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Are male patients less interested in spirituality? Results of an open survey with the SpREUK questionnaire

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Abstract: Using the 29-item SpREUK questionnaire, we analyzed the spiritual and religious attitudes of 129 patients from the Communal Hospital Herdecke (Germany) with severe diseases. The scores of the 4 sub-scales did not correlate with disease or duration of disease, but with denominational affiliation and spiritual attitude. Women had significantly higher SpREUK scores for the sub-scale 1 ("search for meaningful support") and sub-scale 2 ("Guidance, control and message of disease"), while patients with > 70 years of age had significantly higher scores for sub-scale 2. Moreover, in contrast to men women significantly view their illness as a chance for their own development. In trend, for only a few men the engagement in spirituality/religion plays a major role in life, or is helpful in the dealing with illness. In regard of the supporting and stabilizing effects of spirituality/religiosity no significant differences were observed between women and men.

Keywords: patients; questionnaires; spirituality; diseases; coping; gender-specific differences

Introduction

Several studies have shown that religious involvement and spirituality are associated with better health outcomes, coping skills, and health-related quality of life (Mueller *et al*., 2001; Nelson *et al*., 2002; Powell *et al*., 2003; Seeman *et al*., 2003). Despite from these well-known facts, it still remains unclear whether patients are really interested in spiritual and religious support. It cannot be ignored that several patients have turned away from institutional religion, but may be attracted by some kind of spirituality which is often an individual patchwork of various existing esoteric and religious resources. Thus, we analyzed the basic attitudes of patients with life-changing diseases towards spirituality/religiousness and their disease (Ostermann *et al*., 2004; Büssing *et al*., 2004). This paper focuses on the differences in the attitudes of female and male patients.

Materials and Methods

Subjects

Patients were informed of the purpose of the study and were assured of confidentiality. All of them gave informed consent to participate and completed the questionnaire by themselves. 129 patients with a mean age of 54 ± 14.3 years were recruited in the cancer service, the multiple sclerosis service and two internal medical units of the Communal Hospital in Herdecke (Germany). 76% had a Christian denomination, 4% others, and 19% had none. 45% of the patients were diagnosed with cancer, 18% with multiple sclerosis, 22% with other chronic diseases, and 15% with acute diseases. Patients in final stages of their disease were not enrolled.

Questionnaire

The preliminary SpREUK questionnaire (SpREUK is an acronym of the German translation of "Spiritual and Religious Attitudes in Dealing with Illness") was designed to examine the attitudes of patients with life-threatening and chronic diseases towards spirituality/religiousness (Ostermann *et al*., 2004). The internal consistency of the 29-item scale is high. The 4 sub-scales examine (1) "Search for meaningful support", (2) "Guidance, control and message of disease", (A) "Support of the external relations through spirituality/religiosity", (B) "Stabilizing the inner condition through spirituality/religiosity". The items are scored on a 5-point scale from disagreement to agreement (0 - does not apply at all; 1 - does not truly apply; 2 - don´t know; 3 - applies quite a bit; 4 - applies very much) and were accumulated and transformed on a 100% level for each sub-scale.

Statistics

Statistical analysis was performed with SPSS for Windows 10.0. Differences in the SpREUK scores were tested using the Kruskal-Wallis-Test for asymptomatic significance. To measure associations between the frequencies of given answers and distinct variables, we used cross-tabulation and Pearson´s Chi^2 statistic. We judged $p<0.05$ as significant.

Results

As reported elsewhere (Ostermann *et al*., 2004; Büssing *et al*., 2004), the SpREUK scores of the sub-scales correlated with denominational affiliation, and religious/spiritual attitude. However, women had significantly higher scores for sub-scales 1 and 2 ($p<0.05$, Kruskal-Wallis-Test; Table 1), which as for the "Search for meaningful support" respectively "Guidance, control and message of disease". This correlates with the finding that women more than men view their illness as a chance for the own development ($p=0.03$; Chi^2; Table 2).

Table 1: SpREUK scores of patients

	All (n=129)	women (n=87)	men (n=41)
sub-scale 1	54.8 ± 21.5	55.3 ± 21,8	48.2 ± 19.7 *
sb-scale 2	64.9 ± 15.6	67.0 ± 15.6	60.7 ± 14.9 *
sub-scale A	57.8 ± 24.3	61.2 ± 23.4	54.4 ± 24.8
sub-scale B	61.2 ± 23,4	64.7 ± 22.9	57.2 ± 28.8

* different from females ($p<0.05$, Kruskal-Wallis-Test)

Although men had lower scores in sub-scales A and B which asks for the supporting and stabilizing effects of spirituality/religiosity, the differences are not significant ($p<0.20$, Kruskal-Wallis-Test; Table 1). In fact, only a few men had a renewed interest in spiritual/religious questions through illness, and for only a few the engagement in spirituality/religion plays a major role in life, is deepened when practicing alone and in silence, or is helpful in the dealing with illness (Table 2).

Regarding their religious or spiritual attitude, women and men did not significantly differ (Table 2), especially the reliance to a higher (external) power resp. to an inner power, or their trust in a higher power at all was not significantly different. In contrast to patients with both a religious and spiritual attitude, patients with a spiritual-non religious attitude had lower perception of the beneficial effects of their spirituality/religiousness (Büssing *et al*., 2004; submitted for publication). Just half of the spiritual-non religious group and 42% of religious patients are convinced that finding an access to a spiritual source has a positive influence on their illness. As shown in Table 2, male patients were less convinced than females, but this difference is not statistically significant.

Table 2: Frequencies of answers

	+			-			p
	all	**W**	**M**	**all**	**W**	**M**	**Chi²**
1: Search for meaningful support							
positive influence on illness by access to a spiritual source	38	43	29	27	28	27	/
renewed interest in spiritual/religious questions	43	51	29	38	33	49	0,09
searching for an access to spirituality/religiosity	25	28	20	42	39	49	/
urged to spiritual/religious insight	31	34	27	32	25	44	/
others might teach and help to develop spirituality	45	51	34	36	33	41	/
does not need spiritual advice	39	39	39	38	40	34	/
spiritual/religious ideas are out-of-date	10	6	15	71	74	68	/
spiritual attitude	41	43	39	33	31	39	/
2: Guidance, control and message of disease							
* what happens is due to own fault	22	23	20	56	49	61	/
life is fixed by fate	35	39	27	53	39	54	/
disease acceptance	57	61	51	29	26	34	/
doctor or therapist help to keep illness at bay	55	53	61	22	22	22	/
trust in a higher power	67	69	63	16	13	24	0,18
religious attitude	66	70	60	21	18	28	/
trust in inner strength	61	61	63	17	17	17	/
illness encourages to get to know himself better	67	70	63	15	13	20	/
Illness as a hint to change life	74	77	68	12	9	17	0,16
* illness has brought down aim and purpose in life	15	10	24	60	64	54	/
* development of new goals in life	47	46	49	34	32	39	0,16
* illness as a chance for development	60	66	51	24	17	39	0,03

A: Support of the external relations of spirituality/religiosity							
plays a major role in life	49	54	39	36	37	34	0,06
* help in decision making	47	54	34	29	24	39	0,19
helps to manage life more consciously	64	66	63	16	13	22	/
provides deeper connection with others and world around	60	62	56	18	17	20	/
helps to cope better with illness	56	59	51	25	25	24	0,05
helps to restore mental and physical health	48	53	39	23	22	27	/

Table 2: Frequencies of answers (continued)

helps to view disease as a beneficial challenge for own development.	40	41	29	37	30	44	/
deepened when practicing with others	36	39	29	53	49	63	0,19
deepened when practicing alone and in silence	65	70	56	24	25	22	0,06
stimulated by distinct places	74	76	73	19	20	15	0,08
B: Stabilizing the inner condition through spirituality/religiosity							
provides feeling of contentment and inner peace	58	67	41	19	16	27	0,15
promotes inner strength.	50	54	44	26	24	32	/
refers to a higher (external) power	60	64	54	24	24	24	/
refers to an inner power	43	41	46	32	31	34	/

Results are % of women (W) and man (M) (one patient gave no answer regarding his gender) which agreed (**+** : "applies quite well" and "definitely applies") or disagreed (**-** : "does not apply at all" and "does not really apply"); indifferent answers ("I don't know") are not given.

* For the current version of the questionnaire, some items were deleted which are still given in this table.

Discussion

Women are said to have different coping strategies than men, since men are more problem-oriented and women more emotionally-oriented (Vingerhoets and van Heck, 1990). Women give their partner more emotional support than men and are more active in social networks (Umberson *et al*., 1992), and are often the main, or even the sole source in a partnership providing social support (Lubben, 1988). Thus, in life-threatening diseases one could expect differences in the attitudes towards spirituality and its use in disease coping. In fact, we observed that women more than men are in search for meaningful support by spirituality, have trust in transcendental guidance, and interpret their disease positively. Preliminary results of an ongoing study with our patients (n=57) reveal that women prayed more regularly or often (f/m: 64% vs. 30%; $p = 0.01$, Chi^2), although this did not imply a regular or frequent attendance of the service in church (f/m: 25% vs. 15%; difference not significant). This is in agreement with findings of Kremer (2002) who observed that women more often use religious coping strategies than men, probably as an attempt to restore an intact world. Thus, males were in fact less interested in spiritual concerns, probably because they use more rational coping strategies.In regard of the beneficial effects of spirituality/religiosity on the individual relations and concerns there were no significant differences between women and men.

However, gender-specific differences cannot easily be diminished or dismissed. The mechanisms by which gender differentially cope with severe illness need to be further explored in order to intervene appropriately in medical care. But one may not ignore the fact that patients with severe diseases are not necessarily interested in religious or spiritual topics, especially patients without spiritual and religious attitudes (Büssing *et al.*, 2004), and probably those widowed, divorced or living alone.

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