Association of Religiosity and Spirituality with the Perception of Cancer Patients' Spiritual Wellbeing and Spiritual Needs

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Key Words: *cancer, religiosity, spirituality, spiritual wellbeing, spiritual needs.*

Summary. *The aim was to determine the association of religiosity and spirituality with cancer patients' perception of their spiritual wellbeing and unmet spiritual needs.*

Methods. The cross-sectional study was performed in nursing and supportive treatment units. The data were collected between January and November, 2018. In total, 273 cancer patients participated in the study. Spiritual wellbeing was assessed with Spiritual Health Scale (SHALOM) developed by John Fisher (2010) and spiritual needs were measured with the Spiritual Needs Questionnaire (SpNQ), developed by Arndt Büssing (2010).

Results. The age of patients varied from 32 years to 96 years with the mean of 67.8 ± 10.8. There were more female patients (58.0%) than male (42.0%). The majority were affiliated with the Roman Catholic religion (95.9%), two patients (1.4%) were Russian Orthodox, and three (2.1%) were Russian Orthodox Old Believers.

The scores on each domain of SHALOM and SpNQ were compared in relation to self-assessed religiosity and spirituality of respondents. The results revealed significant associations as patients who noted being religious and spiritual rated their spiritual wellbeing and spiritual needs higher (3.89 ± 0.51) than non-religious (3.40 ± 0.38) and non-spiritual ones (2.44 ± 0.63). The personal, communal, and environmental domains of spiritual wellbeing on both SHALOM domains (ideals and lived experience) and the giving/generativity and forgiveness needs dimension of the SpNQ scale were rated higher by non-religious, but spiritual respondents in comparison with the non-religious and non-spiritual group. Spiritual needs on four dimensions inter-correlated stronger among religious patients than among spiritual patients (Spearman's rho 0.524 and 0.471, respectively). The strongest associations were observed between the SHALOM's transcendental domain and religious and existential needs. Similarly, the strongest correlation was observed between dissonance on transcendental spiritual wellbeing and religious needs.

The spiritual wellbeing on the SHALOM's lived experience domains was more strongly related to all spiritual needs than spiritual wellbeing on the SHALOM's ideal domains.

Conclusions. Individual sense of religiosity and spirituality in personal life is associated with spiritual wellbeing and unmet spiritual needs of cancer patients. Even if religious and spiritual believes are very personal and private matters, spiritual needs and spiritual wellbeing should be part of cancer patient's comprehensive health and care assessment and planning.

Introduction

In the biomedical model, a person is treated as a biological creature with his/her physical expression in the first place. Nurses realize that this model is limited in recognizing the basic human needs and necessary patient care interventions. According to a more comprehensive ("holistic") approach to care, patients as human beings are more than the expression of their physiological and functional dimensions (i.e., physical symptoms and deficiencies). This perception guides health care professionals, regardless of whether they are themselves religious or not, towards a moral obligation to address patients' spiritual concerns by providing care through a bio-psychosocial-spiritual model (1).

Spirituality is multidimensional and highly specific in its individual and/or communal experiences and expressions, often understood as encompassing the relationship to and experience of transcendence or sense of peace, purpose, and interconnectedness, including beliefs about the meaning of life (2). Physicians, nurses, psychologists, pastoral workers, and others, i.e., patients' relatives, may identify spirituality as a source of individual strength while eliciting

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a patient's spiritual history. They also should recognise when a spiritual care professional may need to intervene for the wellbeing of the patient (3).

In some cases, religiosity and spirituality are used interchangeably, whereas in others, they hold different meanings. In general, religiosity has been defined as a person's adherence to the beliefs, values, and practices proposed by an organised institution, which is devoted to the search for the divine through prescribed ways of viewing and living life (4). The term *spirituality*, however, often relates to a search for the sacred or divine through any life experience or route (5). The major distinction between religiosity and spirituality, suggested by Thoresen and Harris (2002), is that religiosity inherently reflects a social (communal) and institutional nature whereas spirituality is related more to individual trust and experience (6). Religiosity is assessed by simply asking brief questions, such as one's participation in an organised religious institution and adherence to established guidelines for beliefs and behaviour (7). Conversely, spirituality typically is assessed with a range of concepts encompassing meaning, wholeness, transcendence, connection, joy, and peace (8).

During the past decade, there has been a renewed emergence of spirituality (and religiosity) in health care services, public health, social work, education, management and work organisations, and across other disciplines both in industry and in academia (9). Significant associations that have been determined between religiosity, spirituality and health-related outcomes provide an evidence of connection between biological, mental, emotional, social and transcendental dimensions of human beings in health care. There is further evidence that the attitudes towards a broader understanding of human beings as spiritual individuals in the European region, especially in eastern and central parts, has emerged by perceiving and actualising the transcendental dimension of human existence in care (10–12).

Significant empirical research on the topic of spirituality in health care has been recently conducted in Lithuania (13). The political thinking and atheistic ideology during, and just after, post-Soviet era made the biomedical model of care the norm through decades of health care delivery, with disregard for the religious/spiritual dimension of a person (14). The freedom of faith returned with the restoration of independence in 1991. During the 2011 census, 86% of the Lithuanian population identified themselves as following a religion: 82.2% were Christians and 77.2% of the population indicated being Roman Catholics; 6.1% did not attribute themselves to any religious community (Statistic Lithuania). In the Christian faiths, spiritual wellbeing forms an essential part of a person's capacity maintaining a quality of life that respects their personal needs and expectations (14, 15).

The aim of this study was to assess the association of religiosity and spirituality with the perception of cancer patients' spiritual wellbeing and spiritual needs.

Methods

Study Design and Sample. The cross-sectional study was performed at nursing and supportive treatment units of five hospitals. The data were collected between January and November, 2018.

The inclusion criteria for respondents were as follows: oncology illness of non-terminal stage, knowledge of the Lithuanian language and the ability to comprehend and answer the questions. In total, 273 patients participated in the study. According to patients' answers, they were defined to assigned importance to religion and spirituality group (R+S+); 'no assigned importance to religion, but assigned importance to spirituality group (R–S+)'; no assigned importance neither to religion nor to spirituality group (R–S–) and group of those who gave importance to spirituality only (S+).

Instruments. Spiritual wellbeing was measured by the Spiritual Health and Life-Orientation Measure, called SHALOM (Fisher, 2010) (16). The Lithuanian version of SHALOM was adapted by Riklikiene et al. (13). The SHALOM has four domains: personal, communal, environmental and transcendental. The 20-item questionnaire sought two responses to indicate: 1) patients' ideals for SWB where participants rate *the importance* of each item for their optimum spiritual health and 2) lived experience where participants rate how they feel each item *reflects* their personal experience most of the time. Each response is graded as 1 – very low important/typical, 2 – low important/typical, 3 – moderate important/typical, 4 – high important/typical, and 5 – very high important/typical.

The importance of religiosity and/or spirituality to the respondents was estimated by asking two questions: *Is religion important in your life?* and *Is spirituality important in your life*? Those two questions belonged to the last part of the SHALOM instrument. Importance of spirituality and religiosity was assessed by a 5 point Likert scale from 1 meaning less important to 5 meaning extremely frequently important. Groups 'R+S+', 'R–S+' and 'S+' were composed of respondents who rated the importance of religiosity and spirituality in life with 4 or 5 points. Respondents who rated the importance of religiosity and spirituality with 1 or 2 points composed the group 'R–S–'. Respondents who rated these two questions with 3 points were not included in any group and further analysis as not having clear self-determination.

The Spiritual Needs Questionnaire (SpNQ), created by Arndt Büssing, is a standardized measure of psychosocial, existential and spiritual needs (17). The underlying theoretical basis for the SpNQ refers to four dimensions of spiritual needs: inner peace, existential, religious and giving/generativity needs. The intensity of unmet needs was scored using a 4-point scale ranging from disagreement to agreement (0 – not at all; 1 – somewhat; 2 – strong; 3 – very strong). The higher the scores, stronger the patient's respective spiritual needs.

The SpNQ was translated into the Lithuanian language and back-translated into English following the methodological considerations for double translation and reconciliation (18). Personal consultations between the principal investigator (OR) of this study and the developing author (AB) provided a wider exploration of meaning, which led to an accurate interpretation and avoidance of semantic errors during the translation process. Equivalence and congruence was achieved when the author of both instruments made a comparison of both English versions, original and back translated, providing comments on discrepancies and corrections.

Ethical Consideration. The study protocol was approved by the the Lithuanian Regional Committee of Bioethics (No. BE-2-84).

Statistical Analysis. The data were recorded and analysed using the Statistical Package for Social Sciences (IBM SPSS Statistics) version 25.0. Descriptive statistics, single factor analysis of variance (one-way ANOVA, with Tukey Post Hoc test comparing three or more groups), correlation (Spearman's rho) and multiple linear regression analysis were used to examine the data. With respect to the correlation analysis, we regarded $r > 0.5$ as a strong correlation, $0.3 < r < 0.5$ as a moderate correlation, $0.2 < r < 0.3$ as a weak correlation, and $r < 0.2$ as no or a negligible correlation. The significance was defined by a P value of 0.05.

Results

The age of patients varied from 32 years to 96 years with the mean of 67.8 ± 10.8. There were more female patients (58.0%) than male (42.0%). Most of the patients were married (71%), religious (76.9%), and with urban residence (59.7%). Most of the patients (77.0%) considered themselves as religious persons. The majority were affiliated with the Roman Catholic religion (95.9%), two (1.4%) patients were Russian Orthodox, and three (2.1%) were Russian Orthodox Old Believers.

The scores of each spiritual wellbeing domain of the SHALOM and the spiritual need dimension of the SpNQ were compared in relation to importance of religiosity and/or spirituality how it was described by cancer patients. According to patients' answers, a trinary comparison was made: among those who treated religion and spirituality as important in their life 'R+S+' (n = 159, 83.7%), who gave weight to spirituality only 'S+' (n = 14, 7.4%) and those who expressed importance neither to religion, nor to spirituality 'R–S–' (n = 17, 8.9%). From further analysis, 30.4% (n = 83) of the respondents were excluded as they did not have a clear understanding about the importance of religion and/or spirituality in their life (scoring grade equal or less than 3 points). Having in mind non-equal distribution of the respondents in the related groups, the results indicate only the tendencies of significant associations.

Cancer patients in group 'R–S–' rated their spiritual wellbeing in three domains and on both SHALOM parts significantly lower than the patients in group 'R+S+' and group 'S+'. The transcendental domain of ideal and lived experience of spiritual wellbeing was rated significantly higher by the 'R+S+' group than the 'S+' or the 'R–S–' group (Table 1).

Similarly, the cancer patients in group 'R+S+' expressed higher spiritual needs on four SpNQ dimensions and on the overall spiritual needs than 'S+' and 'R–S–' individuals. Giving/generativity and forgiveness needs were rated significantly higher by non-religious, but spiritual respondents ('S+' group) than by non-religious and non-spiritual patients ('R–S–' group) (Table 1).

According to Fisher (2006), spiritual dissonance is indicated by a difference in the mean value of greater than 1.0 between the 'ideal' and 'lived experience' in any domain of SWB. The result on all four domains of the SHALOM scale indicated limited spiritual dissonance in the personal domain (n = 25, 9.9%), communal domain (n = 17, 6.5%), environmental domain (n = 27, 10.8%), as well as the transcendental domain (n = 22, 8.9%).

Correlation analysis showed a weak but statistically significant negative association between dissonance of spiritual wellbeing and spiritual needs. The dissonance of transcendental spiritual wellbeing associated with religious needs and overall spiritual needs at the strongest extent (Table 2).

It was apparent from Table 3 that there was a significant moderate or weak positive correlation between respondents' spiritual wellbeing and spiritual needs. The strongest association was observed between the SHALOM transcendental domain and religious needs. The association of spiritual wellbeing with giving/generativity and forgiveness needs was the most consistent and the strongest on both SHALOM domains and with overall spiritual wellbeing.

Association of the SHALOM lived experience domains with four spiritual needs dimensions was stronger than in the SHALOM Iieal domains and spiritual needs.

Table 1. Comparison of Spiritual Wellbeing Domains (SHALOM) and Spiritual Needs Dimensions (SpNQ) among Religiosity/Spirituality Groups (N = 190)

Variables	Respondent's Groups by the Importance of Religion and Spirituality			F Value	P Value
	'R+S+'	'S+'	'R–S–'		
	Mean ± SD	Mean ± SD	Mean ± SD		
SHALOM_Ideals					
Personal	4.25 ± 0.55[a]	4.31 ± 0.32[a]	3.04 ± 1.02[b]	29.854	< 0.001
Communal	4.38 ± 0.57[a]	4.46 ± 0.41[a]	3.25 ± 1.00[b]	25.544	< 0.001
Environmental	4.01 ± 0.67[a]	3.91 ± 0.62[a]	2.99 ± 0.98[b]	16.322	< 0.001
Transcendental	4.28 ± 0.57[a]	2.23 ± 0.89[b]	1.84 ± 0.71[b]	165.415	< 0.001
Overall spiritual wellbeing	4.23 ± 0.48[a]	3.69 ± 0.24[b]	2.72 ± 0.85[c]	56.211	< 0.001
SHALOM_Lived Experience					
Personal	3.85 ± 0.66[a]	4.02 ± 0.67[a]	2.80 ± 0.95[b]	16.547	< 0.001
Communal	4.07 ± 0.61[a]	4.35 ± 0.47[a]	2.90 ± 0.85[b]	27.744	< 0.001
Environmental	3.63 ± 0.69[a]	3.83 ± 0.74[a]	2.73 ± 0.96[b]	12.877	< 0.001
Transcendental	4.02 ± 0.72[a]	1.80 ± 1.00[b]	1.54 ± 0.60[b]	122.712	< 0.001
Overall spiritual wellbeing	3.89 ± 0.51[a]	3.40 ± 0.38[b]	2.44 ± 0.63[c]	49.494	< 0.001
SpNQ needs					
Religious	1.66 ± 0.73[a]	0.36 ± 0.51[b]	0.39 ± 0.53[b]	42.353	< 0.001
Giving/Generativity and Forgiveness	1.80 ± 0.63[a]	1.50 ± 0.79[a]	0.94 ± 0.52[b]	14.925	< 0.001
Inner peace	1.87 ± 0.60[a]	1.43 ± 0.68[b]	1.25 ± 0.72[b]	10.490	< 0.001
Existential	1.56 ± 0.59[a]	0.78 ± 0.69[b]	0.86 ± 0.65[b]	18.508	< 0.001
Overall spiritual needs	1.70 ± 0.51[a]	0.89 ± 0.57[b]	0.78 ± 0.50[b]	34.999	< 0.001

SHALOM, Spiritual Health and Life-Orientation Measure; SpNQ, Spiritual Needs Questionnaire;
[abc]ANOVA equal letters do not differ on Tukey post hoc comparison (P < 0.05).
R+S+, assigned importance to religion and spirituality;
R–S+, no assigned importance to religion, assigned importance to spirituality;
R–S-, no assigned importance to religion and spirituality.

Table 2. Correlation between Dissonances of SHALOM Ideals and Lived Experience Values and SpNQ Dimensions (N = 273)

Dissonance between SHALOM Ideals and Lived Experience Values on Four Fomains	SpNQ Dimensions				
	Religious Needs	Giving/ Generativity And Forgiveness Needs	Inner Peace Needs	Existential Needs	Overall Spiritual Needs
Personal	–0.034	–0.103	–0.079	–0.142*	–0.089
Communal	–0.146*	–0.138*	–0.072	–0.148*	–0.163*
Environmental	–0.102	–0.175**	–0.126*	–0.213**	–0.190**
Transcendental	–0.256**	–0.104	–0.186**	–0.219**	–0.255**
Overall spiritual wellbeing	–0.133*	–0.155*	–0.133*	–0.213**	–0.197**

SHALOM, Spiritual Health and Life-Orientation Measure;
SpNQ, Spiritual Needs Questionnaire;
*P < 0.05. **P < 0.01

Linear regression analysis was performed on each domain of the SHALOM to ascertain the relative contribution made to each of the SpNQ dimensions (Table 4). β-values showed that the transcendental domain of spiritual wellbeing had the strongest impact on each dimension of spiritual needs, especially religious needs.

Table 3. Correlation between SHALOM Domains and SpNQ Dimensions (N = 273)

SHALOM Domains	SpNQ Dimensions				
	Religious Needs	Giving/ Generativity and Forgiveness Needs	Inner Peace Needs	Existential Needs	Overall Spiritual Needs
SHALOM Ideals					
Personal	0.085	0.274**	0.161*	0.187**	0.189**
Communal	0.065	0.293**	0.077	0.165**	0.144*
Environmental	0.078	0.229**	0.173**	0.152*	0.164*
Transcendental	0.590**	0.297**	0.230**	0.346**	0.484**
Overall spiritual wellbeing	0.313**	0.326**	0.235**	0.297**	0.349**
SHALOM Lived Experience					
Personal	0.105	0.328**	0.227**	0.244**	0.239**
Communal	0.164**	0.392**	0.162**	0.251**	0.263**
Environmental	0.125*	0.354**	0.246**	0.263**	0.268**
Transcendental	0.692**	0.352**	0.334**	0.440**	0.589**
Overall spiritual wellbeing	0.400**	0.462**	0.337**	0.444**	0.487**

SHALOM, Spiritual Health and Life-Orientation Measure; SpNQ, Spiritual Needs Questionnaire;
*P < 0.05; **P < 0.01

Table 4. β-values from Linear Regression Analyses of SHALOM Values on Four Dimensions of SpNQ Spiritual Needs (N = 273)

SHALOM Domains	Spnq Dimensions				
	Religious Needs	Giving/Generativity and Forgiveness Needs	Inner Peace Needs	Existential Needs	Overall Spiritual Needs
SHALOM Ideals	*R^2 = 0.40*	*R^2 = 0.15*	*R^2 = 0.11*	*R^2 = 0.17*	*R^2 = 0.28*
Personal	0.03	0.16	0.23	0.06	0.14
Communal	–0.10	0.11	–0.18	0.02	–0.07
Environmental	–0.16	–0.06	0.07	–0.04	–0.08
Transcendental	0.70	0.24	0.23	0.39	0.52
SHALOM Lived Experience	*R^2 = 0.49*	*R^2 = 0.21*	*R^2 = 0.17*	*R^2 = 0.25*	*R^2 = 0.38*
Personal	–0.05	0.03	0.19	–0.01	0.03
Communal	–0.01	0.20	–0.20	0.07	0.01
Environmental	–0.07	0.11	0.18	0.13	0.08
Transcendental	0.73	0.25	0.31	0.41	0.56

SHALOM, Spiritual Health and Life-Orientation Measure; SpNQ, Spiritual Needs Questionnaire.

Discussion

A paradigm shift of cancer care from a disease-focused management to a patient-centred approach was emphasised by multidisciplinary care professionals and decision makers, calling for the increasing attention to cancer patients' rights, quality of life, empowerment and psychosocial aspects of care they need and deserve. This study reveals how spirituality and religiosity are important for the cancer patients' perception of spiritual wellbeing and expression of unmet spiritual needs. Among those respondents with a clear denomination of religion and spirituality in personal life, the majority treated themselves as religious and spiritual persons, although one-third of the whole study sample did not have a clear understanding about the importance of either religion or spirituality in their life. The result shows that spirituality and religiosity are very personal issues and that each person is different in this sense, depending on cultural and historical back-

grounds, different socio-economic and political situations, varied psychological conditionings and personal values. As van Niekerk (2018) demonstrated, it is notoriously difficult to define both religion and spirituality and to point out the differences between them (19). Even if spirituality is closely connected with religion, on the contrary of it, spirituality unifies the sacred, human beings and nature, providing a holistic approach and presenting its adherents with an all-encompassing worldview.

This study showed that spiritual wellbeing as well as unmet spiritual needs were more expressed by those cancer patients who assigned the importance of both, religion and spirituality, in personal life. These patients and their family caregivers may want to talk about spiritual concerns, but may feel unsure about how to bring up the subject. Realities and questions that usually appear during a life-threatening disease in large are associated with a patients' religious, spiritual, or philosophical orientation, and that influences how cancer patients experience the illness, its meaning, how they feel about it, how strong they are to cope with it, what medical decisions they take and what health care costs they consume (20) and how well they come to terms with it.

This study revealed that cancer patients, mainly Roman Christians (95.9%), who gave a weight to both, religion and spirituality in their life, rated their spiritual wellbeing higher in all four domains in comparison with non-religious and non-spiritual ones. From the perspective of Christian theology, personal spiritual wellbeing is a fundamental part of quality of human life being a state of health apparent on the levels of personal advancement, self-actualisation and transcendence (14). With some precaution, the results of our study indicate that the cancer patients who considered themselves 'religious and spiritual' or only 'spiritual' rated their spiritual relationships with themselves, others and environment higher than the patients from the group 'neither religious nor spiritual'. Moreover, the relationship with the transcendental other was more important for the 'religious and spiritual' group than other groups. Literature supports the fact that high levels of both spirituality and religiosity are associated with a better quality of life (psychological, social and environment), optimism, and happiness as compared with those having only spirituality, only religiousness, or none of them (21). Nevertheless, scientific evidence is inconsistent on the role of spirituality and religiosity on spiritual wellbeing as an Italian study of Vilani et al. (2019) proved a strong impact of spirituality on spiritual wellbeing, although this relationship appears the same regardless of the individual's religious status (i.e., religious, non-religious, and uncertain) (22).

The literature confirms that religiosity, religious participation and commitment towards a particular religion are positive contributors to various wellbeing measures (23, 24) that help both religious and uncertain persons to feel positive emotions (22). The personal connectedness with a higher power and higher religious and spiritual involvement stipulate a more positive appraisal of lived experience (25). Diener et al. (2011) also found that in very religious nations and states (Lithuania may be called as such, with 86% of adults associated with some religion) religious people report higher spiritual wellbeing than irreligious people; this difference disappears in the least religious societies (26). In the study of Musa et al. (2016), religiosity, as a specific relationship with God, was positively associated with spiritual wellbeing among Jordanian Arab Christians (15). Moreover, Vitorino et al. (2018) state that high levels of religiousness instead of high levels of spirituality are more related to better outcomes (21). At the same time, it has been argued that religion is not a universal predictor of higher spiritual wellbeing across societies as a positive correlation between these two factors is found to be small (27). It was not possible for us to test the entire association of religiousness with spiritual wellbeing and spiritual needs because no respondents in this study assigned the importance to religiousness only.

The instrument SHALOM relies on a novel technique to compare each person's 'lived experience' with their 'ideals' for spiritual wellbeing (16). The difference between the 'ideals' and 'lived experience' score indicates the level of harmony or dissonance in each domain. This is a fairer approach of assessing spiritual wellbeing because each person becomes the standard against which they are measured and is allowed to view each term in light of their own understanding of it, rather than having their view compared with someone else's (28). In our study, the strongest negative correlations were observed between the dissonance of transcendental spiritual wellbeing and unmet religious needs. Similarly, existential needs with the same strength and direction were associated with the dissonance of environmental and transcendental spiritual wellbeing. These results suggest that in approaching the harmony of spiritual wellbeing (in other words, by trying to anticipate the 'lived experiences' to 'ideals'), cancer patients actively voice and express their spiritual concerns and seek help to solve them. On the other hand, the respondents might be more content with their lower lived experiences rather than their ideals on the SHALOM, therefore, not needing any/much help, as determined by the SpNQ. Further detailed investigation in a sample with a higher percentage of dissonance among SHALOM domains is necessary to provide more precise ex-

planation on the account that the greater the dissonance the lower the expressed need for help.

The analysis of interconnection between spiritual wellbeing and spiritual needs indicated significant associations. The cancer patients' unmet spiritual needs of Giving / Generativity and Forgiveness, two human virtues, have had the most consistent and the strongest relationship with overall spiritual wellbeing and with each dimension of it. To explain this we argue on the specific characteristics of our sample as it includes hospitalized non-terminally ill cancer patients that prefer to be connected with a family, to participate in a family life and to pass on life experiences to the next generation assuring that life was meaningful and of value (29). Further it was confirmed that Transcendental domain of spiritual wellbeing was the strongest predictor of spiritual needs, especially Religious needs. All this indicates the overlap among the categories of cancer patients' spiritual wellbeing and spiritual needs alongside with the personal religious and spiritual belief system.

The patients with cancer who are undergoing treatment consider spirituality and religion to be important in their lives, and they expect health professionals to address this issue by offering spiritual care (30) and introduce interventions to enhance spiritual wellbeing (life review, dignity therapy, meaning-centred psychotherapy, etc.). As Dhar et al. (2011) state (31), 'becoming spiritually healthy is not becoming special, but <...> learning to become grateful to life around and consciously explore the meaning of this life.' A clinical team is essential in accompanying patients in this learning journey, when a doctor, a nurse, a social worker and a spiritual adviser work together to help patients in identifying their purpose and goals in life and to provide care to those who require both clinical and spiritual care. At the same time, Austin et al. (2018) remind us that health professionals themselves must be supported by emotional, social and spiritual resources while helping patients to cope with religious and spiritual issues both individually and as part of a multi-disciplinary team (32). And for scientists, as van Niekerk (2018) suggests (19), in order to be more *in keeping with the spirit of spirituality,* further research is needed to develop more accurate definitions of spirituality and to understand more clearly what exactly people mean when they say they are spiritual and how their spiritual concerns should be understood and addressed.

Conclusions

The individual sense of religiosity and spirituality in personal life is associated with spiritual wellbeing and unmet spiritual needs of cancer patients. Although spirituality and religion are very personal and private matters, they should be taken into account during a cancer patient's comprehensive assessment and care planning in hospital care.

Spiritual wellbeing of cancer patients is related to unmet spiritual needs underpinning the presence of connection between emotional, social and transcendental dimensions of human beings in health care. The transcendental domain of wellbeing remains the strongest predictor of religious needs supporting the integrity of the personal religious and spiritual belief system.

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