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Spiritual care needs and influencing factors among inflammatory bowel disease patients

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ABSTRACT

Aims: This study aimed to determine the spiritual care needs of individuals diagnosed with inflammatory bowel disease (IBD) and to examine the relationship with some sociodemographic and clinical characteristics.

Methods: This descriptive and correlational study was conducted with individuals diagnosed with IBD (n=203). Data were collected using the "Descriptive Information Form," "Spiritual Care Needs Inventory," "Simple Clinical Colitis Activity Index," and " Harvey-Bradshaw Index." Descriptive statistics, t-test for independent groups, one-way analysis of variance, and Pearson correlation analysis were used to analyze the data.

Results: The mean total spiritual care need score of the participants was found to be 59.38±20.00. According to the sub-dimensions, the mean score of the "meaning and hope" sub-dimension was 35.56±13.45, and the mean score of the "caring and respecting" sub-dimension was 23.82±8.17. The "meaning and hope" sub-dimension scores of single and employed individuals were significantly higher than those of married and unemployed individuals ($p<0.05$). In addition, total spiritual care needs scores of individuals who did not use medication for IBD were found to be higher than those who used medication ($p<0.05$). A significant positive correlation was found between the Harvey-Bradshaw Index and the "caring and respecting" sub-dimension ($p<0.05$).

Conclusion: It was determined that the spiritual care needs of individuals diagnosed with IBD were generally above average. The increase in disease activity especially increases individuals' expectations for attention, being valued, and meaning in life. These findings suggest that nurses should be physically, spiritually, and psychosocially sensitive.

Keywords: Inflammatory bowel disease, spiritual care, spiritual need, chronic disease, nursing

INTRODUCTION

Inflammatory bowel diseases (IBD) are lifelong diseases characterized by chronic inflammation leading to progressive and irreversible destruction of the gastrointestinal tract.[1] IBDs negatively affect the quality of life of patients in many ways. Chronicisation of the disease, physical and psychosocial effects related to the disease, and treatment are the main reasons for the decrease in patients' quality of life.[2] The main physical symptoms affecting the quality of life of patients can be listed as abdominal pain, chronic and recurrent diarrhea attacks, sudden need for a toilet, nausea, vomiting, weight loss, anorexia, fatigue, etc.[3] Apart from the physical symptoms of the disease, psychosocial effects such as anxiety, depression, and social isolation also affect patients negatively.[4]

In diseases that require long-term treatment and in situations that reduce the quality of life, individuals' physical, emotional, spiritual and social needs as well as spiritual needs increase.[5] In addition, every patient with severe chronic illness needs basic spiritual care, including compassionate treatment.[6] However, spiritual and psychosocial needs are more abstract and complex than physical and difficult to measure.[5] The need for spiritual care refers to people's inner and dynamic dimension.[7] The fundamental element of holistic care is paying attention to the patient's spiritual needs.[8] Spiritual care can promote optimism and effective stress management, increase self-control, support self-care, and contribute to the regain of self-confidence and self-concept.[9] In a study examining the barriers to spiritual care for cancer patients in Turkiye, it was determined that nurses lacked knowledge about spiritual care, did not have enough time to provide this care, and there were insufficient private areas where they could discuss spiritual issues with the patient.[10]

Healthcare professionals recognize that coping with a chronic disease such as IBD can be extremely challenging and can have a significant negative impact on the patient's quality of life. These patients regularly worry about the many uncertainties associated with their disease, such as when

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the next flare-up will occur, whether they will be able to control the urge to defecate during social events or at work, whether current medications will wear off, and whether surgery will be required. These worries also affect their interactions with family members, children, colleagues, and friends, contributing to increased difficulties in coping with their illness and mood disorders.[11] A study conducted with individuals with chronic disease determined that increasing spiritual well-being also increases compliance with chronic disease.[12] In addition, in a study, it was stated that the spiritual needs of cancer patients are related to fatigue, depression, social support, and other factors.[13]

Although the physical and psychosocial impacts of IBD have been well documented, studies examining the spiritual care needs of these patients are limited. Addressing spiritual needs is a fundamental aspect of holistic care, which can enhance coping strategies, foster self-confidence, and improve overall quality of life. Understanding these needs is essential for healthcare professionals to provide patient-centered care that addresses not only physical symptoms but also emotional and spiritual well-being. Investigating the spiritual care needs of IBD patients therefore fills an important gap in the literature and contributes valuable insights to holistic care practices. Therefore, it is essential to meet the spiritual care needs of patients. This study aimed to determine the level of spiritual care needs of IBD patients to promote holistic care, improve their quality of life, and investigate the relationship with variables such as sociodemographic and disease/treatment characteristics.

METHODS

Ethics

Before starting the study, permission was obtained from the Gazi University Ethics Committee (Date: 30.04.2024, Decision No: 2024-827), and institutional permission was obtained. After receiving detailed information about the study, the patients provided written and verbal informed consent, voluntarily agreeing to participate. The research process was conducted in accordance with ethical principles, ensuring the confidentiality and rights of the participants, and the data were used solely for research purposes. The study was conducted according to the ethical principles outlined by the World Medical Association's Declaration of Helsinki.

Study Design and Setting

This study is a descriptive and correlational study. The study population was conducted in Gazi University Gastroenterology Department IBD Outpatient Clinic between June and November 2024. This clinic serves an average of 500 patients 5 days a week. Patients receive treatment during flare-ups of their disease and routine follow-ups during remission periods. Additionally, procedures for patients using anti-TNF and biological agents are coordinated with the infection department, and their treatments are scheduled. All patients receive education and psychological support regarding their disease, medications, and diet. Patients with rheumatological, dermatological, and autoimmune diseases are also monitored in coordination with the relevant departments. Depending on the patient's condition, support is also provided by a psychiatrist for patients with conditions such as depression and anxiety.

Study Population

In this study, convenience sampling was used as the sampling method. Participants were invited to the study during their routine outpatient visits, and those who volunteered were included in the study. Patients diagnosed with IBD who met the inclusion criteria, volunteered to participate in the study, and obtained written and verbal consent were included in the study sample. The inclusion criteria for the study sample were patients over 18 who could read and write, did not have communication difficulties, and volunteered to participate.

The study calculated the sample size at a 95% confidence level using the "G-power-3.1.9.2" program. As a result of the analysis calculated, the minimum sample size was 138 at α=0.05 level, based on a standardized effect size of 0.3 and a theoretical power of 0.95.[14] The study was completed with 203 patients.

Data Collection Tools

Data collection tools "Patient Introduction Form," "Simple Clinical Colitis Activity Index", "Harvey-Bradshaw Index" and "Spiritual Care Needs Inventory" were used to collect the research data.

Patient Introduction Form: It was created by the researchers in the light of literature information. It consists of questions related to sociodemographic data, health, disease, and treatment.[13,15,16]

Spiritual Care Needs Inventory (SCNI): The scale developed by Wu et al.[17] in 2016 provides information about the spiritual care needs of patients. A Turkish validity and reliability study was conducted by Günay İsmailoğlu et al.[5] in 2019. The scale differs from other scales because it can be used in all patients and patients with different religious beliefs, regardless of the reasons for hospitalization. The SCNI is a scale consisting of 21 items. The items in the scale include the potential spiritual care needs of the patients. Patients are asked to rate the necessity of the spiritual care needs in each item on a 5- point Likert scale. The evaluation is as follows: 1="not at all necessary", 2="not necessary", 3="does not matter", 4="necessary", 5="absolutely necessary". The average score that can be obtained from the scale varies between 21-105. The higher the mean total score on the scale, the more spiritual care the patient needs. The scale consists of 2 components: "meaning and hope" (1-12, 14) and "caring and respecting" (13, 15-21). The meaning and hope component includes expressions of spiritual well-being towards oneself, nature, and environmental factors; the caring and respect component includes expressions toward relationships with others. In the Turkish validity and reliability study of the scale, the general scale internal consistency Cronbach Alpha value was found to be 0.935.[5] In this study, the Cronbach Alpha value of the scale was determined as 0.957.

Simple Clinical Colitis Activity Index (SCCAI): A diagnostic tool and questionnaire used to assess the severity of symptoms

in people with ulcerative colitis. The index was created in 1998 and is still used to determine the severity of symptoms. Active disease scores five or higher.[18]

Harvey-Bradshaw Index (HBI): This index consists of questions that allow the patient to quickly categorize the severity of Crohn's disease and detect remission. Harvey and Bradshaw published the index in The Lancet in 1980 as a shorter and simpler alternative to the standard classification technique called the Crohn's Disease Activity Index. Patients answer five questions and are scored according to the severity of their symptoms. A score below 5 indicates remission.[19]

Data Collection

The study data were collected between June and November 2024 at a University Gastroenterology Department IBD Outpatient Clinic after obtaining the ethics committee's approval and institutional permission. Data were collected by the researchers through face-to-face interviews. Participants were invited to participate in the study during routine outpatient visits, and those who agreed to participate were taken to a quiet and appropriate room to ensure privacy and comfort. After providing detailed information about the study and obtaining written and verbal consent, the data collection process was initiated. The forms used were, in order, the "Patient Information Form," the "Simple Clinical Colitis Activity Index," the "Harvey-Bradshaw Index," and the "Spiritual Care Needs Inventory." Researchers only provided assistance when questions were unclear, refraining from any guidance that might influence responses. The entire application process took an average of 15 minutes per participant.

Statistical Analysis

The data obtained in the study were analyzed using SPSS (Statistical Package for Social Sciences) for Windows 25.0 and DataBeeg 1.0 software. Descriptive statistical methods (number, percentage, min-max values, mean, standard deviation) were used to evaluate the data. The data used were tested for conformity to normal distribution. Q-Q Plot drawing can analyze Compliance with a normal distribution.[20] In addition, the normal distribution of the data used depends on the skewness and kurtosis values being between ±3.[21] In the comparison of quantitative data in normally distributed data, an independent t-test was applied for the comparison of two independent groups, a one-way analysis of variance was applied for the comparison of more than two independent groups, and Bonferroni was used to find the group that made a difference in case of a difference. Pearson correlation was applied to test the relationship between two numerical variables.

RESULTS

The mean age of the patients who participated in the study was 41.79±14.51 years. 51.7% of the patients were female, 63.5% were married and 62.6% had children. The rate of primary school graduates was 40.9%, and the rate of employees was 66.0%. 56.7% of the patients reported their income level as "income equal to expenses." 26.1% of the patients were smokers, and 10.3% were alcohol users. 53.7% of the patients were diagnosed with Crohn's disease, and the proportion of patients with a diagnosis of IBD of 11 years or more was 30.5%. 45.3% of the patients were hospitalized due to IBD, and 19.2% underwent surgery due to IBD. It was determined that 61.1% of the patients had other chronic diseases/disorders in addition to IBD, and 55.2% of them were taking medication for these diseases/disorders. Harvey Bradshaw Activity Index in Crohn's disease patients: 3.88±2.61, and in patients with ulcerative colitis, the Ulcerative Colitis Simple Clinical Colitis Activity Index: 1.44±2.07 (**Table 1**).

The mean scores of the "meaning and hope" sub-dimension of the SCNI were 35.56±13.45, the mean scores of the "caring and respecting" sub-dimension were 23.82±8.17, and the mean total score of the scale was 59.38±20.00 (**Table 2**).

The comparison of the mean scores of the SCNI sub-dimension and total scores according to the characteristics of the patients participating in the study is given in **Table 3**. When the statistically significant differences were examined, it was determined that the mean scores of the "meaning and hope" sub-dimension of single patients were higher than those of married patients ($p<0.05$). It was also found that the mean scores of the "meaning and hope" sub-dimension of the employees were statistically significantly higher than the non-employees ($p<0.05$). The mean total scores of the SCNI of those who did not use medication for IBD were significantly higher than those who did not use medication ($p<0.05$).

Pearson correlation was applied to test the relationship between some characteristics of the patients and the mean scores of the SCNI sub-dimension and total scores. As a result, it was determined that there was a significant positive correlation between the mean scores of the "caring and respecting" sub-dimension and Harvey-Bradshaw Index scores ($p<0.05$). The relationships between other characteristics were not statistically significant ($p>0.05$) (**Table 4**).

DISCUSSION

The lack of standard clinical practice guidelines for addressing spirituality in adults with serious health problems reveals an essential deficiency in this field. Studies have shown that ignoring spiritual needs can lead to unresolved spiritual and physical pain, as well as avoidable distress and suffering.[22,23] This situation shows how vital spiritual care is, especially for individuals struggling with chronic and life-threatening diseases. It is seen that previous research has primarily focused on cancer patients, cancer survivors, or those at the end of their lives.[13,24-26] However, in the existing literature, studies specifically addressing the spiritual care needs of individuals with IBD are limited.[16,27] However, it is known that this patient group also experiences various difficulties at both physical, psychosocial, and spiritual levels due to chronic symptoms that negatively affect quality of life. In this respect, this study, which aims to evaluate the spiritual needs of IBD patients, has a unique quality that fills the existing gap in the literature and contributes to the understanding of holistic care.

In our study, it was determined that the spiritual care needs of individuals diagnosed with IBD were above average. When

Table 1. Distribution of the patients participating in the study according to their characteristics (n=203)

	n	%
Gender		
Female	105	51.7
Male	98	48.3
Marital status		
Single	74	36.5
Married	129	63.5
Child presence		
There is	127	62.6
None	76	37.4
Education status		
Primary and secondary school	43	21.2
High School	83	40.9
Undergraduate and postgraduate	77	37.9
Employment status		
Yes	134	66.0
No	69	34.0
Income level		
Income less than expenditure	50	24.6
Income equals expenditure	115	56.7
Income more than expenditure	38	18.7
Smoking status		
Yes	53	26.1
No	150	73.9
Alcohol use status		
Yes	21	10.3
No	182	89.7
Medical diagnosis		
Ulcerative colitis	94	46.3
Crohn's disease	109	53.7
Time to diagnosis of IBD		
0-5 years	107	52.7
6 years and over	96	47,3
Hospitalization due to IBD		
Yes	92	45.3
No	111	54.7
Operation due to IBD		
Yes	39	19.2
No	164	80.8
Presence of chronic disease		
Yes	124	61.1
No	79	38.9
Medication use due to chronic disease		
Yes	112	55.2
No	91	44.8
Age: 41.79±14.51 (minimum=18.00, maximum=83.00)		
Harvey-Bradshaw Index: 3.88±2.61		
Simple Clinical Colitis Activity Index: 1.44±2.07		

IBD: Inflammatory bowel disease

Table 2. Patients' mean scores of the Spiritual Care Needs Inventory (SCNI) subscale and total scores (n=203)

	Mean±SD	Minimum	Maximum
Meaning and hope	35.56±13.45	13.00	65.00
Caring and respecting	23.82±8.17	8.00	40.00
Total score	59.38±20.00	21.00	105.00

SD: Standard deviation

Table 3. Comparison of the mean scores of the Spiritual Care Needs Inventory (SCNI) subscale and total scores according to the characteristics of the patients (n=203)

Characteristics		Meaning and hope	Caring and respecting	SCNI total score
		Mean±SD	Mean±SD	Mean±SD
Gender	Female	35.05±12.69	24.31± 8.44	59.36± 19.48
	Male	35.50± 13.69	23.30± 7.90	58.80± 20.11
	Test value	-0.244**	0.886**	0.204**
	p	0.807	0.377	0.839
Marital status	Single	36.36± 13.01	23.91± 8.16	60.26± 20.01
	Married	33.36± 13.27	23.68± 8.26	57.04± 19.22
	Test value	2.166**	0.194**	1.120**
	p	0.031*	0.847	0.264
Child presence	Yes	35.75±13.19	23.83±8.14	59.58±19.88
	No	34.46±13.13	23.80±8.30	58.26±19.60
	Test value	0.674**	0.027**	0.460**
	p	0.501	0.979	0.646
Education status	Primary and secondary school	37.23±13.47	24.79±8.43	62.02±20.37
	High school	34.51±13.18	23.39±8.60	57.89±20.33
	Undergraduate and postgraduate	34.99±13.01	23.75±7.61	58.74±18.81
	Test value	0.6434***	0.420***	0.638***
	p	0.531	0.657	0.530
Employment status	Yes	36.04±13.67	23.84±8.70	59.87±20.89
	No	33.77±12.04	23.80±7.12	57.57±17.32
	Test value	2.168**	0.032**	0.788**
	p	0.025*	0.975	0.431
Income level	Income less than expenditure	36.68±12.56	24.04±8.19	60.72±19.40
	Income equals expenditure	35.47±12.98	23.90±8.02	59.37±19.51
	Income more than expenditure	32.79±14.39	23.29±8.81	56.08±21.03
	Test value	0.976***	0.103***	0.622***
	p	0.378	0.902	0.538
Smoking status	Yes	34.26±11.70	22.85±8.46	57.11±18.77
	No	35.62±13.65	24.17±8.08	59.79±20.08
	Test value	-0.644**	-1.008**	-0.847**
	p	0.520	0.314	0.398

The table continues

Table 3. Comparison of the mean scores of the Spiritual Care Needs Inventory (SCNI) subscale and total scores according to the characteristics of the patients (n=203) (The table continues)

Alcohol use status	Yes	35.90±14.16	24.67±8.29	60.57±20.96
	No	35.19±13.07	23.73±8.18	58.92±19.65
	Test value	0.235**	0.499**	0.363**
	p	0.815	0.619	0.717
Medical diagnosis	Ulcerative colitis	34.94±13.03	23.41±7.74	58.35±19.21
	Crohn's disease	35.55±13.31	24.17±8.56	59.72±20.25
	Test value	-0.331**	-0.659**	-0.494**
	p	0.741	0.511	0.622
Time to diagnosis of IBD	0-5 years	35.53±13.92	23.76±8.30	59.29±20.56
	6 years and over	34.97±12.30	23.90±8.08	58.86±18.88
	Test value	0.304**	-0.120**	0.153**
	p	0.761	0.904	0.879
Medication use status	Yes	35.27±13.21	23.75±8.11	59.02±19.75
	No	35.25±11.62	27.50±11.79	62.75±21.75
	Test value	0.002**	-0.908**	-2.271**
	p	0.998	0.365	0.025*
Hospitalization due to IBD	Yes	35.40±12.00	23.52±8.28	58.92±18.67
	No	35.15±14.08	24.07±8.12	59.23±20.67
	Test value	0.134**	-0.476**	-0.108**
	p	0.894	0.634	0.914
Operation due to IBD	Yes	36.77±14.12	23.33±8.87	60.10±22.19
	No	34.91±12.93	23.94±8.03	58.85±19.18
	Test value	0.793**	-0.415**	0.356**
	p	0.428	0.679	0.722
Presence of chronic disease	Yes	35.50±12.87	23.87±8.21	59.37±19.37
	No	34.90±13.66	23.75±8.18	58.65±20.42
	Test value	0.317**	0.105**	0.255**
	p	0.752	0.916	0.799
Medication use due to chronic disease	Yes	35.61±13.16	23.97±8.43	59.58±20.06
	No	34.85±13.21	23.64±7.90	58.48±19.43
	Test value	0.409**	0.290**	0.393**
	p	0.683	0.772	0.695

SCNI: Spiritual Care Needs Inventory, IBD: Inflammatory bowel disease, SD: Standard deviation, *p<0.05, **Independent t-test, ***One-way analysis of variance

Table 4. The relationship between some characteristics of the patients and the mean scores of the subscales and total scores of the Spiritual Care Needs Inventory

	Age		Harvey-Bradshaw Index		Simple Clinical Colitis Activity Index	
	r	p	r	p	r	p
Meaning and hope	0.045	0.521	-0.046	0.515	-0.054	0.442
Caring and respecting	0.023	0.746	0.196	0.047*	0.048	0.497
Total score	0.040	0.574	0.000	0.996	-0.016	0.818

r: Pearson correlation coefficient, *p<0.05

evaluated in general, it can be said that the spiritual care needs of the patients are significant and at a level that should not be ignored. This finding parallels the results of studies conducted with individuals with different chronic conditions in the literature.[6,13,28] For individuals with serious illnesses, spirituality stands out as an essential source of support in the process of coping with life. Studies show that most individuals (71-99%) find spirituality meaningful, and more than half (50-96%) demand spiritual care within the scope of health services. However, despite this high demand, it is seen that spiritual care needs are not sufficiently met in clinical practices. It is stated that the rates of patients who report that the health system does not meet their spiritual needs vary between 49% and 91%.[22,29] This situation shows that spiritual care is still secondary in clinical practice, and the holistic care approach has not been fully realized. It is thought that the main reasons for the high need for spiritual care in individuals diagnosed with IBD may be related to the chronic, unpredictable nature of the disease, which directly affects the quality of life. At the same time, psychosocial burden and social stigmatization increase the search for meaning, the need for hope, and the search for inner support.

Long-term hospitalization of patients treated in internal medicine clinics is an important factor that increases their spiritual care needs.[30] In particular, individuals with chronic diseases or faced with conditions such as IBD that radically affect life may enter a deep spiritual questioning process over time. In this process, they may perceive the disease as divine punishment, experience a sense of injustice, and lose hope in prayer and belief systems. Such spiritual distress may damage not only the psychological but also the spiritual well-being of the person.[27] However, data on the spiritual care needs of individuals diagnosed with IBD are limited. However, determining these needs is essential in developing patient-centered care practices and planning appropriate support services. In previous studies, it was reported that adult individuals stated that spirituality helped them to reinterpret the disease process, gain a new perspective on their lives, and experience inner relief during challenging periods.[31] In a study conducted by Starnella et al.[16] with individuals with IBD (n=103), it was determined that patients developed their spirituality by maintaining their lives by their core values (47.7%), staying in contact with nature (30.5%), praying (15.8%), engaging in introspection and self-knowledge activities (14.7%), volunteering (12.6%) and doing extreme sports (10.5%).

Various studies have suggested that spirituality may positively affect psychosocial outcomes in individuals with chronic physical illnesses.[31,32] Although the exact mechanisms through which this effect occurs cannot be clearly explained, it is thought that spirituality contributes to individuals coping with the disease more harmoniously, which may result in a decrease in anxiety and depression levels, an increase in quality of life, and alleviation of physical symptoms. In a meta-synthesis study conducted by Hodge and Horvath,[33] 11 qualitative studies were analyzed on the spiritual needs

expressed by individuals with non-fatal health problems in healthcare settings. The main themes that emerged from this analysis were summarised as the search for meaning, purpose, and hope in life; emotional needs related to a relationship with God (e.g., guilt or questioning); the need to engage in spiritual practices such as prayer, meditation, and scripture reading; sensitivities towards the fulfillment of religious obligations (e.g. special dietary practices); the desire for strong social bonds with family members and clergy; and finally the desire for an empathetic, supportive relationship with health professionals (e.g. compassionate approach and advocacy).[33] These findings show that spiritual care is a multidimensional need that can contribute not only to the physical aspect of the disease but also to the individual's holistic well-being.

In our study, the sub-dimension of meaning and hope indicates a need slightly above the medium level. It shows that patients have a measured but significant need to search for inner meaning, a sense of hope, and harmony with nature and the environment. It shows that patients are more focused on personal belief, meaning of life, hope, and inner integrity and need more support. The meaning and hope component also includes spiritual well-being towards oneself, nature, and environmental factors.[5] In the process of coping with chronic diseases, individuals may face vital crises such as loss of status and role, fear of death, insufficient social support, loneliness, pain, and hopelessness about the future. In such periods, patients' spiritual needs, such as feeling safe, adding meaning to their lives, receiving love, and belonging to a place, come to the fore.[34] In this context, it is not surprising that this dimension emerges as an essential need in individuals diagnosed with IBD.

In our study, the moderate level of need in the "caring and respect" sub-dimension of the spiritual care scale shows that patients have a confident expectation of being respected, feeling valuable, and receiving social support from the people around them. This sub-dimension points to the importance of a caring approach based on empathy, respect, and sensitivity to individual values, especially in relationships with others.[5] The understanding and caring approach shown in patient-physician and patient-nurse interactions makes patients feel more secure and understood. The fact that patients want to be seen and cared for both physically and spiritually reveals the need to address them with a more holistic care approach. This finding coincides with the study conducted by Zumstein-Shaha et al.[7] with cancer patients. In this study, nurses stated that individuals living with chronic illnesses were not only physiological but also questioned the meaning of life and needed to give their lives a purpose. While some participants saw overcoming chemotherapy as a life goal, others started spending more time with family members or their pets as their primary goal. These examples reveal that individuals need to be supported biologically, emotionally, socially, and spiritually during the disease process. In addition, some patients reported that maintaining their ties with their faith communities was essential to spiritual support. These individuals ask their faith communities to pray for them, and nurses respect the patient's spirituality by integrating this request into the care process.[7] All these findings show that including the individual's spiritual, social, and emotional aspects in the care process can increase patient satisfaction and well-being.

In our study, significant differences were observed in the spiritual care needs of individuals diagnosed with IBD according to their demographic characteristics. In particular, the higher scores of single individuals in the "meaning and hope" sub-dimension compared to married individuals suggest that this group may have a more pronounced need for loneliness, lack of emotional support and sense of belonging. Lack of spousal or family support may cause individuals to turn more to internal resources and spiritual support systems in coping with the disease. Indeed, Büssing et al.[35] and Höcker et al.[36] similarly stated that spiritual coping mechanisms are activated more intensively in individuals who lack social support. In addition, in a study conducted by Shi et al.[13] with cancer patients, it was reported that the spiritual care needs of widowed and divorced individuals were significantly higher than those of married individuals. These findings show that family structure and social support networks are among the critical factors affecting the level of spiritual needs of the individual and point to the importance of considering the social situation in patient-centered care.

Similarly, it is noteworthy that the scores of working individuals in this sub-dimension are significantly higher than those of non-working individuals. Working life may increase the need to question more about the meaning of life, the desire to achieve success, or the need to cope with stress, and this may trigger the need for spiritual support. Another important finding was that the total spiritual care needs scores of individuals who did not use medication for IBD were higher than those who used medication. This suggests that access to medical treatment or perception of treatment may affect spiritual needs in the management of the disease. Individuals who do not use medication may tend to turn more to spiritual resources to cope with the disease. All these findings reveal that individual and clinical characteristics may affect spiritual care needs and it is essential to consider these variables in care planning.

Our study found a significant positive correlation between the "caring and respecting" sub- dimension and Harvey-Bradshaw Index scores. This suggests that as the symptoms of IBD become more severe, patients expect more attention and understanding from their social environment and health professionals. This reveals that spiritual care needs are internal and have a relational/psychosocial dimension. This finding reveals that individuals desire to be cared for and seen more in coping with the disease, and requires that caring professionals respond to this need with a sensitive approach. The fact that no significant relationship was found between the need for spiritual care and other variables suggests that spiritual needs are shaped more by the course of the disease and individual coping capacity. These results emphasize the importance of planning spiritual care in chronic diseases in a manner sensitive to disease activity.

Limitations

This study has some limitations. First, since the study was conducted at a single center, the findings cannot be directly generalized to all IBD patients; however, they are indicative for patient groups with similar characteristics. In addition, the fact that spirituality is a concept that can show individual and cultural differences may make it difficult to reach the same results in similar studies to be conducted in different social structures. Finally, the study did not assess whether the participants had received any professional spiritual care services before; this shows that an important variable that may affect the spiritual need levels of individuals is ignored. In line with these limitations, obtaining more in-depth information with longitudinal designs and qualitative data collection methods in future studies is recommended.

CONCLUSION

This study revealed that individuals with IBD have significant spiritual care needs, and these needs should not be ignored in clinical care processes. The findings indicate that nurses should be sensitive not only to physical symptoms but also to the spiritual and psychosocial needs of individuals. Especially in the axis of "meaning and hope," creating an environment where individuals can express their thoughts about the meaning of life, and in the dimension of "caring and respect," protecting privacy, respecting individual beliefs, and encouraging active listening should be among the basic components of patient-centered spiritual care. Coping skills play a key role in the self-management of chronic diseases, and nurses' recognition and support of patients' spiritual coping resources can strengthen self-management processes. In this context, making nurses more aware and equipped to assess spiritual needs can potentially improve the quality of care. However, the limited literature on spirituality in individuals with chronic diseases, especially in individuals diagnosed with IBD, and the lack of comparative studies with healthy individuals draw attention. In this respect, this study can provide a basis for future longitudinal and multi-method studies.

ETHICAL DECLARATIONS

Ethics Committee Approval

The study was conducted with the permission of Gazi University Ethics Committee (Date: 30.04.2024, Decision No: 2024-827).

Informed Consent

All patients signed and free and informed consent form.

Referee Evaluation Process

Externally peer-reviewed.

Conflict of Interest Statement

The author declares no conflicts of interest.

Financial Disclosure

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Author Contributions

All of the authors declare that they have all participated in the design, execution, and analysis of the paper, and that they have approved the final version.

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