



RELIGIOSITY, QUALITY OF LIFE, AND SUBJECTIVE HAPPINESS IN HOSPITALIZED PATIENTS*

RELIGIOSIDADE, QUALIDADE DE VIDA E A FELICIDADE SUBJETIVA DE PACIENTES INTERNADOS

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RESUMO

Objetivo: Investigar se há correlação entre religiosidade, qualidade de vida (QV) e a felicidade subjetiva (FS) de pacientes internados. **Método:** Trata-se de uma pesquisa exploratória analítica de abordagem quantitativa, realizada com pacientes de uma unidade de internação clínica de um hospital privado na Região Norte do Brasil. Foram aplicados quatro formulários online: caracterização sociodemográfica, avaliação da QV - WHOQoL-Bref, Escala de religiosidade Duke Durel e Escala de felicidade subjetiva. Os dados foram analisados por meio de correlações e testes não-paramétricos usando o programa IBM SPSS Statistics versão 22. **Resultados:** Participaram do estudo 132 pacientes, com idade média de $37,24 \pm 11,29$ anos e hospitalizados por três dias em sua maioria (53%). Os escores da QV geral dos pacientes apresentaram média e mediana respectivamente iguais a $65,69 \pm 13,01$ e 67,02. A média do score total da FS dos pacientes foi de $19,8 \pm 3,8$, considerada boa. A Religiosidade Organizacional (RO) apresentou correlação positiva significativa com o domínio Meio Ambiente (17,5%; $p=0,045$) e com a QV geral (17,6%; $p=0,043$). O domínio Religiosidade Não Organizacional (RNO) apresentou correlação positiva significativa com as dimensões relações sociais (23,8%; $p=0,006$) e meio ambiente (21,1%; $p=0,015$), assim como com a QV geral (23,8%; $p=0,006$). Já o domínio Religiosidade Intrínseca (RI) apresentou correlação positiva significativa com todos os domínios da QV ($p<0,05$). No que se refere à FS, observou-se que esta apresentou correlação positiva significativa com os domínios RNO (22,0; $p=0,011$) e RI (28,3%; $p<0,0001$), isto significa que ambos os domínios estão associados à FS, e que quanto maior for o índice de religiosidade de ambos os domínios, maior será a magnitude da FS. **Conclusão:** Observou-se uma correlação significativa entre religiosidade, qualidade de vida e FS em pacientes hospitalizados, ressaltando a importância desses aspectos no enfrentamento do processo saúde-doença e seu impacto no bem-estar emocional e psicológico de indivíduos enfermos. Tais associações servem como um suporte para o cuidado integral.

Descritores: Pacientes Internados; Qualidade de Vida; Espiritualidade; Felicidade Subjetiva.

ABSTRACT

Objective: To investigate whether there is a correlation between religiosity, quality of life (QoL), and subjective happiness (SH) in hospitalized patients. **Method:** This is an exploratory analytical study with a quantitative approach, conducted with patients from a clinical inpatient unit of a private hospital in the Northern Region of Brazil. Four online forms were administered: sociodemographic characterization, quality of life assessment - WHOQoL-Bref, Duke University Religion Index (DUREL), and Subjective Happiness Scale. Data were analyzed using correlations and non-parametric tests with IBM SPSS Statistics version 22. **Results:** The study included 132 patients, with a mean age of 37.24 ± 11.29 years, most of whom were hospitalized for three days (53%). The patients' overall QoL scores showed mean and median values of 65.69 ± 13.01 and 67.02, respectively. The mean total SH score of patients was 19.8 ± 3.8 , considered good. Organizational Religiosity (OR) showed a significant positive correlation with the Environment domain (17.5%; $p=0.045$) and with overall QoL (17.6%; $p=0.043$). The Non-Organizational Religiosity (NOR) domain showed a significant positive correlation with the social relationships (23.8%; $p=0.006$) and environment (21.1%; $p=0.015$) dimensions, as well as with overall QoL (23.8%; $p=0.006$). The Intrinsic Religiosity (IR) domain showed a significant positive correlation with all QoL domains ($p<0.05$). Regarding SH, it showed a significant positive correlation with the NOR (22.0; $p=0.011$) and IR (28.3%; $p<0.0001$) domains, meaning that both domains are associated with SH, and the higher the religiosity index in both domains, the greater the magnitude of SH. **Conclusion:** A significant correlation was observed between religiosity, quality of life, and SH in hospitalized patients, highlighting the importance of these aspects in coping with the health-disease process and their impact on the emotional and psychological well-being of ill individuals. These associations serve as support for comprehensive care.

Descriptors: Inpatients; Quality of Life; Spirituality; Subjective Happiness.

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What is already known about this:

- Insufficient studies addressing subjective happiness in the context of hospitalization.
- Scarcity of comprehensive studies on the topic, as most focus only on groups of patients with specific pathologies, such as nephropathies and cancer.
- Incipient scientific production on the correlation of quality of life, religiosity, and subjective happiness variables in hospitalized patients.

What this article adds:

- Comprehensive care that considers aspects such as quality of life, religiosity, and subjective happiness can contribute more broadly to coping with the health-disease process compared to traditional biomedical models.
- Understanding the correlation between subjective variables of human experience is crucial for promoting the emotional and psychological well-being of hospitalized individuals.
- Religiosity has a positive impact on people's quality of life and serves as coping support in difficult situations such as illness.
- Higher levels of religiosity positively influence subjective happiness indices. The higher one is, the higher the other will be as well.

INTRODUCTION

The health-disease process involves multiple factors related to Quality of Life (QoL), religiosity, and happiness. When considering hospital admission, the human health experience can take different directions. The healthcare system appropriates hospitalization as an important resource aimed at recovery and reestablishing balance between these dimensions⁽¹⁻²⁾. However, the length of stay, the environment, the illness, pain, fears, invasive procedures, and waiting for diagnoses represent factors that frequently evoke feelings of uncertainty and anguish in patients⁽³⁾.

Given this context, the concept of quality of life proposes a paradigm shift by seeking to encompass complex and subjective aspects of human existence, often difficult to measure. These elements contribute significantly to a broader and more humanized clinical approach, which contemplates health in an integral manner: biopsychosocial and cultural, indispensable to health promotion, prevention, and rehabilitation processes⁽¹⁾.

Researchers in the field point out that investigating the quality of life of hospitalized patients is essential for planning and executing comprehensive care, capable of promoting well-being and life satisfaction. Thus, QoL assessment can serve as an important foundation for more assertive clinical decisions and for improving team care practices⁽⁴⁾. Scientific evidence reinforces the relevance of including dimensions such as religiosity and spirituality in health assessment, recognizing them as factors that directly influence individuals' quality of life and perception of well-being⁽⁵⁾. Thus, religiosity becomes a means that patients appropriate to face the stressors of hospitalization, which relieves their suffering and fills their lives with hope regarding QoL.

Similarly, the study of happiness, deepened by positive psychology, expands understanding of subjective aspects related to well-being, values, virtues, positive emotions, meaning of life, and personal fulfillment. Happiness also relates to the human capacity to face challenges, finding in religiosity and spirituality resources for transcendence and overcoming adversities⁽⁶⁾. QoL scores relate to the level of happiness; however, this relationship is complex and influenced by cultural and social issues. From understanding this relationship, it is understood that the reasons that lead people to happiness go beyond philosophical aspects and Western values, including the very concept of health and disease, such as a hospitalization process⁽⁷⁾.

Considering that spirituality and quality of life have great potential in generating the promotion of subjective happiness and well-being in human life, leading to zones of relief, well-being, better physical and mental health, and quality of life, it becomes increasingly necessary to study such

themes in healthcare practice, since these aspects even cause clinical repercussions in patients who have them contemplated while being assisted⁽⁸⁾.

Understanding the correlation between religiosity, quality of life, and subjective happiness generates great impact on the daily care of hospitalized patients, especially when the focus of care is comprehensive, individualized, and personalized care, as it requires numerous tools and strategies that contemplate all human dimensions. Thus, this study aims to investigate possible correlations between these variables, producing evidence that can strengthen practices based on scientific and humanistic foundations.

METHOD

Type of study

This is an exploratory analytical study with a quantitative approach⁽⁹⁻¹⁰⁾ conducted from June to September 2024. The study considered the characterization of its participants and their responses to specific and validated instruments on happiness, quality of life, and religiosity, aiming to analyze the possible correlation between the variables obtained from these instruments.

Study location

The study was conducted at the Adventist Hospital of Manaus (HAM), a Christian confessional institution located in Manaus-AM. The 140-bed institution serves the private network of the national health system in low, medium, and high complexity care; and has an average occupancy rate of 82% with an average hospitalization period of 4 days. The research was developed in the medical clinical inpatient unit with 25 beds. Among the main conditions treated in the unit are: heart failure, chronic obstructive pulmonary disease, respiratory, urinary, or intestinal tract infections; acute and chronic renal failure; stroke, sexually transmitted infections, and acute myocardial infarction.

Some interventions related to religiosity are already institutionally standardized in the unit in question, namely: bedside visits from hospital chaplaincy, worship services with praise, singing in the corridors, Bible study, distribution of religious literature, and prayers.

Study population

The study population consisted of clinical patients with a hospital stay period of 01 to 04 days.

The study included: patients with stable clinical condition on the day of data collection; age equal to or above 18

years and below 60 years (due to comorbidities that may exist in more advanced age phases, in addition to health conditions resulting from senescence and senility); having conditions to respond to self-report instruments, alone or with help from a trained researcher; having hospital stay time between 1 and 4 days during data collection; diagnoses of acute or serious diseases clinically compensated, such as: heart failure, chronic obstructive pulmonary disease, respiratory, urinary, or intestinal tract infections; renal failure.

Excluded were: illiterate patients or those unable to understand and respond to the instruments alone or with the researcher's help; patients affected by mental health disorders; patients in palliative or end-of-life care.

The sample size was calculated based on the annual average total of patients admitted to the Medical Clinic of the Adventist Hospital of Manaus in 2023 (N=285), and the frequency of subjective happiness in relation to hospitalization found by Vosgerau⁽¹¹⁾, which was 7.7%. A 95% confidence level and a precision (margin of error) of 3.5% were set, with the estimated sample size equal to 125 patients. The sampling extension was estimated considering the statistical parameters of the sample size calculation formula for finite population, described by Bussab and Morettin⁽¹²⁾.

Non-random convenience sampling (or spontaneous demand) was performed, considered non-probabilistic, which considers an informal approach to the patient, who is invited to participate in the study after ethical clarifications and about the research objectives.

Data collection

For data collection, four instruments already validated for use in this study's population were used, namely:

I. Questionnaire with Sociodemographic and Medical-Clinical Variables containing questions about the socio-demographic and clinical profile of the research participant, such as: age, marital status, education level, profession, number of children, reason and number of days of hospitalization, constructed by the research team;

II. Quality of Life Assessment Questionnaire (QoL) WHOQoL-Bref, validated in Brazil by Fleck et al. in 2000. This is an abbreviated version of WHOQOL-100, developed and recommended by WHO and covers aspects such as: physical and psychological health, level of independence, social relationships, and personal beliefs.

At a structural level, WHOQOL BREF consists of 26 questions (with questions 1 and 2 about overall quality of life) and responses follow a Likert scale (from 1 to 5, the higher the score the better the quality of life). In addition to the first two questions (1 and 2), the instrument presents 24 facets, which comprise 4 domains: physical, psychological, social relationships, and environment. In this instrument, the result should only count the correct average points (1 to 5) per domain and per facet, as the results will later be converted to a scale of 0 to 100 and then interpreted, where a higher score indicates a better perception of quality of life. Lower scores reflect a worse perception of quality of life in a specific domain. Therefore, no cutoff point is established that determines whether a score is below or above which quality of life can be assessed as "poor" or "good." The average score in each domain indicates the individual's perception of their satisfaction in each aspect of their life, relating to their quality of life. The higher the score, the better this perception⁽¹³⁻¹⁴⁾.

III. Duke University Religion Index (DUREL), validated in the Brazilian version by Taunay et al. in 2012⁽¹⁵⁾, consists of a five-item scale that measures three of the main dimensions of religious involvement that have relationships with health outcomes, namely: item 1 - Organizational Religiosity (OR): frequency of religious meetings; item 2 - Non-Organizational Religiosity (NOR): frequency of private and individual religious activities; items 3 to 5 Intrinsic Religiosity (IR): refers to the search for internalization and full experience of religiosity as the individual's main objective. The response options for the last three items are on a Likert-type scale (1 to 5), while the previous ones have scores ranging from 1 to 6 evaluating the frequency with which activities occur, that is, from least frequent to most frequent.

Regarding the calculation of the instrument score, it is recommended that the three individual domains not be summed into a total score, but that they be analyzed separately. Higher scores on each item indicate greater involvement in each domain, thus allowing understanding of how religiosity and spirituality manifest in the individual's life.

IV. Subjective Happiness Scale, validated in Brazil by Pais-Ribeiro in 2012⁽¹⁶⁾. The response scale is Likert-type, and in the first two questions, it varies between 1 (item 1: "a not very happy person"; item 2: "less happy") and 7 (item 1: "a very happy person"; item 2: "happier"). In the other two items, individuals are asked to indicate the extent to which they identify with the characterization of happiness and unhappiness. The response scale follows a pattern similar to the first two (Likert), varying between 1 ("not at all") and 7 ("largely") for both items. It is important to note that item 4 of the scale is reversed. The total score is obtained through the average of responses on the four items. Higher scores correspond to higher levels of subjective happiness in a possible range of 4 to 28 points.

The results obtained through the different instruments should be interpreted in an integrated manner, considering the specific nature of each measure. The results obtained through the different instruments should be interpreted in an integrated manner, considering the specific nature of each measure. WHOQoL-Bref makes it possible to assess the overall perception of quality of life in its different domains (physical, psychological, social, and environmental), while the Duke Religion Index (DUREL) provides support for understanding the role of organizational, non-organizational, and intrinsic religiosity in experiencing the health-disease process. The Subjective Happiness questionnaire, applied at two distinct moments, namely: 1st day of hospitalization and 4th day of hospitalization, allows observing possible variations in self-perception of happiness, evidencing the impact of clinical and emotional conditions on patient well-being.

All questionnaires were applied on the patient's first day of hospitalization and the subjective happiness questionnaire was applied a second time on the 4th day of hospitalization, for those who remained hospitalized until that period, aiming to analyze whether there were significant differences in self-perception of happiness as the days of hospitalization passed.

Thus, the joint analysis of these instruments offers a comprehensive and multidimensional view of the health status and subjective experiences of hospitalized individuals. The instruments consist of questions (variables), whose responses are scalar, that is, all questions are considered quantitative variables, with their scores analyzed according to the

calculation specifications of each one.

Statistical analysis

A descriptive and exploratory analysis of quantitative variables was performed, and analysis of frequencies of nominal variables. Associations between variables were verified using non-parametric Mann-Whitney tests, Kruskal-Wallis ANOVA, and Spearman's Correlation Coefficient. Statistical analysis of data was performed using IBM SPSS Statistics version 22.

Ethical aspects

The research protocol was submitted to the Research Ethics Committee, following the requirements and precepts established in Resolution No. 466, of December 12, 2012⁽¹⁷⁾, being approved through Substantiated Opinion No. 7897602 4.9.0000.5020.

RESULTS

The study obtained participation from 132 patients, hospitalized from June to September 2024, whose predominant characteristics were: female sex (75 – 56.8%); age range from 19 to 30 years (47 – 35.6%), with mean age equal to 37.24 ± 11.29 years; married marital status (69 – 52.3%); with 1 to 2 children (64 – 48.5%) with complete secondary education (53 – 40.2%) and with employment (80 – 60.6%). The majority of the study population followed the Catholic religion (50 – 37.9%) or called themselves Evangelicals (46 – 34.8%). The absence of religious affiliation was reported by 10 (7.6%) participants; furthermore, 98 (74.2%) of the studied sample considered themselves practitioners of religion, while 34 (25.8%) reported otherwise. The reason for hospitalization in 104 (78.8%) participants was for clinical treatment and most 70 (53%) were hospitalized for three days (Table 1).

Table 1 - Sociodemographic characterization of participants. Manaus, AM, Brazil, 2024 (n=132)

CHARACTERISTIC	n (132)	%
Gender		
Female	75	56.8
Male	57	43.2
Age group		
Mean age 37.24 ± 11.29 years		
19 to 30	47	35.6
31 - 40	29	22.0
41 - 50	38	28.8
51+	18	13.6
Marital status		
Single	50	37.9
Married	69	52.3
Stable union	13	9.8
Number of children		
None	46	34.8
1 - 2	64	48.5
3 - 4	15	11.4
5+	7	5.3
Religion		
Catholic	50	37.9
Evangelical	46	34.8
Christian without denomination	19	14.4
Others	7	5.3
No	10	7.6
Religious		
Yes	98	74.2
No	34	25.8
Schooling Level		
Elementary School	6	4.5
High School	53	40.2
Higher Education	37	28.0
Graduate studies	36	27.3
Employment contract		
Yes	80	60.6
No	52	39.4
Reason for hospitalization		
Clinical treatment	104	78.8
Surgical treatment	10	7.6
Clinical examinations	18	13.6
Days hospitalized		
2	18	13.6
3	70	53.0
4	44	33.3

Source: prepared by the authors, 2024.

Table 2 presents the descriptive statistical analysis of scores and the reliability coefficient of QoL domains of hospitalized patients analyzed in this study. The social relationships domain presented the highest mean score (70.33 ± 18.60) and the physical domain presented the worst mean

score (59.79 ± 1.89). The patients' overall QoL scores ranged from 28.76 (very low) to 92.0 (high), with mean and median scores respectively equal to 65.69 ± 13.01 and 67.02 (Table 2). The patients' overall QoL showed high internal consistency ($\text{Alpha} = 0.805$).

Table 2 - Scores of Quality of Life domains of hospitalized patients, using the WHOQOL-BREF instrument and Cronbach's Alpha reliability coefficient. Manaus, AM, Brazil, 2024 (n=132)

DOMAINS	DESCRIPTIVE MEASURES (n = 132)					ALPHA
	Mean	Standard Deviation	Minimum	Median	Maximum	
Physical	59.79	16.89	7.14	60.71	89.29	0.262
Psychological	66.16	15.87	20.83	66.67	95.83	0.475
Social Relations	70.33	18.60	8.33	75.00	100.00	0.726
Environmental	66.48	13.48	25.00	65.63	96.88	0.776
Overall Quality of Life	65.69	13.01	28.76	67.82	92.00	0.805

Source: prepared by the authors, 2024.

Table 3 presents the frequencies by domains and questions of hospitalized patients' responses to the Duke University Religion Scale. The first domain concerns Organizational Religiosity (OR), which refers to question 1. When asked about the frequency with which they go to church, the most frequent responses were "a few times a year" (36 – 27.3%) and "more than once a week" (32 – 24.2%), which together represent 51.5% of the sample.

Regarding the Non-Organizational Religiosity (NOR) domain, still in table 3, represented by question 2 of the scale, it was observed that, regarding the frequency that the patient dedicates their time to religious activities or religious meetings, the most frequent responses were "a few times per month" (21 – 15.9%), "daily" (45 – 34.1%) and "more than once a day" (21 – 15.9%).

As for the Intrinsic Religiosity (IR) domain of table 3, represented by the following three questions of the aforementioned scale, it was observed that for the question "In my life, I feel the presence of God (or the Holy Spirit)" the most frequent response was "definitely true of me" (92 – 69.7%). For the question "My religious beliefs are really behind my whole approach to life," most responded "definitely true of me" (63 – 47.7%). And regarding the question "I try hard to carry my religion over into all other dealings in life," the most frequent response was "definitely true of me" (50 – 37.9%).

For the OR domain, it was observed that the highest frequency of patients goes "a few times a year" to a church, temple, or other religious meeting (27.3%). NOR showed the highest frequency (34.1%) of the response "daily" to the question "how often do you spend time in private religious activities, such as prayer, meditation, or Bible study?"

Table 4 presents the descriptive analysis of SH scores obtained by hospitalized patients. In this context, it was observed that the highest mean score occurred for question 1 (in general I consider myself), being 5.6 ± 1.3 points, determining that the analyzed patients have SH slightly above 20.0 points. Its coefficient of variation was 18.9% (medium). Overall, the general SH score ranged between 9.0 and 28.0 points, with mean and median values respectively equal to 19.8 ± 3.8 (low), indicating that patients' scores were similar. The results in Table 4 also demonstrate that the analyzed patients have a high level of SH.

Still considering Table 4, the SH score was verified

on the first and last day of hospitalization. Forty-four patients who were discharged on the 4th day of hospitalization were included to respond again to the SH Questionnaire. Their scores ranged between 24.0 and 32.0 points, with mean and median scores respectively equal to 24.8 ± 3.4 and 26.0 points. The coefficient of variation was 14.0% (low), indicating that patients' scores were similar. When comparing the mean SH scores from the first day of hospitalization with the SH from the fourth day of hospitalization, it was observed that there was a significant difference between them ($p < 0.0001$), with the mean SH score on the fourth day of hospitalization being significantly higher than the mean SH score on the first day of hospitalization ($p < 0.0001$).

The analysis of initial and final SH scores allows us to infer that despite being hospitalized longer, patients showed greater perception of happiness on the 4th day of hospitalization than on the first. Possibly this result is related to meeting/addressing these patients' needs such as: rest, symptom control, pain relief, medical evaluation, performing procedures and resolving their health problems, in addition to interventions carried out by hospital chaplaincy in the unit.

The overall SH score is obtained through the average of responses on the four items. Higher scores correspond to higher levels of subjective happiness in a possible range of 4 to 28 points. In the table, instead of "score," use "global score" or "total score."

Table 5 describes the correlation between religiosity, quality of life, and subjective happiness of hospitalized patients. In the context of QoL, the results showed that the OR domain presented a significant positive correlation with the Environment domain (17.5%; $p = 0.045$) and with overall QoL (17.6%; $p = 0.043$). As for the NOR domain, it showed a significant positive correlation with the social relationships (23.8%; $p = 0.006$) and environment (21.1%; $p = 0.015$) dimensions, as well as with overall QoL (23.8%; $p = 0.006$). And for the IR domain, it was observed that it showed a significant positive correlation with all QoL domains ($p < 0.05$).

Regarding SH, it was observed that it showed a significant positive correlation with the NOR (22.0; $p = 0.011$) and IR (28.3%; $p < 0.0001$) domains, meaning that both domains are associated with SH, and the higher the religiosity index in both domains, the greater the magnitude of SH (Table 5).

Table 3 - Frequency by domain of responses to questions comprising the Duke University Religion Index, of patients. Manaus, AM, Brazil, 2024 (n=132)

DOMAIN / QUESTION	RESPONSE	n (132)	%
Organizational Religiosity (OR)			
1 How often do you attend church or other religious meetings?	1. Never	11	8.3
	2. Once a year or less	11	8.3
	3. A few times a year	36	27.3
	4. Two or three times a month	14	10.6
	5. Once a week	28	21.2
	6. More than once a week	32	24.2
Non-Organizational Religiosity (NOR)			
2 How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?	1. Rarely or never	17	12.9
	2. A few times a month	21	15.9
	3. Once a week	13	9.8
	4. Two or more times a week	15	11.4
	5. Daily	45	34.1
	6. More than once a day	21	15.9
Intrinsic Religiosity (IR)			
3 In my life, I experience the presence of God (or the Holy Spirit).	1. Definitely not true	5	3.8
	2. Tends not to be true	0	0.0
	3. Unsure	4	3.0
	4. Tends to be true	31	23.5
	5. Definitely true of me	92	69.7
4 My religious beliefs are what really lie behind my whole approach to life.	1. Definitely not true	7	5.3
	2. Tends not to be true	3	2.3
	3. Unsure	13	9.8
	4. Tends to be true	46	34.8
	5. Definitely true of me	63	47.7
5 I try hard to carry my religion over into all other dealings in life.	1. Definitely not true	13	9.8
	2. Tends not to be true	11	8.3
	3. Unsure	15	11.4
	4. Tends to be true	43	32.6
	5. Definitely true of me	50	37.9

Source: prepared by the authors, 2024.

Table 4 - Descriptive analysis of responses to questions comprising the Subjective Happiness Scale, of hospitalized patients. Manaus, AM, Brazil, 2024 (n=132)

QUESTION	n	Mean*	SD	CV	Minimum	Median	Maximum
1 In general, I consider myself:	132	5.6	1.3	23.7	1.0	6.0	7.0
2 Compared to most of my peers, I consider myself:	132	5.5	1.5	27.6	1.0	6.0	7.0
3 Some people are generally very happy. They enjoy life regardless of what is going on, getting the most out of everything. To what extent does this characterization describe you?	132	5.2	1.6	29.6	1.0	5.0	7.0
4 Some people are generally not very happy. Although they are not depressed, they never seem as happy as they might be. To what extent does this characterization describe you?	132	3.5	1.9	54.6	1.0	4.0	7.0
- Total SH score (initial)*	132	19.8	3.8	18.9	9.0	20.0	28.0
- Total SH score (final)**	44	23.8	3.4	14.0	24.0	26.0	32.0
Cronbach's Alpha: 0.377		<i>p</i> significant at <i>p</i> < 0.05 (5%)				Mann-Whitney Test	

*- Subjective happiness scale score on the first day of hospitalization.

** - Subjective happiness scale score on the 4th day of hospitalization.

Source: prepared by the authors, 2024.

Table 5 - Correlation between religiosity, quality of life, and subjective happiness of hospitalized patients. Manaus, AM, Brazil. 2024 (n=132)

DIMENSION / INSTRUMENT		DUKE INDEX DIMENSION		
		RO	NOR	IR
QoL - Physical	Correlation	11.4%	13.4%	20.6%
	p	0.195	0.124	0.018*
QoL - Psychological	Correlation	12.4%	16.4%	35.2%
	p	0.156	0.060	p<0.0001*
QoL - Social Relationships	Correlation	16.2%	23.8%	31.1%
	p	0.063	0.006*	p<0.0001*
QoL - Environment	Correlation	17.5%	21.1%	27.2%
	p	0.045*	0.015*	0.002*
QoL - Overall	Correlation	17.6%	23.8%	36.1%
	p	0.043*	0.006*	p<0.0001*
FS	Correlation	12.1%	22.0%	28.3%
	p	0.167	0.011*	p<0.0001*

*Significant at $p < 0.05$ (5%)
 Spearman Correlation

Source: prepared by the authors, 2024.

DISCUSSION

The present study revealed a correlation between religiosity, higher levels of happiness, and better quality of life among hospitalized patients. This is the first study to simultaneously investigate subjective happiness, quality of life, and religiosity in this population. For comparative purposes in similar samples, such as hospitalized patients or those with chronic diseases.

The majority of participants were female (56.8%), data similar to that found in other studies with patients admitted to medical clinics, which reported frequencies between 52% and 54%⁽¹⁸⁻¹⁹⁾. This predominance may be related to sociocultural factors, as women tend to seek health services more, historically associated with care and fragility. Regarding age, a lower average was observed than reported in other investigations, in which elderly patients predominated⁽¹⁸⁾.

Regarding marital status, 62.1% of participants were married or living in a stable union, a percentage higher than observed in similar research^(1,18). Family support proved relevant, as 65.2% of patients had children, although this variable is rarely described in hospitalization studies.

The Catholic religion was the most frequent (37.9%), a result lower than another study with hospitalized patients, which recorded 72%⁽¹⁾. Religiosity has been identified as a factor of emotional and spiritual protection, associated with lower levels of depression, less pain, and better quality of life⁽¹⁹⁾. The results regarding quality of life corroborated previous findings, in which the physical domain was the most compromised and the social relationships domain presented better scores^(1,20-21). Physical limitation may be related to pain, fatigue, and reduced mobility, conditions that interfere with sleep and self-care during hospitalization. In contrast, social support seems to play a protective role, favoring coping and life satisfaction.

Quality of life, as a subjective and multidimensional construct, reflects the individual's perception of their own existence, considering social, cultural, and spiritual aspects⁽²²⁻²³⁾. In this study, the "social relationships" and "environment" domains showed better evaluation, suggesting that the hospital context and interpersonal support are positive determinants for the perception of well-being.

Regarding religiosity, most reported participating in organizational religious activities only a few times a year (27.3%), behavior similar to that observed in preoperative patients⁽²⁴⁾. On the other hand, individual practice, such as prayers and religious readings, was more frequent, with emphasis on the response "daily." This indicates that, although community participation is limited, the personal dimension of faith remains active⁽²⁵⁻²⁶⁾. In the domain of intrinsic religiosity, patients demonstrated high involvement, reporting living their religion in all dimensions of life.

These findings reinforce the literature that points to spirituality and religious involvement as important coping resources in the face of illness, associated with greater resilience and less stress⁽²⁷⁾. Spiritual and religious needs contribute to psychological well-being and should be recognized as relevant components of healthcare⁽²⁸⁻³¹⁾.

Subjective happiness was also shown to be associated with religiosity and quality of life. Studies indicate that high levels of optimism and happiness are related to better physical and mental health, greater life expectancy, and better psychological adaptation⁽³¹⁻³²⁾. Thus, promoting spirituality and quality of life can favor positive emotional states and greater personal satisfaction during hospitalization.

Still considering the discussion of mean scores of QoL domains of hospitalized patients, in a study conducted with patients admitted to three hospital units in a city in Portugal, it was generally observed that the best and worst QoL domain of patients, including the three health units, were social relationships and the environment domain, thus confirming the results of our study⁽²³⁾.

Corroborating the above data, a longitudinal study that investigated the quality of life of hospitalized patients in the period between 2011 and 2021, infers in its studies that spirituality and religious involvement with institutionalized groups serve as a source of interpretation and coping with life's conditions and events, in addition to empowering people who experience critical situations to reduce the sense of loss of control and lack of support, since these feelings are associated with greater resilience and resistance to illness-related stress⁽²⁷⁾.

Spiritual and religious needs represent significant influences in promoting individual happiness and well-being, in addition to playing a crucial role in healthcare, especially

regarding psychological responses to suffering. For decades, the influence of religiosity/spirituality (R/S) on society's health conditions has been studied, and scientific studies have demonstrated that incorporating religiosity/spirituality (R/S) in healthcare can prevent diseases or recover individuals from their illnesses⁽²⁸⁻³¹⁾.

Regarding happiness, addressed in the present study, a meta-analysis that investigated whether psychological interventions could increase optimism, being here linked to happiness, associated it with the risk of developing diseases and health behaviors and concluded that a higher level of optimism is related to a higher level of physical and mental health⁽³²⁻³³⁾.

Given the above, the relevance of developing more comprehensive studies on this topic and using the instrument in question in heterogeneous audiences is inferred, allowing contemplation of the various populations to which it can be applied, for example, in hospitalized patients. Otherwise, results may be restricted and limited in their applicability.

The present study has limitations. Given the novelty of our findings, it is relevant that other researchers on the addressed topic attempt to replicate them in longitudinal studies. Care must be taken in generalizing these results to other contexts, as the study in question was conducted in Brazil, where the population is highly religious and in a private healthcare institution. It is worth noting the difficulty in finding references from current studies with similar patient profiles for discussing the results of the present study, as well as updated references on subjective happiness.

The strengths and positive points of the present study are due to its originality, significant sample, use of well-established and validated instruments, in addition to its broad clinical repercussions, which serve as support for comprehensive care and foster scientific evidence for person-centered care. It is increasingly necessary that this perspective of patient care be expanded to public and private health services with the objective of transforming care models restricted and limited to the physical demands of human beings.

From the present study, the academic-scientific community will have the possibility to know and understand in a broader way the correlation between quality of life, religiosity, and subjective happiness of hospitalized patients; and such knowledge will enable greater humanization in healthcare and a more critical view of the condition of the sick person who needs hospitalization.

CONCLUSION

The present study achieved its objective by investigating the correlation between religiosity, quality of life, and

subjective happiness in hospitalized patients. The results indicated a positive and significant correlation between SH and the Duke Religion Index, especially in the domains of Non-Organizational Religiosity and Intrinsic Religiosity. This suggests that higher levels of personal religiosity and spiritual involvement are associated with greater perceptions of happiness. Furthermore, SH showed a positive association with different QoL domains, reinforcing the interdependence between subjective well-being, spirituality, and perception of quality of life during hospitalization.

These findings show that religiosity and subjective happiness can act as relevant factors for promoting QoL in hospitalized patients, contributing to more comprehensive and humanized care approaches. It is recommended that future research, preferably longitudinal, deepen the analysis of these relationships in order to understand the evolution of happiness throughout hospitalization and support psychosocial interventions and public policies aimed at improving the experience and well-being of hospitalized patients.

*This article is extracted from the Master's thesis entitled "*Associação entre religiosidade, qualidade de vida e a felicidade subjetiva de pacientes internados*," presented to the Postgraduate Program in Health Sciences of the Federal University of Amazonas, Manaus, AM, Brazil, in 2025.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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Data analysis: Souza YR, Lopes Neto D.

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All authors are responsible for the textual writing and critical review of the intellectual content, for the final published version, and for all ethical, legal, and scientific aspects related to the accuracy and integrity of the study.



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