

Effect of nurses' religious beliefs on their empathy and life satisfaction

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ABSTRACT

Introduction: Nursing is one of those medical professions that are inseparably associated with being in continuous contact with other people, and it is worth noting that there are things that cannot be acquired in the course of an education. These include conscience and empathy as subjective and ultimate standards of morality, which help nurses make morally good decisions and that represent criteria for assessing their behavior.

Purpose: To assess the effect of nurses' religious beliefs on their empathy and life satisfaction.

Materials and methods: The study included 150 nurses and 150 nursing, using our own questionnaire, the Empathy Understanding Questionnaire (KRE) by Węgliński, and The Satisfaction with Life Scale (SWLS).

Results: The mean level of KRE-based empathic understanding was 65.7 ± 9.4 points, which indicates that it was relatively high. The lowest

level was 39, and the highest was 92 points. Mean SWLS score was about 20 points, which indicates that the studied nurses were neither satisfied nor dissatisfied with their life. Respondents with the highest level of empathy would discontinue treatment due to their beliefs or they would choose another unspecified solution. No significant correlations were found between the levels of empathy and life satisfaction and the opinion on the role of religious beliefs in the choice of nursing profession, and regarding religion as an obstacle in performing work-related tasks.

Conclusions: Nurses showed relatively high levels of empathy and average levels of life satisfaction. The importance of nurses' religiousness in making therapeutic decisions did not correspond with life satisfaction nor their level of empathy.

Keywords: Empathy, The satisfaction with life scale, religion, nurses

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INTRODUCTION

Nursing is one of those medical professions that are inseparably associated with being in continuous contact with other people, and it is worth noting that there are things that cannot be acquired in the course of an education. These include conscience and empathy as subjective and ultimate standards of morality, which help nurses make morally good decisions and that represent criteria for assessing their behavior.

As a result of the geopolitical situation and migration, nurses more frequently encounter patients from many different cultural and religious backgrounds. This is a challenge for this group of professionals, who due to their duties stay in constant contact with patients. Lack of basic knowledge on cultural and religious differences, being guided by stereotypes, and concentrating on emotions associated with these contacts hinder providing professional care.

Medical students and medical personnel are required to show high professional competence and adequate personality traits, including empathy, which just as professionalism should be noticeable from the first contact with a patient.

The ability to recognize a patient's emotional problems as well as to emphatically respond to these problems is a key component of professional training for nurses and physicians [1].

The term 'empathy' derives from *emfühlung*, which was used for the first time in German aesthetics, but was not used until 1909 when it was introduced in psychology by Titchener to refer to the process of sharing the mental states of others. The Greek *empathes* means suffering [as cited in 2,3].

Most authors dealing with the subject of empathy [4,5] distinguish between emotional and cognitive empathy. According to Stotland, Gawriłow, Mehrabian, and Smith, emotional empathy involves experiencing another person's affective states; it is a response to perceiving other people's emotions, which results in experiencing other's emotions and feelings as one's own. Whereas cognitive empathy involves a process of *putting oneself in someone's place, and therefore a correct understanding of others' feelings, thoughts and needs as well as an accurate perception of others' responses* [as cited in 4].

Turczyńska et al. [6] studied the relationship between empathy and motives for choosing medical studies, and showed that an increase in subjects' empathy correlated with increased importance of two motives, i.e. 'I have always dreamed of studying medicine' and 'the possibility to help others.'

The aim of this paper was to assess the impact of nurses' religious beliefs on their capacity of empathic understanding and life satisfaction.

MATERIALS AND METHODS

The study was conducted in 2010-2011, after approval No. R-I-002/244/2009 was obtained from the Bioethics Committee of the Medical University of Białystok. The study included 150 professionally active nurses. A total of 160 questionnaires were distributed, but 150 were used. The major study was preceded by a pilot study conducted in a group of 50 patients to verify the clarity of the statements included in the questionnaire. The study used a diagnostic survey method using:

- Our own questionnaire consisting of a general part (10 questions) and 17 questions pertaining to assessing job satisfaction;
- The standardized Empathy Understanding Questionnaire (KRE) by Węgliński [7-9], based on a concept of empathy understood as emotional-cognitive syndrome. The test included 33 items to be answered by a respondent using: 'yes,' 'rather yes,' 'rather no,' and 'no' responses. A four-grade scale for assessing each statement inventory was used to calculate the results, using conversion factors in accordance with formula A or B, depending on the sex and the recommendations of the questionnaire's author. The final results range between 0 and 99, where a higher result means higher empathy [7-9].
- The Satisfaction with Life Scale (SWLS), by Diener, Emmons, Larsen, and Griffin, a Polish adaptation by Juczyński [10]. The scale had five statements. Respondents evaluated to what extent each of the statements referred to their current life: from 1 - I completely disagree to 7 - I completely agree. Reliability indicator (Cronbach's *alfa*) was 0.81, scale stability indicator 0.86. The obtained scores were summed, and the overall result described the level of satisfaction with life. Results ranged from 5 to 35 points. The higher the result, the greater life satisfaction [10].

RESULTS

The study group included 33.3% nurses aged 20-30 years, 32.7% aged 31-40, 32% aged 41-50, and 2% aged 51-60 years. Women (94.7%) and city dwellers (77.3%) dominated among the respondents. Males accounted for only 5.3%, and residents of rural areas for 17.3% of respondents. The place of residence was not provided by 5.3%. Individuals with an undergraduate education (54%) dominated among the respondents, followed by secondary (40%) or higher education, including nursing (4%) and other faculties (2%). Nurses worked on different wards: surgical (30.7%), treatment (26%), other wards (23.3%), outpatient

clinics (18%), or did not provide their place of work (2%). A total of 56% of the respondents worked as divisional nurses. Other respondents worked as surgical nurses (11.3%), coordinating nurses (6.7%), a different position (24%), or did not provide details in this regard (2%). The seniority of respondents ranged from 1 year to over 30 years (1-5 years reported by 36.7% of respondents, 6-10 years by 6%, 11-15 or 16-20 years by 12.7% each, 21-30 years by 26.7%, and over 30 years by 3.3%). Only 2% did not state their seniority.

In a self-assessment of religiosity, the nurses most frequently declared themselves as rather religious (65.3%). They less often claimed to be religious (22%), rather not religious (5.3%), not at all religious (0.7%), or that their level of religiousness was only associated with family traditions (2.7%). Four percent of respondents had difficulty answering the question.

According to the largest group of nurses, the importance of religion has declined significantly worldwide (53.3%), slightly declined in Poland (46%), and remained unchanged in their personal life (56%), work life (50.7%), and family life (56%). Other respondents claimed that compared with the past, the importance of religion worldwide was currently slightly lower (25.3%), unchanged (10%), slightly higher (0.7%), or significantly higher (1.3%). The importance of religion in Poland was significantly lower (26%), unchanged (13.3%), slightly higher (4%), or significantly higher (7.3%). The importance of religion in the respondents' personal lives was significantly lower (4%), slightly lower (14%), slightly higher (9.3%), or significantly higher (12.7%). The importance of religion in family life was significantly lower (4.7%), slightly lower (13.3%), slightly higher (10.7%), or significantly higher (1.3%). The importance of religion in work life was significantly lower (6%), slightly lower (9.3%), slightly higher (12.7%), or significantly higher (11.3%). Only 9.3% of the respondents had difficulty assessing the importance of religion worldwide, 3.3% in Poland, 4% in personal and family life, and 14.7% in work life.

Most respondents found baptism (82%), marriage (70.7%), and funeral (80.7%) equally important. The remaining nurses found baptism rather important (13.3%) or were indifferent (2%). Marriage was rather significant for 16.7% of respondents, 7.3% were indifferent, rather unimportant for 2%, and unimportant for 1.7%. Funeral was rather important for 12.7% of respondents, whereas 4% were indifferent. 2.7% did not express their opinion on baptism, marriage, or funeral.

The KRE questionnaire was used to assess empathic understanding of other people. The mean level of KRE-based empathic understanding in the study population was 65.7 points \pm 9.4 points,

which indicates that it was relatively high. The lowest observed level was 39, and the highest was 92 points. The level of emphatic understanding did not exceed 59 points in every fourth respondent. On the other hand, emphatic understanding was assessed as at least 72 points in every fourth respondent. The KRE score ranged from 35 to 40, 41-45, and 46-50 in 1% of respondents; 51-55 in 11%; 56-60 in 16%; 61-65 in 21%; 66-70 and 71-75 in 17% each; 76-80 in 9%; 81-85 in 4%; 86-90 and 91-95 in 1% each.

Mean SWLS score for the study population was about 20.1 points, which indicates that the studied nurses were neither satisfied nor dissatisfied with their life. The lowest observed level was 8, and the highest was 35 points. The level of life satisfaction did not exceed 16 points in every fourth respondent. On the other hand, life satisfaction was assessed as at least 24 points in every fourth respondent.

Based on the SWLS scale categorization, it can be estimated that life satisfaction in the studied group of nurses was at the average level – the percentages of positive and negative scores were comparable. A total of 31.3% of respondents was rather satisfied with their life (21-25 points); 26.7% was rather dissatisfied with their life (15-19 points); 14.7% was very satisfied with their life (26-30 points); 13.3% was very dissatisfied (10-14 points); 10% was indifferent (20 points); and strong dissatisfaction (5-9 points) or strong satisfaction (31-35 points) were expressed by 2% of respondents each.

A total of 78% of nurses claimed that religion had no effect on making new acquaintances. The opposite opinion was expressed by 6% of nurses, and 16% had no opinion on this matter. A total of 14.7% of nurses were convinced that religious beliefs can affect job choice. The opposite opinion was expressed by 42% of patients, and as many as 43.3% were unable to express their opinion on this matter. As can be seen from the table below (Table 1), no correlation was found between the level of empathy and life satisfaction, and the opinion on the role of religion in the choice of nursing profession.

According to 61.1% of nurses, religion had no effect on performing work-related tasks, whereas 24.8% were of the opposite opinion, and 14.1% had difficulty answering this question. No correlation was found between life satisfaction and the level of empathy, and regarding religion as an obstacle in performing work-related tasks. In the case of the KRE, a logical orientation in the mean level of this measure may be observed in the compared groups (the highest empathy was shown by those who believed that religious belief is an obstacle in their work, while those of the opposite view were characterized by the lowest empathy), however this

correlation cannot be considered reliable due to the lack of statistical significance (Table 1).

A majority of the respondents (69.3%) declared that they never asked their patients about religion. An occasional inquiry about religion was reported by 17.3% of nurses, and 4.7% admitted that they always asked their patients about their religion, while 8.7% did not answer this question. There were no statistically significant differences in the assessment of the relationship between the numerically described attitudes using the scales and inquiries about patients' religious beliefs. However,

it should be noted that the level of empathy (KRE) was higher in those who inquired (either frequently or occasionally) about religion compared with those who did not ask about religion or did not provide an answer to this question. If an analysis was performed for two groups: subjects asking about religious beliefs ('yes' or 'sometimes') and those not asking about religion ('no' or 'difficult to say'), the Mann-Whitney test result of $p = 0.0441^*$ would indicate a non-accidental, statistically significant correlation between empathy and inquiring about religious beliefs (Table 2).

Table 1. Opinions on the importance of religion in choice of profession in relation to the KRE, SWLS

scale	yes		no		difficult to say		p
	\bar{x}	s	\bar{x}	s	\bar{x}	s	
Role of religion in choosing profession							
KRE	65.3	7.2	65.5	10.4	65.9	9.2	0.9565
SWLS	20.9	6.3	19.8	5.6	20.2	4.3	0.6984
Religion as an obstacle in performing work-related tasks							
KRE	68.1	8.9	64.5	9.4	66.4	10.2	0.1332
SWLS	20.4	5.3	19.8	5.4	21.1	4.5	0.5122

Table 2. Asking patients about their religion in terms of measurement scales

Measurement scales	Asking patients about their religion				p
	yes	no	sometimes	difficult to say	
KRE (points)	68.7	65.0	68.7	63.4	0.2301
SWLS (points)	21.3	20.3	18.9	20.3	0.4711

As reported by every fifth nurse (23.5%), the patient's religion could affect decisions regarding treatment. This was denied by one in three respondents (35.3%); and one in four respondents (26.7%) was not able to present their views on the subject. Nurses' religion, on the other hand, had a much smaller impact on therapeutic decisions as it did not seem to affect the treatment of patients, as reported by 50% of respondents. A different opinion was expressed by 13.3% of nurses; 1.3% of respondents confirmed that such a situation may sometimes occur, whereas as many as 35.5% did not know how to answer this question. Furthermore, there was no correlation between the importance of patients' or nurses' religiousness in making therapeutic decisions and life satisfaction or the level of empathy in nurses (Table 3).

A total of 68% respondents was not able to list procedures which would depend on a nurse's

religiousness. According to the remaining nurses, the most important procedures included: blood transfusion (18.7%), abortion (12.7%), euthanasia (7.3%), in vitro fertilization (2.7%), and transplant (2.7%). 37.3% of nurses had difficulty providing examples of procedures which would depend on a patient's religiousness. The remaining nurses indicated blood transfusion (58%), transplant (14%), abortion (8.7%), euthanasia (5.3%), and in vitro fertilization (4%). The question regarding procedures dependent on a patient's religious beliefs was very complex. To perform the analysis, the nurses were divided into two different categories: those able to identify procedures potentially dependent on a patient's religious beliefs and others (Table 4). No significant correlations were found between the answers to these two questions and the level of empathy or quality of life. Mann-Whitney p-values quite clearly exceed the cutoff level of 0.05.

Table 3. Impact of religion on performing procedures by a nurse

Scale	Impact of religion on making therapeutic decisions								p	
	yes		sometimes		no		difficult to say			
	\bar{x}	s	\bar{x}	s	\bar{x}	s	\bar{x}	s		
patient										
KRE	64.9	8.9	62.0	9.8	67.0	9.1	66.6	9.8	0.1673	
SWLS	19.8	5.5	18.6	3.9	20.9	5.6	20.1	4.9	0.3790	
nurses										
	\bar{x}	s	\bar{x}	s	\bar{x}	s	\bar{x}	s		
KRE	66.1	8.1	66.0	8.8	65.1	10.8			0.8485	
SWLS	20.2	5.5	20.6	5.3	19.4	4.9			0.4440	

Table 4. Ability to indicate procedures which may be affected by religious beliefs in relation to measurement scales

Scale	Ability to indicate procedures which may be affected by religion		p
	no (N = 56)	yes (N = 94)	
patient			
KRE	67.1	64.8	0.2192
SWLS	19.8	20.3	0.6571
nurses			
KRE	65.5	66.0	0.7163
SWLS	19.9	20.6	0.7374

Nurses' answers related to coping with the necessity to perform procedures against a patient's religious convictions were not clear. Most respondents had difficulty providing an unambiguous response (30%) or selected treatment discontinuation (29.3%). Other responses included assigning the patient to another nurse (9.3%) and performing the procedure against the patient's beliefs (2%); whereas 29.3% of nurses claimed they would take another course of action, but did not provide any details in this regard. In the case of a procedure against a nurse's religious beliefs, patients were usually assigned to another nurse (38%). Other respondents would refuse to participate in a therapeutic procedure that was contrary to their conscience (15.3%); whereas some of the nurses would participate in the procedure (6.7%), and 11.3% of respondents would take

another course of action, but did not provide any details in this regard. More than ¼ of the respondents (28.7%) were unable to take a clear stance on this issue. Table 5 shows data on the relationship between the types of nurses' behaviors in a situation involving a conflict between the procedure and a nurse's religious beliefs or a patient's beliefs and the level of quality of life and empathy. Only empathy was in some way connected with answers to these two questions, especially the one related to behavior in a situation of conflict between the procedure and a nurse's religious beliefs. However, even this relationship cannot be considered statistically significant (p=0.1125). Respondents with the highest level of empathy would discontinue treatment due to their beliefs or they would choose another unspecified solution.

Table 5. Nurse's choice if a procedure is in conflict with religious beliefs in relation to the KRE, SWLS

KRE, SWLS	Nurse's choice if a procedure is in conflict with religious beliefs										p
	assign the patient to another nurse		perform the procedure		treatment discontinuati on		take another course of action		difficult to say		
	\bar{x}	s	\bar{x}	s	\bar{x}	s	\bar{x}	s	\bar{x}	s	
patient											
KRE	69.4	6.9	62.7	7.1	66.4	10.5	66.4	9.2	63.2	9.0	0.1928
SWLS	21.2	6.4	21.3	3.2	19.5	5.5	20.1	4.5	20.2	5.3	0.8603
nurses											
KRE	64.6	9.8	64.6	7.7	68.2	11.9	70.1	8.3	64.1	7.6	0.1125
SWLS	19.9	5.2	20.0	3.9	18.9	6.1	20.3	6.5	21.0	4.4	0.6300

DISCUSSION

The literature on the subject [4-9] emphasizes that the concept of empathy has recently gained new aspects and meanings, depending on the represented schools and currents in psychological research. It is understood as: understanding others, fellow-feeling, social awareness, sympathy, as well as an insight into another person [4-9]. There are differing views on the genesis of empathy among researchers [4-9]. Some of them regard empathy as an inborn mechanism, others as a learned phenomenon; whereas some researchers distinguish several types of empathy: mood-related (developed by feeling the subject in an observed piece of art), apperceptive (based on visual and auditory apperception), intellectual (being the basis for speech development, as speech has always been a reflection of intellectual development, from primitive forms to those occurring today), and ethical (consisting of altruistic acts, which are the basis for creating societies) [4-9].

Węgliński [7-9] identified five emphatic tendencies: sensitivity to the experiences of others, emotional syntony (co-sounding), being moved by the positive and negative emotions of others, empathizing with the experiences of others, and a willingness to sacrifice for others. Węgliński believes that the course of empathic contacts based on empathizing with partners of a given interaction significantly increases the probability of responsibility for others, kindness, warmth, and tolerance [7-9].

Rembowski [2,3] believes that there is a wide range of scientific methods for indirect or direct investigation of empathy. The first one is an experimental method aimed at exploring ways of inducing empathy in a laboratory setting using an experiment supplemented with observation and a conversation between the experimenter and the subjects, during which the subjects report what they experienced during the experiment they participated in. The second method is based on a mechanism involving the projection of internal subjective states of the subject onto reality, and includes classical projective tests based on images, such as: TAT by Murray or the Rorschach inkblot test, as well as slides, which comprise of unfinished stories and stories with specific content. The third method is a scale-questionnaire method, such as "Dymond's Score Test" or the "Empathy Test" by A. Hastor and I. Bender, the "Empathy Test" by Hogan, and the "Emotional Empathy Scale" by A. Mehrabian and N. Epstein [2,3]. The most recent tools include the Interpersonal Reactivity Index developed by Davis in 1980 [as cited in 9]. Polish questionnaires include the Empathy Understanding Questionnaire (KRE) developed by Węgliński in 1983 [7-9], which was used in this study.

Pawelczyk et al. [11], who included medical students in their research, found a statistically significant relationship between sex and the level of empathy, value attitudes, and the system of values. Female students showed higher levels of empathy, a stronger attachment to religious values, and a lower economic attitude compared with male students [11]. Krajewska-Kułak et al. [12] showed in their analysis of attitudes in 237 undergraduate nursing students that third-year students showed the highest level of empathy, i.e. an average of 70.5 ± 8.3 . These relationships were statistically significant for each year at university [12]. Kliszcz et al. [13] showed that female students were significantly more empathic than male students; however, their empathy levels decreased during their university education, whereas empathy levels in male students did not change. Motyka [1] showed positive effects of undergraduate nursing degrees on the ability to verbally show empathy, a tendency to provide psychological support for those needing it, and a significantly lower tendency to offer trite consolations. Motyka [1] found a twofold increase in the frequency of empathic responses in third-year students compared with first-year students.

We found that mean empathy level was 65.7 points in the study population, which is relatively high.

Wilczek-Różyczka and Tobiasz-Adamczyk [14,15], in their studies on empathy, found that empathy training had significant effects on increasing empathy levels and improving satisfaction with nursing care. Therefore, it is advisable to continue research on the importance of empathy in medical professions. Also, we agree with Wilczek-Różyczka's [14,15] suggestion to implement empathy training in the education of psychiatric nurses. However, extending empathy training to all nursing specialties and perhaps even medical degrees is worth considering [14,15].

One of the many factors that have a significant impact on human health is health culture, which consists of a system of values attributed to physical and mental health, objective and subjective, individual and public [16,17,18]. This is manifested by an awareness of regulating the human-environment relationship out of a sense of responsibility for one's own and public health as well as sensitivity to the health needs, particularly the suffering, of others. The literature on the subject [16-18] emphasizes that health attitudes and behaviors related to a disease are determined by: religion (attitude of accepting disease and death without reservations as a result of higher forces and lack of human control); magic (active attitude toward a disease regarded as a result of the actions of gods or other mysterious powers, which are manifested by prayer for the dead or making offerings, for example); nursing care activities

provided as part of social support and psychological care, whose aim is to reduce stress in patients, gain their trust, provide them with a feeling of safety; and medical activities that involve providing health services to control a disease using scientific means.

Ogórek-Tęcza et al. [18] included 167 nurses in their study and showed that the subjects had difficulties establishing relations with patients from different cultural/religious backgrounds. This was usually associated with a lack of knowledge (19.8%) and a communication barrier (19.2%). Almost half of the respondents declared positive emotions associated with a patient of a different religion [18]. Direct contact with patients from different cultural/religious backgrounds contributed to increased anxiety (19.8%), the occurrence of hostility and reservation (13.8%) as well as rejection (9%). The majority of respondents achieved an average level of empathy (76.6%). No correlation was found between empathy levels and the perception of people from different cultural/religious backgrounds due to small differences in empathy levels [18].

Our study showed no correlation between religious beliefs and the level of empathy and life satisfaction, and regarding religion as an obstacle in performing work-related tasks as well as making therapeutic decisions.

Notwithstanding the above, it seems reasonable to continue further research and to supplement knowledge on the care of patients of different religions as well as to establish procedures for the management of patients from different cultural backgrounds to improve professional nursing care.

CONCLUSIONS

1. The study group of nurses showed relatively high levels of empathy and average levels of life satisfaction.
2. No significant correlations were found between the levels of empathy and life satisfaction and the opinion on the role of religious beliefs in the choice of nursing profession, and regarding religion as an obstacle in performing work-related tasks.
3. The importance of nurses' religiousness in making therapeutic decisions did not correspond with life satisfaction nor their level of empathy.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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