

The significance of spiritual care in situational preoperative anxiety in surgical patients

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Abstract

Objective: To determine the significance of spiritual care in the situational preoperative anxiety in surgical patients. **Methods:** Applied study, quasi-experimental, randomized pre-test post-test study group. Sample of 70 patients, divided into intervention and control groups. Anxiety was measured using the Beck's Test. **Results:** In the pre-test, the difference in anxiety levels between the control and intervention groups was not significant, while after the intervention, the difference between the groups was significant, with mild anxiety predominating (60.0%) in the control group; however, in the experimental group, the absence of anxiety predominated (94.3%). In the dimensions of somatic and cognitive anxiety, the differences were not significant between the control and intervention groups in the pretest, with significant differences emerging after the intervention in both the control and experimental groups, in both dimensions. **Conclusions:** The importance of spiritual care is significant, decreasing the level of situational anxiety in surgical patients.

Keywords: Spiritual therapy. Anxiety. Preoperative.

Introduction

Spiritual care is a fundamental aspect of presurgical patient care, and allows for adequate coping with the transient anxiety that threatens their life and physical integrity due to the surgical intervention, considering that "people scheduled for surgery will be subjected to greater stress and depression."¹ In other words, surgery is one of the most frequent procedures for alleviating pain and death worldwide. According to the World Health Organization (WHO), 234 million major surgical operations are performed annually worldwide, or one operation for every 25 individuals.² Surgery is a treatment that arouses considerable anxiety and is an experience that often causes stress, as well as physical and psychological changes in patients.³

In this regard, the WHO indicates that anxiety is a very common mental syndrome worldwide in 2019, affecting 301 million individuals and being more prevalent in women. It is estimated that 4% of individuals worldwide currently suffer from anxiety.⁴ In Peru, the Ministry of Health (MINSa) indicates that anxiety is the leading pathology for patients which mental health centers are seeking care, with 433,816 cases diagnosed in 2022.⁵

The Pan American Health Organization (PAHO) highlighted in 2017 health estimates of anxiety disorders, revealing higher percentages in Latin America than in Europe.⁶ Regarding preoperative anxiety, the international average is 60-80%. This is happening in Mexico with 76%,⁷ similar figures in Peru with 76%.⁸ In this context, the preoperative period is an action prior to surgery that can trigger psychological problems, such as anxiety, and is the spiritual force capable of helping individuals towards healing and the fulfillment of their life goals.⁹

Where spiritual care should be integrated into palliative healthcare.^{10,11} Thus, preoperative anxiety is related to the increased use of drug doses anesthetics or analgesia, greater postoperative pain or death, and longer hospital stays.¹² Regarding this, studies report percentages of pre-surgical anxiety at different levels, with the mild level being significant at 99.3% and 50.7% in Mexico and Ecuador, respectively.^{13,14} Therefore, the surgical patient faces moments of situational anxiety crisis caused by the surgery to be performed, needing help to overcome the moment, where "research has shown that spiritual practices have been recognized as a powerful coping mechanism to deal with traumatic and life-changing events."¹⁵ Spiritual care and spirituality

are vital aspects of patient care. In recent years, it has become evident that spirituality is a crucial, yet often overlooked, component of patient healthcare.¹⁶ We all experience situations of crisis and opportunity; illness, suffering, and the feeling of being close to death are intense situations for spiritual care, in which there is a need to encounter oneself, others, and one's transcendence, allowing us to discover our deepest selves.¹⁷ Consequently, the transcendence or impact of nursing care with a spiritual focus is beneficial in preoperative care. Even nonreligious individuals may have specific spiritual needs.¹⁸

The nursing professional is the one who provides comprehensive or holistic care, and in this case, participates in spiritual care, which is one of the characteristics of the nursing discipline in the patient management process.¹⁹ Studies support that the holistic approach to nursing should include spiritual interventions, since suffering, pain, and negative experiences are frequently present in pre-surgical patients whose emotional state is not good.²⁰ The spiritual care provided by nurses includes support for spiritual practices such as prayer.²¹ While prayer is valued by Christians as a powerful weapon of faith, the culture, religion, and circumstances of patients and their families also influence on the provision of care.²²

Currently, spirituality has begun to gain relevance in the care of patients, by providing tools such as hope and coping with illness.²³ Spiritual care is defined as the ability to meet patients' spiritual needs, being a dynamic and interactive process between the unique life experiences of patients and nurses.²⁴ The evolution of and response to spiritual concerns are crucial components of high-quality supportive care.²⁵ Therefore, there is a consensus in the literature that nurses are the ones who provide spiritual care.²⁶ Spiritual care constitutes a non-pharmacological strength that should be applied to assist reduce preoperative anxiety, which is a risk factor and can be prevented.

The research has shown the publication of studies referring to the importance of spiritual care in different diseases; however, it is insufficient or not very well studied in terms of the impact it has on the preoperative anxiety of the surgical patient, and still scarce at the national level.

In 2023, a study in Taiwan by Diah et al. reported that 52% of pre-surgical patients who received spiritual support showed mild anxiety, compared to 80% in the control group.³ In Peru, in 2021, Hernandez reported findings of moderate to severe situational anxiety prior to the application of spiritual care in 86.66% of patients; however, after the application of spiritual care, anxiety was absent in 96.66% of cases.²⁷ Therefore, we consider it important to address this topic, as it is under-researched in pre-surgical patients, given their vulnerability and the anxiety they experience regarding the unknown and the surgical outcome. It is therefore necessary to prioritize care from a spiritual perspective that allows patients to meet their emotional needs and successfully cope with their surgical intervention. Furthermore, the data obtained allows for the establishment of guidelines for improving nursing care, contributing to the improvement of the patient's quality of life and that of their environment, and the implementation of spiritual education programs within the institution that promote the habit of spirituality. This study aimed to determine the significance

of spiritual care in the situational preoperative anxiety of the surgical patient.

Methods

This applied, quasi-experimental study was conducted at the Santa Maria del Socorro Hospital, Surgery Department, Ica, Peru, as an interventional study with a pre-test-post-test randomized group design between May and July 2024. A convenience sample of 70 patients was selected according to specific criteria and divided into two groups: an intervention group (n=35), who received spiritual care sessions, and a control group (n=35), who received conventional care. Anxiety was measured at a specific level through the Beck's Anxiety Test.2.8 Questionnaire validated internationally by Padros with a reliability of 0.911.29. It has 21 items divided into 2 dimensions (somatic and cognitive factors), with multiple-choice questions designed on a Likert scale. The survey technique was used in the research, preceded by an interview with the questionnaire and a pilot test with 15% of the sample to determine the reliability of this inventory in our population. The medium was reported to have high reliability according to Cronbach's Alpha of 0.918. Regarding the spiritual care variable, an intervention was carried out based on spiritual accompaniment, preparing the patient emotionally, providing them with the corresponding material and education through a booklet that taught the practice of prayer, through prayer (means of religion expression), and reading of verses, Psalm and Proverbs from the Bible, psychological preparation by instructing on the wisdom of suffering, providing confidence, active listening, and a welcoming environment during hospitalization. We applied the questionnaire before and after 1-2 hours after receiving the administration of the intervention that was performed for 30 minutes, carried out one day before the operation. A spiritual guidance brochure was given to the intervention group after anxiety was measured. The questionnaire was also applied to the control group; however, they did not receive the treatment or stimulus (spiritual care).

In the study, the 4 levels and 2 dimensions were determined, considering the cut-off points (percentiles) of the anxiety test in surgical patients, obtaining the following scores: Situational Anxiety (Global): Absent 0-5 pts, Mild 6-17 pts, Moderate 18-29 pts, Severe 30-63 pts. Somatic factor: Absent 0-3 pts, Mild 4-11 pts, Moderate 12-19 pts, Severe 20-42 pts. Cognitive Factor: Absent 0-2 pts, Mild 3-6 pts, Moderate 7-10 pts, Severe 11-21 pts.

The data obtained were analyzed through the SPSS statistical program Version 27, free license. To analyze them, descriptive statistics were applied, using the mean, standard deviation (SD), and maximum and minimum values among the independent groups relationship that do not originate from a normal distribution ($p < 0.05$).

Similarly, non-parametric statistics were used, and the Mann-Whitney U test was employed for the comparison of the control and experimental groups and by dimensions.

Regarding ethical aspects, bioethical principles of privacy, non-welfare, reliability, welfare, confidentiality, and the application of informed consent were taken into consideration. This study was approved by the Research Ethics Com-

mittee of the National University of San Luis Gonzaga, Ica, Peru (CEI-UNICA No. 0003/03-2024)

Results

According to the pretest results, mild situational anxiety predominated in the control group (54.3%), as it did in the experimental group (57.1%), with similar arithmetic means in both groups. The Mann-Whitney U test confirmed that there were no significant differences in the level of situational anxiety between the groups ($p=0.568$). In the post-test, mild situational anxiety predominated in the control group (60.0%). However, in the experimental group (who received spiritual care), the absence of situational anxiety predominated (94.3%). The Mann-Whitney U statistical test confirmed that there were significant differences in the level of situational anxiety among the groups in the post-test ($p=0.000$) (Table 1).

Table 1. Situational anxiety in the pre-test and post-test control and experimental group, surgical patients

Pretest	Control		Experimental		U-Whitney = 564,000 p = 0.568
	\bar{x} = 9.02 DE = 5.29		\bar{x} = 9.00 DE = 7.44		
	No.	%	No.	%	
Absent	12	34.3	11	31.4	
Mild	19	54.3	20	57.1	
Moderate	4	11.4	3	8.6	
Severe	0	0	1	2.9	
Total	35	100	35	100	

Posttest	Control		Experimental		U-Whitney = 32,500 p = 0.000
	\bar{x} = 10.51 DE = 7.07		\bar{x} = 1.40 DE = 1.73		
	No.	%	No.	%	
Absent	10	28.6	33	94.3	
Mild	21	60	2	5.7	
Moderate	2	5.7	0	0	
Severe	2	5.7	0	0	
Total	35	100	35	100	

The pre-test results for the first factor in surgical patients are shown, with a mild level of somatic anxiety predominating in the control group (51.4%), as well as in the experimental group (65.7%), with no significant differences between the both groups according to the Mann-Whitney U test ($p=0.121$). In the post-test results, it was found that 51.4% of the control group presented a mild level of somatic anxiety, similar to the pre-test results. However, in the experimental group, the absence of somatic anxiety predominated in 97.1%, results that show significant differences between the both groups, confirmed by the Mann-Whitney U statistical test ($p=0.000$) (Table 2). In the pretest results, the mild level predominated in the control group. In the pretest results, mild cognitive anxiety predominated in both the control group (48.6%) and the experimental group (51.4%), with no significant differences between both groups according to the Mann-Whitney U test ($p=0.745$). In the post-test, mild cognitive anxiety predominated in the control group (48.6%). However, in the experimental group (those who received spiritual care), the absence of cognitive anxiety predominated (91.4%), a difference that was significant according to the Mann-Whitney U test ($p=0.000$) (Table 3).

Table 2. Somatic anxiety in the pre-test and post-test control and experimental group, surgical patients

Pretest	Control		Experimental		U-Whitney = 482,000 p = 0.121
	\bar{x} = 3.91 DE = 2.95		\bar{x} = 3.31 DE = 4.40		
	No.	%	No.	%	
Absent	17	48.6	11	31.4	
Mild	18	51.4	23	65.7	
Moderate	0	0	1	2.9	
Severe	0	0	0	0	
Total	35	100	35	100	

Posttest	Control		Experimental		U-Whitney = 91,000 p = 0.000
	\bar{x} = 4.54 DE = 4.66		\bar{x} = 0.28 DE = 0.75		
	No.	%	No.	%	
Absent	15	42.8	34	97.1	
Mild	18	51.4	1	2.9	
Moderate	1	2.9	0	0	
Severe	1	2.9	0	0	
Total	35	100	35	100	

Table 3. Cognitive anxiety in the pre-test and post-test control and experimental group, surgical patients

Pretest	Control		Experimental		U-Whitney = 585,000 p = 0.745
	\bar{x} = 5.11 DE = 3.35		\bar{x} = 5.68 DE = 4.07		
	No.	%	No.	%	
Absent	7	20.0	8	22.9	
Mild	17	48.6	18	51.4	
Moderate	8	22.9	4	11.4	
Severe	3	8.6	5	14.3	
Total	35	100	35	100	

Posttest	Control		Experimental		U-Whitney = 71,000 p = 0.000
	\bar{x} = 5.97 DE = 3.26		\bar{x} = 1.11 DE = 1.38		
	No.	%	No.	%	
Absent	5	14.3	32	91.4	
Mild	17	48.6	2	5.7	
Moderate	9	25.7	1	2.9	
Severe	4	11.4	0	0	
Total	35	100	35	100	

Discussion

Spiritual care is a crucial aspect of pre-surgical care, providing powerful coping strategies to overcome transient anxiety. In this context, several studies demonstrate the implications of spiritual support as part of spiritual care in significantly reducing anxiety levels in different situations for surgical patients and those with other illnesses.^{3,30} Likewise, Biawan and Suroso in Indonesia point out that spiritual strength can help individuals heal and achieve life goals.⁹ Hernández and Velásquez in Peru concluded that the power of intervention with applied spiritual care was effective in reducing the level of situational anxiety in surgical patients who were subjects of study.²⁷

The study findings report that the female sex predominated in the group investigated. Another prominent socio-demographic characteristic was that the patients had not undergone previous surgeries (55.7%). The mean age of the study sample was \bar{x} = 41.61 years with a standard deviation of DE = 16.58.

The study demonstrated that surgical patients, before the intervention, mostly experienced mild levels of anxiety. After receiving spiritual care, the situational preoperative anxiety of the surgical patient in the experimental group

decreased significantly with the help of prayer, with an absence of anxiety reported (94.3%). However, the situational preoperative anxiety of the surgical patient in the control group remained at mild levels (60%). Therefore, it was demonstrated that the importance of spiritual care linked to nursing care is one of the characteristics of these professionals, who reduce anxiety in the preoperative period of surgical patients. This anxiety stems from the psychological state to which these patients are subjected during this phase, such as fear of the unknown, anguish, and despair, providing them with calm, peace, and tranquility through spiritual intervention. The results are consistent with the study by Diah et al., who indicate that spiritual therapy reduces preoperative anxiety, since through prayer, patients obtained calm and satisfaction, significantly decreasing their anxiety.³ In turn, Trihandini et al. confirm that spiritual nursing care has a significant effect on anxiety levels in stroke patients.³¹ Biawan and Suroso report a statistically significant correlation between patients' spiritual level and a reduction in preoperative anxiety in surgical units after providing spiritual care.⁹ Álvarez and Villagra suggest, based on their results, that spiritual practices carried out by nurses influence preoperative anxiety levels.³⁰ Mahomet et al. demonstrated that the implementation of a spiritual care program significantly reduced death anxiety in stroke patients.³² Tuba et al. found that spiritual care assisted in the intensive care unit positively affected levels of spiritual well-being, hope, loneliness, and life satisfaction in patients.³³ This differs somewhat from studies by Azaimian et al., who report that, although death anxiety in cardiac patients decreased after the implementation of spiritual care, this reduction was not statistically significant.³⁴ Along the same lines, Santos et al. indicate that anxiety and depression were lower in the intervention group, with no statistically significant differences.³⁵

Regarding the anxiety factors considered in the study, two were considered: Somatic factors, that is, the symptoms manifested physically by the patient as a result of the anxiety generated by the surgical event, such as leg tremors, heart palpitations, instability, a feeling of blockage, restlessness, digestive problems, fainting, etc.; and the cognitive factors, which are basic aspects of mental activity that manifest as a result of the imminent surgical event, such as inability to relax, fear to the worst, nervousness, fright, fear of losing control, general fear, and fear of dying. The study reported in the pre-test that in both the control and experimental groups, these factors were mostly mild.

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In this sense, the study maintains that the administration of the intervention provides additional elements to conventional and palliative care, because providing spiritual care to surgical patients in the preoperative period is crucial, since they go through moments of anguish, fear, despair, suffering, and somatic-cognitive symptoms that are often not addressed in the medical setting. Consequently, the intervention is not only a crucial component of quality supportive care but also constitutes a mind-body-spirit approach that considers the spiritual aspect of the human being as the integral essence of holistic care.

Thus, spiritual care should be considered a complementary tool for surgical patients, as it fosters physical and psycho-emotional benefits. Likewise, spiritual care should be tailored to the needs of surgical patients, respecting their beliefs and opinions.

However, despite the reported positive benefits of spiritual care in the somatic and cognitive dimensions, its application in pre-surgical patients remains a challenge, considering that the spiritual aspect is the essence of the human being and must be considered when providing comprehensive or holistic care. "The importance of the spirituality provided by the nursing team to both patients and their families positively influences the care provided, enhancing activities that support others: the act of caring, social interaction, dialogue, and the practice of religious practices."³⁷

Regarding limitations, the study was conducted on surgical patients in the preoperative period at a public institution in Peru, which cannot be generalized to all surgical patients in the surgical service of different hospitals in Peru or the world.

Conclusions

Statistical results have shown that interventions with spiritual care have significantly reduced preoperative anxiety in patients at the Santa María del Socorro Hospital. The application of spiritual therapy facilitated a favorable recovery by reducing situational anxiety levels, allowing the patient to successfully cope with the surgical intervention. Therefore, we recommend that a program of spiritual assistance be implemented in hospitals in our country for the care of surgical patients vulnerable to states of anxiety and stress due to surgery.

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