially those that are tragic and stressful, lifts their spirit, and provides them with satisfaction.[5]

The World Health Organization (WHO) defines health in four aspects, namely physical, mental, social, and spiritual, and emphasizes attention to the patient's beliefs during treatment and the professional's relationship with them.[6] Spirituality is an inherent quality in all human beings endorsing a harmonious relationship with oneself, others, nature, and god and finding meaning and purpose in life. Addressing spiritual needs is considered an essential element of holistic care in nursing. Since refraining from spiritual needs leads a person to experience internal conflicts, feelings of emptiness, hopelessness in the face of deprivations, adversity, and mental pressure, holistic care is known to be an ideal method of treatment.[7] Regarding the various nursing theories provided by Betty Newman, Rosemarie Parse, Callista Roy, Jean Watson and Joyce Travelbee, spirituality is a crucial aspect of holistic care and can contribute to the health of individuals experiencing acute, chronic, and severe physical or emotional ailments.[8]

Patients need attention to all their physical, emotional and spiritual aspects. Therefore, nurses should take this into account in patient care. Therefore, spirituality is a vital element of this process and should not be overlooked while providing care and treatment.[9] The results of studies have indicated that spirituality and spiritual beliefs enhance a patient's ability to cope with the occurrence of a disease. Moreover, they increase the speed of recovery, cause an individual to feel better, and gain more strength and resilience to cope with diseases.[10] Taylor states that spirituality manifests itself as spiritual needs in three levels: intrapersonal, interpersonal, and transpersonal. An example of a transpersonal spiritual need is the desire to communicate and worship a higher being (often god). Meanwhile, the desires to forgive, be forgiven, love, and be loved reflect interpersonal spiritual needs.[11] Moreover, the need for hope, purpose, and superiority over others are instances of intrapersonal spiritual needs. Need is defined as the gap between the current conditions and desired conditions. Need assessment is the process of gathering information about the needs of individuals and prioritizing them to provide the requirements for addressing those needs.[12]

According to the New York Cancer Center, caring for cancer patients and their families should be accomplished in a safe and fully supportive environment so that they can express their physical, emotional, and spiritual needs since cancer patients are at greater risk of spiritual distress due to the diagnosis, a change in illness, or end-of-life challenges. In this regard, Mesquita *et al.* reckon that the spiritual needs of cancer patients often comprise of finding meaning and hope, accessing spiritual resources, and uncovering meaning at the heart of suffering.[13] USA and Canada are leading the way by incorporating spiritual care into standard care. Most nurses have asserted that they provide spiritual care to their patients.[14] Based on the findings of various studies, 70% of clients wished that their physicians know and care about their spiritual needs and half of the patients inquired their physicians to pray with them.[15]

The spiritual needs of patients may be influenced in certain circumstances by the person's physical, mental, and social health and perceptual decline. Most hospital clients believe that spiritual health is as critical as physical health and are interested in asking questions about their spiritual needs.[16] The recognition of the spiritual needs of patients and subsequent provision of spiritual care in line with them are considered a treatment strategy. Allowing clients to express their spiritual beliefs increases their level of satisfaction and diminishes physical and mental hardships.[17]

Attention to a patient's religious care has been neglected in medical wards. The American Psychiatric Association recommends that physicians seek out the patient's religious and spiritual orientations. Accordingly, the basis of this recommendation is that patient care goes beyond curing them and encompasses meeting various needs, such as the fulfillment of spiritual needs, which is requested by the majority of patients.[18] Iran is a country where adherence to religious principles and values is considered an integral part of both life and moments before death, and Iranian constitutions are based on Islamic doctrines. Considering these points, it is essential to follow religious principles, establish the required facilities for religious practices, and fulfill the religious needs of patients at times of ailment and hospitalization.[19] Likewise, various nursing models and theories have revealed the fact that spirituality is an integral part of human existence, affecting all levels and dimensions of human existence from the moment of birth to death. Florence Nightingale always emphasized that paying attention to the spiritual and psychological needs of patients was crucial in nursing. Decent knowledge and understanding of spiritual needs and how they are formed can influence a nurse's relationship with the patient and improve the quality of the patient's spiritual care.[20] Therefore, this study was conducted to evaluate the aspects of spiritual needs of cancer patients in Iran.

Materials and Methods

This cross-sectional study was conducted on patients diagnosed with cancer (n = 96) and who were referred to Khansari Cancer Hospital, Arak, Iran. The required data were collected using a questionnaire. The first part of the questionnaire included

demographic information (e.g. full name, age, education level, occupation, marital status, and residential address) and clinical information regarding the disease (e.g. type of cancer, type of treatment, and time of diagnosis). The second part entailed the 19-item Spiritual Needs Questionnaire designed by Büssing *et al.*[21] to assess the spiritual needs of cancer patients. This questionnaire consists of four subscales, namely, religious needs (6 items), need for inner peace (5 items), existential needs (5 items), and need for giving/generativity (3 items). Responses are scored on a four-point Likert scale of 0 indicating no need; 1 indicating little need; 2 indicating medium need; and 3 indicating high need. The total score of this scale is 0–57, which is calculated by adding the points in the subscales, including religious needs (0–18 points), need for inner peace (0–15 points), existential needs (0–15 points), and need for giving/generativity (0–19 points). Cronbach's alpha for various areas of this questionnaire was reported to be between 0.82 and 0.90. This questionnaire was translated into Persian and its validity and reliability was confirmed with a Cronbach's alpha of 0.8.[22]

Initially, necessary permissions were obtained to conduct the research. Regarding the ethical considerations, the research objectives and procedures were explained to all, and they were informed of the right to leave the study at any time. Moreover, all participants were assured of anonymity and confidentiality in this study. After attaining their consent, the participants completed the questionnaire.

The required data were collected from the hospital within 30 days. The gathered data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 23 software through descriptive statistics (frequency, frequency percentage, mean, and standard deviation) and inferential statistics (correlation coefficient and stepwise regression, analysis of variance [ANOVA], independent *t*-test, Chi-squared test, Fisher's exact test, or, if necessary, equivalent nonparametric tests).

Results

The mean age of the participants was 47.82 ± 14.34 years. In this study, 62.5% and 37.5% of the participants were female and male, respectively. It was found that 27.1%, 82%, and 54.2% of the cases were illiterate, married, and were housewives, respectively. Additionally, 70.8%, 8.3%, 1%, and 19.8% of the subjects were undergoing chemotherapy, surgery, radiation therapy, and other treatments, respectively. Most of the participants (71.9%) lived in urban areas. Among the types of cancer, the highest diagnosis belonged to lung cancer (n = 26), and the lowest was related to kidney cancer (n = 1). The mean of elapsed time since the definitive cancer diagnosis in participants was calculated at 24.84 ± 14.36 months [Table 1].

The mean score of total spiritual needs was obtained at 27.96 ± 7.80. Moreover, the mean values in the subscales of religious needs, need for inner peace, existential needs, and need for giving/generativity were estimated at 12.03 ± 3.18, 7.26 ± 3.26, 4.61 ± 2.96, and 4.06 ± 2.32, respectively [Table 2]. All participants reported a need in the religious aspect. The highest level of need was associated with the field of religion, while the lowest level was related to the field of need for giving/generativity. The mean score of religious needs was significantly different between the two genders, with it being higher in females (12.81 ± 3.26, $P < 0.05$). Moreover, according to the one-way ANOVA the religious need variable was significantly different in various occupation levels (13.00 ± 3.07, $P < 0.024$). According to Tukey's *post hoc* test, the mean score of the need for inner peace was higher for participants having high school or higher education levels, which was significantly different from those with elementary education (17.33 ± 6.03, $P = 0.003$). The mean score of the need for inner peace was lower in participants undergoing chemotherapy than in other treatments (6.69 ± 3.44 vs. 16.83 ± 4.64) and the difference was statistically significant ($P = 0.010$) [Table 1]. There was no significant relationship of existential needs and need for giving/generativity with other variables. Additionally, spiritual needs showed no statistically significant relationship with residential address and cancer type.

Discussion

This study aimed to address the spiritual needs of cancer patients. It is essential to address spiritual needs when providing care and services to cancer patients. However, spiritual needs vary in different cultures, and patients often turn to their definition of spirituality and religion to find purpose and meaning. There is evidence that once the patients are diagnosed with cancer, as the patients undergo the subsequent stages over time, their spiritual needs increase.[23]

In the present study, the participants' demographic characteristics had similarities and differences with those of other studies. Regarding this, the distributions of age, gender, and marital status of the participants in the present study were similar to those in the studies conducted by Büssing *et al.*[24] and Nejat *et al.*[25] In the study conducted by Büssing *et al.*,[24] the majority of participants were Christian, and merely 30% of the subjects were diagnosed with cancer, while the rest suffered from other chronic diseases. In another study, the majority of the New Zealanders were Christian and Iranians were Muslim.[26]

In the present study, most of the participants were married and had primary education, which was consistent with the results of the performed study by Nejat *et al.*[25] However, in the study performed by Büssing *et al.*,[24] most of the participants had high school education.

Mamier *et al.*[27] carried out a study to measure the prevalence of spiritual needs and identify the factors associated with these needs. Based on the findings of the mentioned study, demographic changes had a significant relationship with spiritual needs, which was consistent with those of the current study.

Table 1: Information about the demographic and therapeutic characteristics of the patients participating in the study

Participant Characteristics	Number	Percent	Areas				Total
			Religious needs	Need for inner peace	Existential needs	Actively giving	
Gender							
Male	36	37.5	10.72±2.06	6.61±3.57	4.55±2.96	4.16±2.03	26.06±7.91
Female	60	62.5	12.81±3.25	7.65±3.02	4.65±2.99	4.00±2.50	29.12±7.59
Significance level			0.0001*	0.13	0.88	0.72	0.06
Marital Status							
Never been married	15	15.6	11.53±3.58	7.66±3.28	3.93±2.15	3.46±2.26	26.60±6.52
Married	79	82.3	12.06±3.13	7.12±3.24	4.69±3.03	4.16±2.33	28.05±7.87
Widowed	2	2.1	14.50±0.71	9.50±4.94	6.50±6.36	4.50±3.53	35.00±15.56
Significance level			0.46	0.53	0.44	0.55	0.36
Education Level							
No school completed	26	27.1	12.65±2.26	6.88±2.71	4.15±2.70	3.96±2.35	27.65±6.14
Primary school completed	22	22.9	11.90±3.19	5.36±3.24	5.00±3.20	4.04±2.62	26.32±9.12
Guide school graduate	10	10.4	12.90±2.92	7.00±3.68	4.70±2.90	3.60±2.01	28.20±6.36
High school graduate	22	22.9	12.18±3.56	8.77±2.81	5.13±3.07	4.45±2.48	30.55±8.15
University degree	16	16.7	10.43±3.81	8.56±3.22	4.06±3.08	4.00±2.00	27.06±8.64
Significance level			0.21	0.003*	0.70	0.90	0.46
Employment							
Employed	8	8.3	11.12±4.25	8.87±2.74	3.62±1.99	4.37±1.84	28.00±6.93
Home duties	52	54.2	13.00±3.07	7.38±2.93	4.73±2.92	4.07±2.46	29.19±7.02
Worker	9	9.4	11.33±2.06	6.00±4.44	5.33±2.59	4.11±1.76	26.78±8.49
Self-employed	15	15.6	10.80±2.83	7.13±4.13	4.06±3.28	4.40±2.29	26.40±9.24
Unemployed	12	12.5	10.50±2.96	6.75±2.70	4.91±3.67	3.33±2.60	25.50±9.36
Significance level			0.02*	0.46	0.72	0.81	0.52
Location							
City	69	71.9	12.17±3.32	7.62±3.26	4.59±3.04	4.17±2.41	28.56±8.02
Village	27	28.1	11.66±2.82	6.33±3.12	4.66±2.82	3.77±2.11	26.44±7.16
Significance level			0.486	0.081	0.915	0.457	0.23
Type of Cancer							
Breast	17	17.7	13.17±3.28	6.88±2.82	4.11±3.21	3.94±2.68	28.12±6.95
Colorectal	21	21.9	12.14±2.61	8.09±2.99	5.28±3.14	5.04±2.31	30.57±7.55
Esophagus	3	3.1	8.66±1.52	4.00±3.60	5.00±2.64	4.33±2.51	22.00±7.55
Prostate	2	2.1	12.50±4.94	8.50±0.70	4.00±4.24	4.50±3.53	29.5±12.02
Bone	3	3.1	17.00±1.00	10.33±1.15	5.33±3.21	3.00±2.64	35.67±7.23
Brain	2	2.1	13.50±0.70	11.00±0.00	3.50±3.53	6.00±2.82	34.00 ± ± 7.07
Lung	10	10.4	11.30±2.58	6.50±3.37	5.20±2.09	3.90±1.79	26.90±4.07
Kindy, liver, and pancreas	10	10.4	11.40±3.34	8.50±1.90	4.40±3.24	3.70±1.49	28.00±5.75
Leukemia	23	24.0	11.17±3.31	6.39±3.68	4.47±2.74	3.47±2.39	25.52±8.97
Ovarian	5	5.2	12.60±3.78	6.20±4.65	3.40±4.39	3.60±2.70	25.80±11.92
Significance level			0.075	0.174	0.944	0.686	0.44
Type of Treatment							
Surgery	8	8.3	13.00±3.96	7.62±2.77	5.12±2.35	3.75±1.83	29.50±7.54
Chemotherapy	68	70.8	12.07±3.19	6.69±3.44	4.60±3.03	3.82±2.45	27.19±7.90
Radiotherapy	1	1.0	14.00±0.00	6.00±0.00	1.00±0.00	7.00±0.00	28.00±0.00
Other cases	19	19.8	11.36±2.89	9.21±1.87	4.63±3.04	4.89±1.85	30.11±7.69
Significance level			0.46	0.01*	0.89	0.19	0.31
	Min.	**Max.**	**Mean±Standard Deviation**				
Age	19	81	47.82±14.35				
Pearson correlation coefficient			−0.001	−0.18	−0.06	0.01	−0.09
Significance level			0.99	0.08	0.57	0.91	0.36

*$P<0.05$

The diagnosis of cancer in individuals influences both their body and soul. This disease can lead to a tremendous spiritual crisis in the person, and therefore, demolish one's wishes and ambitions.[28] Patients often resort to their notion of spirituality and religion to find meaning and need spiritual care. The first step in providing optimal spiritual care to the patient is to identify their spiritual needs. The fulfillment of the patient's spiritual needs can have a large impact on the quality of life of patients with cancer; consequently, it is particularly important to explore and assess these needs.[29]

Table 2: Areas of spiritual needs of cancer patients

Areas	Min.	Max.	Mean	Standard deviation
Religious needs	3.00	18.00	12.03	3.18
Need for inner peace	0.000	15.00	7.26	3.26
Existentialistic needs	0.000	12.00	4.61	2.96
Actively giving	0.000	9.00	4.06	2.32
Total	4.00	50.00	27.96	7.80

The findings of a study conducted by Khodaverdi *et al.*[30] indicated that spiritual needs played a major role during the different stages of cancer and in dealing with this disease. According to the results of a study conducted by Xie *et al.*, the uncertainty of life events established the spiritual needs prevailing in every ill individual.[31] The findings of other studies have confirmed the positive impact of religious beliefs and further spiritual approaches on the health and healing process of patients suffering from acute and chronic diseases.[32]

The findings of the present study revealed that once challenged with cancer, all participants reported spiritual needs. The results of a study performed by Ahangarkani *et al.*[33] revealed that spiritual needs and behavioral factors, as two psychological components, could influence the spiritual well-being of patients. Safari *et al.*[34] demonstrated that paying attention to the spiritual needs of cancer patients helped them adjust to their condition and promoted their recovery. Moreover, based on the results of a study conducted by Harorani *et al.*, religious practices can enhance the sense of competence and hope over the sense of isolation; therefore, patients wished to fulfill their spiritual needs.[35] According to the abovementioned findings, it seems that religious instructions play a fundamental role in empowering patients and boosting their adaptation to disease. Appealing to religious practices builds serenity and hope and increases communication and individual and social hopes in patients.[36]

Patients occasionally reflect their spiritual needs in the shape of existential needs. Although there is a theoretical distinction among psychological, spiritual, and existential needs, they are closely interconnected.[37] According to Ahangarani *et al.*, addressing spiritual needs is recognized as a crucial part of holistic care in nursing. Spirituality is interpreted as a dimension of human life that inspires individuals.[33]

The findings of the present study indicated that among all aspects of spiritual needs, the highest mean score was associated with religious need, followed by the need for inner peace. The results of studies conducted by Ghahramanian *et al.*,[38] Sharif Nia *et al.*,[39] Sadeghloo *et al.*,[40] and Khodavardi *et al.*[30] confirmed the positive impact of religious beliefs, spiritual communities, recourse to prayer, religious rites and rituals, and other spiritual approaches on the health and recovery process of patients, which are in line with the those of the present study. Nonetheless, based on the findings of studies performed by Sleight *et al.*[41] and Cheng *et al.*,[42] the highest score was related to the aspect of the need for peace. These findings were inconsistent with those of the study carried out by Büssing *et al.*[24] In their study, religious needs were incredibly notable in 67% of patients with cancer.

In another study conducted by Büssing *et al.*[24] on Chinese participants with cancer, religious needs were less significant than needs for inner peace, which was not in agreement with the findings of the present study. This discrepancy could be attributed to the religion of the participants since many of them did not adhere to any religion. Cheng *et al.* justified the attention to the spiritual needs of Poles as opposed to Germans by highlighting their religious attitude and considered it the primary reason.[42] The results of the study performed by Nejat *et al.*[25] confirmed the findings of the this study.

Another factor affecting spiritual needs is the absence of a comprehensive definition of spirituality. In a study performed by Büssing *et al.*,[24] it was found that the term "spiritual needs" was not well-understood by several participants: while some subjects interpreted spiritual needs as religious needs, others sought an explanation. Büssing *et al.* suggested that researchers utilize alternative terms to prevent misinterpretations.

Patients with cancer often report their mental needs as finding meaning and hope and drawing meaning out of suffering; these are associated with the existential realm. In Islam, there is no distinction between spirituality and religion, and religion guides towards a spiritual mode of life. Perhaps this precise definition can justify the higher score of religious needs in Muslim patients with cancer.[42]

Another finding of the current study was the significant relationship between the patient's spiritual needs and demographic variables. Cheng *et al.*[42] indicated that the spiritual needs of patients vary according to the stage of the disease, time of diagnosis, and frequency of hospitalization. Moreover, the results of a study conducted by Astrow *et al.* demonstrated that spiritual needs differed according to the cultural background in each ethnicity.[43]

In the present study, the need for inner peace varied according to the patient's level of education, meaning that participants with higher education levels needed more inner peace. These results were consistent with those of the studies carried out by Astrow *et al.* and Ghahramanian *et al.*[38,43] The reason for this finding seems to be due to the level of perception and reflection acquired by well-educated individuals; since they require a logical explanation to accept any incident, they desire inner peace, ontology, and mindfulness toward themselves and the outside world more than resorting to prayer and religious rituals. Similarly, Sajadi *et al.* reported that achieving a sense of serenity was the most important end-of-life care for educated patients.[44] The need for inner peace was more evident in patients undergoing chemotherapy. The results of a study performed by Okhli *et al.* confirmed the above finding. The reason for this result can be due to the mental disturbances and disorders caused by chemotherapy in patients leading to a greater need for inner peace in patients.[45]

According to the results, the area of religious need fluctuated significantly between different statuses of occupation, and religious needs were more important in housewives than in others. Moreover, the spiritual needs of the cancer patients had increased after a year of diagnosis. The results of the studies carried out by Nejat *et al.*[25] and Okhli *et al* were consistent with the above findings. In justification of the above results, it can be said that according to human experience in all cultures, man always seeks assistance from a sacred and divine source in emergencies and at times of life-threatening illnesses and their need for spirituality exceptionally becomes more prominent in such circumstances.[45]

Morality, peace, and spirituality are inseparable parts of any culture that lead to the promotion of integrity, growth, and moral health in the society's individuals in all careers; however, their intensity and dependency are higher at some layers of society. For instance, housewives are more inclined to perform rituals and prayers and fulfill their religious needs rather than other needs, such as the need for inner peace, existential need, and need for giving. The reason could be attributed to their level of insight and a more general perception of their surroundings.[45]

The other finding of the current study was that the score of religious needs was higher in women, which was consistent with the results of studies conducted by Sajadi *et al.* and Vazifeh Doust *et al.*[44,46] Furthermore, based on the results of a study performed by Sajadi *et al.*,[44] spiritual consulting had a significant impact on the scale of mental well-being in Iranian women with cancer. Therefore, interventions that improve the spiritual needs of these patients should be incorporated into conventional treatments. In another study gender showed no significant impact on the scale of the needs.[47]

The reason why men and women differ in their religious needs has been the subject of scientific debate for many decades. Some scientists of social studies have argued that religious women outnumber religious men across societies, cultures, and religions. Nevertheless, the findings of another study have highlighted that although women are generally more religious, men show higher levels of religious commitment in some countries and communities. This disparity is associated with the religion of individuals since women are less obliged to attend religious ceremonies in some religions, such as Islam.[46,47]

Some sociologists have argued that this difference might be due to higher testosterone levels in men or other physical and genetic dissimilarities between men and women. According to the results of some research studies, outdoor work is associated with lower involvement in religion.[47] Perhaps the exposure to diverse values and worldviews undermines religious commitment; therefore, relatively more traditional women tend to stay at home.

Limitations of study

One of the limitations of the study is related to the patients' unwillingness to collaborate. The other limitation is the difficulty in following up with patients to complete the questionnaires due to the nature of the disease and the complications linked with the disease and treatment. As a result, the sampling process took longer than expected.

Conclusion

The results of the present study regarding the spiritual needs of participants in the target domains furnish a valuable guide for researchers and nurses to attempt to gain an adequate understanding of the spiritual needs of patients. Not only does discerning the spiritual needs of cancer patients enrich the performance of clinical caregivers but it also boosts the patients' adaptation when confronted with crucial conditions once the findings are put into practice and pursued. Furthermore, knowledge of the needs grants religious scholars a fresh perspective on the circumstances in which these patients live. Moreover, this awareness enhances the quality of life of patients, and therefore, boosts their adaptation, and lays the groundwork for easier death.

Having the healthcare system knowledgeable of the patients' spiritual needs can hence lead to highlighting the necessity of increasing the awareness and proficiency levels of caregivers, clerical specialists, and psychologists; procuring media that produces spiritual contents, such as books and audio-visual materials; conducting research studies and interventions concerning spiritual needs; and spreading awareness of the welfare and psychological deficiencies of cancer patients and their family members. Provided that the results are followed and actions are taken to modify the condition of psychological and spiritual services for these patients, we can improve the recovery process and life satisfaction of cancer patients. It is suggested that in addition to comprehensive planning for therapeutic-supportive and palliative care for cancer patients, the notion of spiritual needs and its coherence in psychotherapy be attended by relevant experts and authorities as important issues.

Declarations

Ethics approval and consent to participate

The present research was the result of a research project approved by the Arak University of Medical Sciences, Arak, Iran (IR.Arakmu.Rec. 13984.33). After acquiring the legal permits, the goals and significance of the research were explained to the participants and their conscious verbal consent was attained. The subjects were assured of confidentiality and anonymity in this research.

Consent for publication

The authors agree to publish this article.

Availability of data and material

Not applicable

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Conflicts of interest

There are no conflicts of interest.

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