

ORIGINAL ARTICLE

Spiritual needs in oncology patients and patients with chronic kidney disease at a public hospital in Cochabamba, Bolivia

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Keywords:

oncology patients; chronic kidney disease patients; spiritual need; interpersonal; intrapersonal; transpersonal; spirituality (source: MeSH-NLM).

ABSTRACT

Objective. To determine the spiritual needs of oncology patients and patients with chronic kidney disease at Hospital Obrero No. 2 of the National Health Fund in Cochabamba, Bolivia. **Methods.** This was a descriptive quantitative study with a non-experimental design. It included a non-probability convenience sample of 50 adult patients, comprising 25 oncology patients and 25 patients with chronic kidney disease undergoing hemodialysis. Participants completed a questionnaire based on the adapted CONIIT instrument, which assesses interpersonal, intrapersonal, and transpersonal dimensions. **Results.** In the interpersonal dimension, both groups showed high levels of emotional support, with 96% reporting meaningful bonds with their family members. In the intrapersonal dimension, a significant gap was found with regard to personal goals; although 60% of oncology patients considered that they had achieved them, this perception decreased to 36% among patients with chronic kidney disease. Regarding the transpersonal dimension, there was a latent demand for external support; 96% of patients with chronic kidney disease and 80% of oncology patients expressed a desire to receive greater spiritual support during the treatment period. **Conclusions.** Spiritual needs were found to be widely present in both oncology patients and patients with chronic kidney disease at Hospital Obrero No. 2 of the National Health Fund, as reflected in the interpersonal, intrapersonal, and transpersonal dimensions.

Necesidades espirituales en usuarios oncológicos y renales crónicos en un hospital público de Cochabamba, Bolivia

Palabras clave:

usuarios oncológicos; renales crónicos; necesidad espiritual; interpersonal; intrapersonal; transpersonal; espiritualidad (fuente: DeCs-BIREME).

RESUMEN

Objetivo. Determinar las necesidades espirituales de los usuarios oncológicos y usuarios renales crónicos del Hospital Obrero N.º 2 de la Caja Nacional de Salud, en Cochabamba, Bolivia. **Métodos.** El estudio tuvo un enfoque cuantitativo y fue descriptivo de diseño no experimental; contó con una muestra no probabilística por conveniencia de 50 pacientes adultos, distribuidos en 25 usuarios oncológicos y 25 usuarios con enfermedad renal crónica en hemodiálisis a quienes se aplicó un cuestionario en base al instrumento adaptado CONIIT, que evalúa dimensiones interpersonales, intrapersonal y transpersonal. **Resultados.** En la dimensión interpersonal, ambos grupos demostraron niveles elevados de apoyo emocional, con un 96 % que manifestó poseer vínculos significativos con sus familiares. En el intrapersonal, se evidenció una brecha significativa respecto a las metas personales; además, el 60 % de los usuarios oncológicos consideró haberlas alcanzado, sin embargo, esta percepción desciende al 36 % en pacientes renales crónicos. Respecto a la dimensión transpersonal, existe una demanda latente de acompañamiento externo; el 96 % de los usuarios renales crónicos y el 80 % de los oncológicos expresaron el deseo de recibir mayor apoyo espiritual durante el periodo del tratamiento. **Conclusiones.** Se determinó que las necesidades espirituales están ampliamente presentes, tanto en usuarios oncológicos como en usuarios renales crónicos del Hospital Obrero N.º 2 de la Caja Nacional de Salud, lo cual se manifiesta en las dimensiones interpersonales, intrapersonales y transpersonales.

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INTRODUCTION

Spirituality is an essential dimension of the human being, related to the search for meaning, purpose, and transcendence through connection with oneself, others, and a higher power or deity ⁽¹⁻³⁾. This dimension influences overall well-being and becomes particularly relevant in the context of chronic and oncological diseases, where it promotes coping, hope, and meaning-making in the face of suffering ^(2,4). Likewise, the World Health Organization ⁽⁵⁾ recognizes spirituality as a fundamental component of comprehensive care, particularly among patients facing situations of high vulnerability and advanced disease ⁽⁶⁾.

Several studies have shown that the spiritual needs of oncology patients and patients with chronic kidney disease, which are related to the search for inner peace, emotional support, and meaning in life, may even influence treatment adherence and quality of life ⁽⁶⁻⁸⁾. In this context, spiritual care provided by nursing professionals represents an important component of comprehensive care. However, despite its clinical and human relevance, the spiritual dimension remains insufficiently addressed in hospital practice because it is frequently not considered a priority within healthcare processes ⁽⁹⁾.

This limited incorporation of spiritual care contrasts with the foundations of nursing proposed by Florence Nightingale ⁽¹⁰⁾, who regarded spirituality as an intrinsic component of comprehensive care and a fundamental resource for patient recovery ^(11,12). Although evidence exists regarding the importance of spirituality in different patient groups, studies comparing spiritual needs between these two populations remain scarce, particularly within the Bolivian hospital setting.

Therefore, the objective of this study was to determine the spiritual needs of oncology patients and patients with chronic kidney disease at Hospital Obrero No. 2 of the National Health Fund in Cochabamba, Bolivia, with the aim of generating evidence that may contribute to strengthening comprehensive nursing care.



METHODS

Study design and area

This study was conducted using a quantitative approach with a descriptive, non-experimental design

aimed at characterizing the spiritual needs of the study population from the Oncology and Hemodialysis Services of Hospital Obrero No. 2 of the National Health Fund in Cochabamba, Bolivia, during 2024.

Population and sample

The accessible population consisted of patients attending the Oncology and Hemodialysis Services of Hospital Obrero No. 2 of the National Health Fund during the study period, comprising a total of 38 oncology patients and 45 patients with chronic kidney disease. Participants were selected from this population using non-probability convenience sampling. The final sample consisted of 50 participants, equally distributed between 25 oncology patients and 25 patients with chronic kidney disease undergoing hemodialysis treatment.

Only patients aged 18 years or older who were conscious, clinically stable, able to understand the data collection instrument, and who voluntarily agreed to participate by signing the informed consent form were included in the study. Exclusion criteria included documented cognitive impairment or critical health conditions that prevented effective communication during the data collection process.

Variable and data collection instrument

The main variable studied was "spiritual needs." To measure this variable, a data collection instrument was developed based on the three dimensions of the guidance instrument for intrapersonal, interpersonal, and transpersonal spiritual needs (CONIIT, by its Spanish acronym), which had been culturally adapted and validated in the Bolivian context by Loza et al. ⁽¹³⁾. These dimensions were used as the theoretical and methodological framework for structuring the items administered to the study groups (oncology patients and patients with chronic kidney disease).

The instrument was organized into three dimensions. The interpersonal dimension assessed aspects related to emotional support, reconciliation, and meaningful relationships; the intrapersonal dimension addressed perceived meaning in life, personal satisfaction, reflection on past experiences, and the achievement of personal goals; whereas the transpersonal dimension explored faith, hope, spiritual beliefs, religious practices, and the need for spiritual support.

The questions were contextually adapted to reflect the clinical characteristics and lived experiences of

both study groups while maintaining consistency with the three dimensions proposed by the CONIIT. The instrument consisted of 17 items with dichotomous yes/no responses, allowing the presence or absence of specific spiritual needs among participants to be identified. Regarding instrument reliability, as reported in the Bolivian hospital setting, adequate levels of internal consistency were observed according to Cronbach's alpha coefficient. The transpersonal dimension showed acceptable internal consistency ($\alpha = 0.75$), followed by the interpersonal dimension ($\alpha = 0.70$). The intrapersonal dimension yielded a coefficient of $\alpha = 0.65$, which was considered moderate and acceptable for descriptive studies in the health sciences.

Data collection techniques and procedures

The fieldwork phase began with institutional coordination and authorization from the Teaching and Research Department and subsequently with the supervisors of the Oncology and Nephrology Services of Hospital Obrero No. 2 of the National Health Fund. This was followed by an orientation phase for the study participants, during which information regarding the purpose of the research was provided and participation was formalized through the signing of the informed consent form, in strict accordance with the principle of autonomy. The instrument was subsequently administered during hospitalization or treatment sessions.

Data analysis

Data were processed and analyzed using SPSS version 27. Descriptive statistics were used for data analysis, including absolute frequencies and percentages, in order to characterize the sample and describe the distribution of the study variables. The database was complete for all 50 participants from both groups; therefore, the entire initial sample was included in the final analysis, with no exclusions due to incomplete

data. Likewise, all instruments were completed in full, and no unanswered items were recorded.

Ethical considerations

From an ethical perspective, the study was conducted in accordance with the principles of the Declaration of Helsinki, ensuring the anonymity and confidentiality of participants throughout the data collection process. The study was approved by the Ethics and Research Committee of Hospital Obrero No. 2 of the National Health Fund, under approval code CE-UAB-2024/05. In addition, participants voluntarily provided written informed consent.

RESULTS

Regarding sociodemographic characteristics, older adults predominated in the study population. Among oncology patients, 52% were between 51 and 70 years of age, with an almost equal sex distribution. In contrast, patients with chronic kidney disease showed an older age profile, with 96% being older than 51 years and a predominance of women (60%). In both groups, participants aged 51–70 years constituted the largest age group, suggesting that the spiritual needs assessed corresponded predominantly to older adulthood (Table 1).

Regarding religious affiliation, Catholicism clearly predominated in the study population, accounting for 76% of the total sample. When analyzed by diagnosis, oncology patients showed greater religious homogeneity, with 84% identifying as Catholic. In contrast, patients with chronic kidney disease showed a more diverse religious profile: 68% identified as Catholic, while smaller proportions identified as Evangelical, Adventist, or Jehovah's Witnesses. In addition, 8% of these patients reported having no religious affiliation. This may be related to the long-term nature of dialysis treatment, involving

Table 1. Sociodemographic characteristics

Age	Oncology patients				Chronic kidney disease patients			
	Sex				Sex			
	Male		Female		Male		Female	
	fi	%	fi	%	fi	%	fi	%
31-50	1	4.0	3	12.0	0	0.0	1	4.0
51-70	8	32.0	5	20.0	6	24.0	7	28.0
71-90	3	12.0	5	20.0	4	16.0	7	28.0

Table 2. Religious affiliation

Religion	Oncology patients		Chronic kidney disease patients	
	fi	%	fi	%
Catholic	21	84.0	17	68.0
Evangelical	3	12.0	4	16.0
Adventist	1	4.0	1	4.0
Jehovah's Witness	0	0.0	1	4.0
None	0	0.0	2	8.0

years of routine treatment and potentially generating a different type of strain on faith compared with an oncological diagnosis (Table 2).

Regarding spiritual support practices, prayer was identified as the predominant practice in both clinical groups, being reported by 56% of oncology patients and 68% of patients with chronic kidney disease. A difference was also observed in the perception of support: whereas only one patient with chronic kidney disease reported receiving no spiritual support, 20% of oncology patients reported a complete absence of spiritual support. Pastoral visits were the least frequent resource and were not reported at all in the oncology unit. These findings suggest that, although patients engage in self-directed spiritual practices through prayer and meditation, formal institutional or religious support is limited, particularly among oncology patients (Table 3).

Regarding the interpersonal dimension, the results showed high levels of emotional support among both oncology patients and patients with chronic kidney disease, with 96% in each group reporting having an important person with whom they could share what they were going through. Likewise, 100% of patients with chronic kidney disease perceived that they had contributed valuable and important things during their lives, compared with 84% of oncology patients. Both groups also reported a high degree of peace and

reconciliation with others, observed in 96% of patients with chronic kidney disease and 92% of oncology patients. Feelings of regret over having harmed other people were reported by 60% of oncology patients and 56% of patients with chronic kidney disease. Finally, oncology patients reported receiving greater support from family and friends (96%) compared with patients with chronic kidney disease (88%).

In the intrapersonal dimension, 100% of patients with chronic kidney disease reported feeling that they had been useful to others during their lives and that they had reflected on positive and negative past experiences, compared with 96% and 84%, respectively, among oncology patients. Regarding satisfaction with life despite their illness, both groups showed similar percentages: 88% among oncology patients and 84% among patients with chronic kidney disease.

An important difference was observed in the achievement of personal goals: only 36% of patients with chronic kidney disease considered that they had achieved what they wanted in life, compared with 60% of oncology patients.

Regarding the transpersonal dimension, both groups exhibited strong faith and hope in relation to their health condition. All oncology patients and patients with chronic kidney disease expressed

Table 3. Type of support received during hospital stay

Type of support	Oncology patients		Chronic kidney disease patients	
	fi	%	Fi	%
Prayer	14	56.0	17	68.0
Meditation	6	24.0	4	16.0
Pastoral visit	0	0.0	3	12.0
None	5	20.0	1	4.0

Table 4. Spiritual needs

Dimensions / Items	Oncology patients				Chronic kidney disease patients			
	Yes		No		Yes		No	
	n	%	n	%	n	%	n	%
Interpersonal								
I have someone important with whom I can share what I am going through	24	96.0	1	4.0	24	96.0	1	4.0
I have contributed important and valuable things in life	21	84.0	4	16.0	25	100.0	0	0.0
I feel hurt about having said certain things that may have hurt someone	16	64.0	9	36.0	17	68.0	8	32.0
I regret something I did	15	60.0	10	40.0	14	56.0	11	44.0
I feel at peace and reconciled with others	23	92.0	2	8.0	24	96.0	1	4.0
My family and friends give me the attention, respect, and love I need during my illness	24	96.0	1	4.0	22	88.0	3	12.0
Intrapersonal								
Throughout my life, I have been useful to some people	24	96.0	1	4.0	25	100.0	0	0.0
Recently, I have reflected on the positive and negative experiences I have lived through	21	84.0	4	16.0	25	100.0	0	0.0
I am satisfied with the life I have, despite everything	22	88.0	3	12.0	21	84.0	4	16.0
I have achieved what I wanted in life	15	60.0	10	40.0	9	36.0	16	64.0
I often think about my past and my life	14	56.0	11	44.0	12	48.0	13	52.0
Transpersonal								
I am confident that everything will turn out well	25	100.0	0	0.0	25	100.0	0	0.0
I believe in some form of eternal life	21	84.0	4	16.0	19	76.0	6	24.0
I believe in or have faith in a supreme being	25	100.0	0	0.0	24	96.0	1	4.0
I engage in activities that foster spirituality, such as praying and reading the Bible	23	92.0	2	8.0	22	88.0	3	12.0
I feel that praying, reading the Bible, or listening to Christian music helps me spiritually	24	96.0	1	4.0	22	88.0	3	12.0
I would like to receive more spiritual support	20	80.0	5	20.0	24	96.0	1	4.0

confidence that everything would turn out well, while belief or faith in a supreme being was also highly prevalent, reflecting a strong spiritual dimension. Spiritual practices were common in both groups. However, a difference was observed in the desire for additional spiritual support, reported by 96% of patients with chronic kidney disease compared with 80% of oncology patients, suggesting a greater need for spiritual accompaniment among those living with chronic kidney disease (Table 4).

DISCUSSION

The results of this study showed a predominance of older adults in both groups, with the 51–70-year age range being the most representative. This finding is similar to that reported by Muñoz et al. ⁽¹⁴⁾, who described that patients with advanced cancer are

predominantly middle-aged and older adults. Likewise, Cervantes et al. ⁽¹⁵⁾ highlighted that aging is associated not only with a higher prevalence of oncological diseases but also with a greater need for emotional and spiritual support. Similarly, Bragado ⁽¹⁶⁾ noted that, in the context of advanced disease, age is a key factor influencing patients' spiritual needs.

In this study, spirituality and interpersonal support emerged as fundamental sources of resilience among both oncology patients and patients with chronic kidney disease. The results showed that 96% of participants in both groups reported having an important person with whom they could share what they were going through. In addition, belief or faith in a supreme being was reported by 100% of oncology patients and 96% of patients with chronic kidney disease.

These findings are consistent with those reported by Sosa et al. ⁽²⁾, who indicated that hospitalized patients have a high need for emotional support, an aspect that directly influences their spiritual well-being. Likewise, Muñoz et al. ⁽¹⁷⁾, Lemus et al. ⁽¹⁸⁾, and Rodríguez et al. ⁽¹⁹⁾ agree that spiritual well-being is an essential resource for strengthening hope throughout the course of illness. Similarly, Okuma et al. ⁽²⁰⁾ reported that spirituality and religiosity, understood as forms of support, are associated with better quality of life and lower emotional distress among oncology patients.

Within the interpersonal dimension, 96% of patients with chronic kidney disease and 92% of oncology patients reported feeling reconciled and at peace with those around them. Similarly, Del Mar Heras Braseró et al. ⁽²¹⁾ reported that needs related to forgiveness and inner peace were present in 85% of patients receiving palliative care. However, feelings of regret or distress over having caused harm to others, reported by 60% of oncology patients and 56% of patients with chronic kidney disease, indicate that this spiritual need remained unmet. This has also been described by Okuma et al. ⁽²⁰⁾, who reported unmet spiritual needs among oncology patients.

The results also revealed a relevant difference in the achievement of personal goals, with a lower proportion among patients with chronic kidney disease (36%) than among oncology patients (60%). This finding could be explained by the prolonged, invasive, and burdensome nature of renal replacement treatment, which may impose physical, emotional, and social limitations that interfere with the continuation of personal projects and aspirations. In this regard, Serrano-Rojas ⁽²²⁾, as well as Herrera et al. ⁽²³⁾, have reported that chronic kidney disease affects personal fulfillment by compromising autonomy and future life planning.

However, this limitation appears to be accompanied by a process of personal meaning reconstruction, as 100% of patients with chronic kidney disease reported having contributed valuable things in life, compared with 84% of oncology patients. This finding suggests that the prolonged experience of kidney disease may promote processes of adaptation and reconstruction of personal meaning. Restrepo ⁽²⁴⁾, in turn, reported that spirituality among patients undergoing hemodialysis is associated with a better perception of quality of life and a stronger sense of purpose. Taken together, these findings indicate that although patients with chronic kidney disease perceive greater limitations in achieving personal goals, they may also

develop a stronger appreciation of their contributions and sense of meaning in life.

Finally, within the transpersonal dimension, both groups showed high levels of faith and hope (100% among oncology patients and 96% among patients with chronic kidney disease), consistent with the findings of Okuma et al. ⁽²⁰⁾, who identified spirituality as a key coping resource in the face of illness. Nevertheless, the greater need for spiritual support among patients with chronic kidney disease (96% vs. 80% among oncology patients) reinforces the importance of providing continuous spiritual care. This finding is consistent with the observations of Herrera and Mendoza ⁽²³⁾, as well as with recent studies on the implementation of spiritual care in nursing, which have demonstrated its positive contribution to comprehensive patient care, as reported by Loza et al. ⁽²⁵⁾.

One of the limitations of the study was the inability to administer the questionnaire to all eligible patients because of the characteristics of the treatment received by each patient. In addition, an inherent methodological limitation was the use of a self-report instrument, particularly because of the potential for social desirability bias. Because the study variables addressed sensitive and intimate dimensions, such as spirituality and faith, participants' responses may have been influenced by a tendency to present themselves in a manner consistent with expected religious norms. This phenomenon may partly explain the high concentration of responses reaching 100%. Although strict anonymity was ensured, future studies should complement these findings with qualitative methods or methodological triangulation. Another limitation was the absence of inferential statistical analyses, which restricts the ability to establish whether the observed differences between oncology patients and patients with chronic kidney disease were statistically significant.

Furthermore, greater integration of spiritual needs into the care of oncology patients and patients with chronic kidney disease is recommended during admission, hospitalization, and treatment sessions. Interventions should be documented in nursing notes and incorporated into the nursing care plan, with nurses coordinating, when appropriate, with psychology services, chaplaincy, or pastoral care while respecting each patient's personal beliefs. Nursing staff should also receive training in therapeutic communication, active listening, and spiritual care to strengthen comprehensive, humanized, and person-centered care.

Conclusions

The results of this study indicate that spiritual needs are widely present among both oncology patients and patients with chronic kidney disease at Hospital Obrero No. 2 of the National Health Fund in Cochabamba, Bolivia, and are manifested across the interpersonal, intrapersonal, and transpersonal dimensions. Both groups showed high levels of emotional support and a strong presence of faith and hope.

Likewise, specific characteristics were observed in each group. Patients with chronic kidney disease showed a greater need for spiritual support and lower rates of personal goal achievement, possibly due to the limitations associated with the chronic nature of the disease and dependence on long-term treatment. Nevertheless, these patients demonstrated a greater ability to find meaning in life, reflected in their perception of having made valuable contributions. These findings highlight the importance of incorporating the assessment of spiritual needs as an integral component of nursing care for patients with chronic diseases.



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Authorship contribution

BQA: study conceptualization, data collection, database organization, descriptive data analysis, writing of the initial draft, and writing of the final version of the manuscript.

CCF: methodological design, supervision of the research process, content validation, critical review, manuscript editing, and approval of the final version.

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Conflict of interest statement

The authors declare that they have no conflicts of interest.