Original Article

Nursing Students' Perspectives on Spirituality and Spiritual Care in Turkey

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Abstract
Studies conducted on spirituality show that nurses are aware of patients' spiritual needs. However, they have difficulty providing spiritual care because they receive limited education in this area. Quality of care can be increased with the determination of nursing students' perspectives regarding spirituality and spiritual care and with the introduction of appropriate interventions. The study was conducted to determine students' perspectives on spirituality and spiritual care. This is a descriptive study. The study population included 430 students studying in the nursing department of a faculty of the health sciences. The study sample included 265 students. Data were collected using the '*Structured Information Form,*' which the researcher prepared based on the literature, and the '*Spiritual Care-Giving Scale*.' The relationships between two independent variables were examined using the Mann-Whitney U test and between multiple independent variables were examined using the Kruskal-Wallis test. Students stated that the biggest obstacle in evaluating spirituality and spiritual care practices was being unable to identify spiritual problems as readily as physical problems (68.7%). The spiritual care practices most frequently utilized by the students were listening to patients, devoting special time to patients, having a conversation with patients. Education regarding spirituality and conversations with patients regarding spirituality positively affected the perspective of spirituality and spiritual care. Students who could not identify spiritual problems had difficulty defining the spiritual care subscale.

Keywords: Spirituality, Perspective on Spiritual Care, Nursing Students, Spiritual Care

Introduction

Nursing is a profession based on the philosophies of humanistic and holistic care and continues to exist in every field including human. One of the essential elements of humanistic and holistic care is the spiritual dimension. Quality of care will increase as long as nursing students are educated with this consciousness and awareness.

Background

Holism is mentioned frequently with the changes in the healthcare system, which puts forward the notion of spirituality (Kalkim et al., 2016). Spirituality, from the Latin "spiritus," encompasses a broad approach to the qualification of life and means "breathing" or "being alive." Spiritus means feeling life in a broader sense (McBrien 2010; McSherry & Jamieson 2011; Ross et al., 2014). Individual experiences regarding diseases and the meaning attributed to the disease are related to one's spiritual lives. Thus, the disease process is affected by spirituality, similar to every other process in life (Abbas & Dein, 2011).

Spirituality helps individuals realize the meaning and aim of life and maintain hope during the disease process. Spirituality is an abstract and hard to define idea, which is a significant obstacle in providing necessary spiritual care to patients (Tiew et al., 2013). Spiritual care is accepted as one of the fundamental elements of holistic care, which is the fundamental philosophy of nursing (Chan et al., 2006; Vlasblom et al., 2011; Davoodvand et al., 2016). Spiritual care helps individuals see their own potential power

when their essential requirements such as goals, meaning, love, and relationships are not met, they have lost their inner peace, and have become vulnerable (Bennet & Thompson, 2015; Adib-Hajbaghery et al., 2014).

Spiritual care is a planned process in which mutual interactions occur to increase patients' spiritual well-being (Burkhart et al., 2011; Ramezani et al., 2014). Spiritual well-being generally increases the quality of life and compliance to treatment, eases symptom control, and decreases anxiety levels (Bukhart et al., 2011; Kaplar et al., 2004). Thus, spirituality and spiritual coping play a significant role in maintaining health (Bukhart et al., 2011.). Although the importance of spirituality and spiritual care are emphasized, studies regarding spiritual care in the nursing literature commonly emphasize that nurses are aware of patients' spiritual needs. However, spirituality evaluation and spiritual care practices are not carried out in a systematic way (Rassouli et al., 2015; Narayanasamy &Owen, 2001; Yılmaz & Gürler, 2014; Davoodvand et al., 2016). One of the most important reasons for this is nursing students receive poor education regarding how to evaluate and meet patients' spiritual needs (Cone & Giske, 2018; McEwen, 2005; Callister et al., 2004).

Studies define methods such as the content of the possible syllabus, curriculum, and special methods in education. However, expected results will not be obtained from education regarding spiritual care as long as students' perspectives on spiritual care and obstacles to spiritual care are not identified (Callister et al., 2004; Van Leeuwen et al, 2008). Nursing students' perspective of spirituality, their roles in spiritual care, and the problems they anticipate during practice may be identified early. In addition, early intervention and educations may allow them to effectively provide spiritual care in their professional lives (Tiew & Creedy, 2012).

Methods

Design: This study design is a descriptive study. This study aimed to determine nursing students' perspectives regarding spirituality and spiritual care and the factors affecting their perspectives.

Study Questions:

1. What are the spiritual care practices performed by the students?
2. What are the obstacles in spiritual care for students?
3. How do students perceive spirituality and spiritual care?
4. How do students' characteristics and the situations they reported as obstacles in spiritual care affect spirituality and spiritual care?

Participants: The study population included 430 students enrolled in the Nursing Department of the Faculty of Health Sciences of a university. The study sample was planned to include 263 students with a 99% confidence level and 5% error margin. The simple randomization method was used to prevent possible losses. Thus, 280 students were approached, and the study was completed with 265 students.

Data Collection: Data were collected using the '*Structured Information Form,*' which the researcher prepared based on the literature, and the '*Spiritual Care-Giving Scale.*'

Structured Information Form: The researcher prepared this form based on the literature. This form included questions regarding students' socio-demographic characteristics (age, gender, etc.) and spirituality (receiving education on spiritual care and problems experienced during spiritual care practice) (Dağhan et al., 2019; Coban et al., 2017; Kalkim et al., 2016).

Spiritual Care-Giving Scale: Tiew and Creedy developed this scale to evaluate nursing students' perspectives regarding spirituality and spiritual care in Australia in 2012. The Cronbach's Alpha coefficient of this six Likert-type scale including 35 items was 0.95. Coban et al., conducted the Turkish validity reliability study of the scale in 2015. The item number did not change in the validity reliability analysis of the scale. The original scale had a 6-Likert type structure. However, the Likert number was decreased to 5 as a result of the feedback provided after expert opinions and a pilot application conducted before the original application. Cronbach's Alpha coefficient was 0.96 in the Turkish validity reliability study. The five Likert-type scale is scored as follows:

strongly agree=5, agree=4, neither agree nor disagree=3, disagree=2, strongly disagree=1. Thus, the minimum score is 35 and the maximum score is 175. Higher total scale scores indicate higher students' perspectives of spirituality and spiritual care. Consequently, the Spiritual Care-Giving scale is a measurement tool having high validity and reliability indicators (Coban et al., 2017). İn this study cronbach's alpha coefficient of the scale was found to be 0.825.

Ethical Approval: Study approval was obtained from Karabuk University Non-Invasive Clinical Studies Ethics Committee (E.13912 numbered issue and 4/30 numbered decision) and the Faculty of Health Sciences where the study was conducted. The research was conducted in accordance with the principles of the Declaration of Helsinki. Written consent was obtained from the students included in the sample group for their participation in the study in accordance with the voluntariness principle.

Data Analysis: Data were analyzed using SPSS for Windows (Statistical Package for the Social Sciences for Windows, Version 21.0) package program. Parametric (continuous) variables were evaluated using the arithmetic mean, standard deviation, and minimum and maximum values, whereas non-parametric (non-continuous) variables were evaluated using frequency and percentage. Suitability to normal distribution was examined using the Shapiro-Wilk test. Because data did not show a normal distribution, the relationships between two independent variables were examined using the Mann-Whitney U test and between multiple independent variables were examined using the Kruskal-Wallis test.

Results

Of the students, 78.1% were female (n: 207), 46.4% were between the ages of 18 and 20, 26.8% were second year students, 70.2% had equal income and expenditures, and 79.2% had a nuclear family structure. Of the students, 82.3% did not receive education regarding spirituality, 63% thought that they could provide spiritual care, and 61.9% had not had a conversation about spiritual needs with patients (Table 1).

Students stated that the biggest obstacle in evaluating spirituality and practicing spiritual care was not being able to identify the spiritual problems as readily as physical problems (68.7%). Students also stated that they could not evaluate spirituality and practice spiritual care because the conversation is hard for the patient, their workload is too high, they experience personal uneasiness, and spirituality is not included in the nursing field of care (53.2%, 46.4%, 15.8%, and 6.0%, respectively)(Table 2).

Of the students, 84.2% listened to the patient's spiritual issues, 69.8% had a conversation with patients and devoted time to them, 69.4% empathized with the patients, 66.4% informed patients, 64.2% stood by patients, 62.6% accepted and respected patients, 40.0% allowed patients to be with their loved ones and helped them maintain hope, and 26.8% supported and helped patients in their religious practices (Table 3).

When Table 4 was examined, it was observed that the students received scores of from the general characteristics of spiritual care 48.61±7,40; 36.84±5,60 from the perceptions of spiritual care sub-dimension; 18.25±4.38 from the definition of spiritual care sub-dimension; 24.76±5.14 from the practices of spiritual care sub-dimension; 11.05±1.78 from the attitudes sub-dimension; and 139.54±17.70 from the sum of the spiritual caregiving scale.

Female nursing students had significantly higher total general properties of spiritual care, spiritual care practices, spirituality perspectives, and spiritual care-giving scores ($p<0.01$). Female students had significantly higher scores in the defining spiritual care subscale than males ($p<0.05$). Students aged 18 to 20 had significantly higher total general properties on the spiritual care subscale and giving spiritual care scale scores than other age brackets ($p<0.01$). These students had significantly higher total spirituality perspective subscale scores ($p<0.05$). Students aged between 21 and 23 had significantly higher spiritual care practice scores than other age groups ($p<0.01$). Fourth-year students had significantly higher spirituality perspectives scores whereas third-year students had higher defining spiritual care subscale scores than other students ($p<0.05$). Students educated regarding

spirituality had significantly higher defining spiritual care subscales and spiritual care giving scale scores than those not educated regarding spirituality ($p<0.05$). Students who did not have a conversation with patients had significantly higher spirituality perspectives than those who did ($p<0.05$). On the other hand, those who had a conversation regarding spiritual issues had significantly higher spiritual care attitude subscale scores ($p<0.01$). Students believing they had the ability to provide spiritual care had significantly higher spiritual care attitude subscale scores ($p<0.01$) (Table 5).

Students who could not identify spiritual problems had statistically higher defining spiritual care subscale scores ($p<0.05$). Students reporting the workload as an obstacle had statistically lower spiritual care practices subscale scores ($p<0.05$). Students experiencing personal uneasiness had statistically lower scores on general properties of spiritual care, defining spiritual care, spiritual care practices subscale, and total spiritual caregiving scales ($p<0.01$). These students also had statically lower spiritual care attitudes subscale scores ($p<0.05$). Students stating that spiritual care practices were not included in the nursing field of care had lower total general properties of spiritual care, defining spiritual care, and spiritual caregiving scale scores ($p<0.05$)

Table 1: Students' Socio-Demographic Characteristics (n= 265)

Characteristics	n	%
Gender		
Female	207	78.1
Male	58	21.9
Age (years)		
18-20	123	46.4
21-23	115	43.4
24-26	20	7.5
27 and more	7	2.6
School Year		
1st Year	66	24.9
2nd Year	71	26.8
3rd Year	85	32.1
4th Year	43	16.2
Income Status		
Income<Expenditure	50	18.9
Income=Expenditure	186	70.2
Income>Expenditure	29	10.9
Family Structure		
Nuclear Family	210	79.2
Fragmented Family	30	11.3
Extended Family	21	7.9
Other	4	1.5
Education Regarding Spirituality		
Yes	47	17.7
No	218	82.3
Conversation on Spirituality with Patients		
Yes	101	38.1
No	164	61.9
Perceived Ability to Provide Spiritual Care		

Yes	167	63.0
No	98	37.0

Table 2: Obstacles in Evaluating Spirituality and Practicing Spiritual Care (n= 265)

Obstacles	n	%
Not being able to identify spiritual problems as easily as physical problems	182	68.7
Having a conversation is hard for the patient	141	53.2
Excessive Workload	123	46.4
Personal uneasiness	42	15.8
Belief it is not included in the nursing field of care	16	6.0

Table 3: Spiritual Care Practices Performed by the Students (n= 265)

Practice	n	%
Listening to Patients (In Spiritual Issues)	223	84.2
Conversation with Patients/Devoting Special Time to Patients	185	69.8
Empathizing with Patients	184	69.4
Informing Patients	176	66.4
Standing by Patients	170	64.2
Accepting/Respecting Patients	166	62.6
Giving an Opportunity for Patients' to be with Loved Ones	106	40.0
Maintaining Patients' Hope	106	40.0
Supporting/Helping Patients' Religious Practices	71	26.8

Table 4: Distribution of the scores of students on the Spiritual Care-Giving Scale and its sub-dimensions

	Min	Max	Mean	SD
General features of spiritual care	24.00	110.00	48.61	7.40
Spiritual perceptions	14.00	51.00	36.84	5.60
Spiritual care definition	9.00	65.00	18.25	4.38
Spiritual care practices	11.00	63.00	24.76	5.14
Spiritual care attitudes	4.00	15.00	11.05	1.78
Total	70.00	225.00	139.54	17.70

Table 5: Comparison of Students' Spiritual Care-Giving Scale and Subscale Scores According to their Reported Obstacles to Spiritual Care

Obstacles to Spiritual Care		General Properties of Spiritual Care		Spirituality Perspectives		Defining Spiritual Care		Spiritual Care Practices		Spiritual Care Attitudes		Total	
	n	Mean±SD	MW U/p	Mean±SD	MW U/p	Mean±SD	MW U/p	Mean±SD	MW U/p	Mean±SD	MW U/p	Mean±SD	MW U/p
Not able to identify spiritual problems													
Yes	182	49.18±7.30	-1.623 0.105	37.09±5.50	-1.375 0.169	18.06±6.99	-2.738	24.51±2.95	-0.906 0.365	11.16±1.61	-1.447 0.148	140.30±15.92	-1.461 0.144
No	183	47.37±7.57		36.28±5.84		18.34±2.46		25.34±8.14		10.80±2.11		137.86±21.24	
Having a conversation is hard for the patients													
Yes	141	49.02±5.84	-0.820 0.412	36.88±5.30	-0.028 0.978	18.14±3.54	-0.245 0.806	25.46±6.20	-1.938 0.053	11.00±1.60	-1.110 0.267	140.52±14.79	-0.829 0.407
No	124	48.16±8.86		36.80±5.94		18.37±5.18		23.97±3.42		11.11±1.97		138.42±20.53	
Excessive workload													
Yes	123	48.12±0.69	-1.368 0.171	36.62±5.03	-1.645 0.100	18.46±4.72	-0.721 0.471	24.09±2.41	-2.209 **0.027***	11.12±1.64	-0.395 0.693	138.43±14.33	-1.372 0.170
No	142	49.04±8.61		37.04±6.06		18.07±4.07		25.35±6.61		10.99±1.90		140.50±20.18	
Personal uneasiness													
Yes	42	45.52±6.63	-3.142 **0.002***	35.02±6.44	-1.852 0.064	16.61±2.81	-3.422 **0.001***	22.38±3.31	-4.065 **0.000****	10.35±2.13	-2.211 **0.027***	129.90±18.61	-3.380 **0.001***
No	223	49.20±7.41		37.19±5.37		18.56±4.55		25.21±5.30		11.18±1.68		141.35±16.97	
Not included in the nursing field of care													
Yes	16	43.93±8.88	-2.281 **0.023***	35.56±7.54	-0.135 0.893	15.62±4.19	-2.496 **0.013***	22.56±3.59	-2.465 **0.014***	10.00±2.50	-1.653 0.098	127.68±21.42	-2.464 **0.014***
No	249	48.91±7.22		36.93±5.46		18.42±4.34		24.91±5.20		11.12±1.71		140.301±7.21	

*p<0.05 **p<0.01

Discussion

Nursing is a profession based on the philosophies of humanistic and holistic care and continues to exist in every field including human. One of the essential elements of humanistic and holistic care is the spiritual dimension. Quality of care will increase as long as nursing students are educated with this consciousness and awareness.

Nursing students stated that the obstacles regarding defining spiritual care and spiritual caregiving were not being able to identify spiritual problems easily, the difficulty of the conversation for patients, excessive workload, personal uneasiness, and not being included in the field of nursing. Previous studies generally stated that obstacles in giving spiritual care are workload, insufficient education regarding spirituality, feeling ashamed and uncomfortable while discussing spirituality, being uncomfortable from situations creating psychological problems such as pain and grief, and seeing spiritual care as an issue to be solved by the patient's family or clergy (Naraynasamy & Owens, 2001; McEwen, 2005; Callister et al., 2004). Students primarily had problems identifying spiritual care. One of the most important points regarding spirituality emphasized in the literature is its abstractness, which is difficult to measure (Baldacchino & Draper 2001, Pesut & Sawatzky 2005). Abbas and Dein (2011) stated nurses' obstacles to identifying spiritual problems are difficulty in telling religious and spiritual problems apart, insufficient time, nurses' uneasiness, and not being able to find the right words defining spirituality. Similarly, student nurses experienced the same difficulties before starting their working life. Of the students, 6.0% (n: 16) stated that spiritual care was not included in nursing care. McSherry (2006) and Van Leeuwen et al. (2006) stated that nurses did not think spiritual problems are included within the scope of nursing and they thought clergy should have the authority on this subject. Study results differed in this respect, perhaps because recently, spiritual subjects have been included and emphasized in nursing education.

Spiritual care practices performed by the nursing students included listening to patients, having a conversation with and devoting time to patients, empathizing with patients, informing patients, standing by patients, accepting/respecting patients, providing the opportunity to be with their loved ones, maintaining hope, and helping their religious practices. A study by Como (2007) included spiritual care practices such as active listening, developing religious practices, therapeutic touch, massage, and music. Wu et al. (2012) stated that student nurses have doubts in basic spiritual care practices such as listening to patients, spending time with the patient, respecting patient confidentiality, and maintaining religious practices. Bussing and Koenig (2010) stated the necessary elements for effective spiritual care as effective communication, building a trust relationship, and maintaining patients' hope. Spiritual care practices frequently mentioned by the students were listening and having a conversation with patients. Communication was one of the fundamental elements of spiritual care.

The practice mentioned least was supporting religious practices. However, religious beliefs play significant roles in recovering from diseases (McManus, 2006). Religion is one of the important components of spirituality, and it is significant to emphasize and support individuals' belief systems and values (Sessanna, Finnell & Jezewski, 2007; McEwen, 2005). The present study results substantially support other studies in the literature.

It was found student nurses had high levels of spiritual care-giving perceptions. Similarly, an analysis of the data of research conducted with the participation of student nurses revealed that student nurses had high levels of spiritual care-giving perceptions. (Pour et al., 2017; Coban et al., 2015). Similarly, in the study conducted by Tuzer et al. (2020), it was determined that nursing students' have high levels of spiritual care-giving perceptions. Tiew et al. (2013) similarly reported that nursing students have high spiritual care perceptions and awareness.

Female students had high scores on the spiritual caregiving scale and its subscales. Similarly, Melhem et al. (2016) stated that female nurses are more sensitive than male nurses regarding spiritual care. Milligan

(2001) stated that female nurses are sensitive regarding the patients' emotions, whereas male nurses focus on physical characteristics.

There was a significant relationship between students' age groups and spiritual caregiving scale scores. Students aged 21-23 had higher spiritual care practices scores, whereas students aged 18-20 had higher spirituality perspectives and spiritual caregiving scale scores. There was no significant relationship between age and spiritual care. The study results differ from the literature in this respect (Kalkim et al., 2016; Aksoy & Coban, 2017). Students in their 4th year had a higher score in spirituality perspective and defining spiritual care than other students. It was thought that nursing students' education caused this difference. Similarly, Wong et al. (2008) stated that as the nurses' education level increased, their spiritual perspective changed positively. Education received in this subject is significant for providing spiritual care (Timmins & Neil, 2013). Students educated regarding spiritual care have higher spiritual care practices subscale and spiritual caregiving scale scores. Other studies state that receiving education increases the spiritual care perspective (Tiew et al., 2013; Tiew & Drury, 2012; Aksoy &Coban, 2017).

Students who did not think spiritual care was included in their field of care do not present efficient spiritual care (Baldacchino, 2008). Students who thought spiritual care was not included in the field of nursing had significantly lower spiritual caregiving scale and subscale scores. Students who thought spiritual care was included in their field and who had a conversation with patients regarding spiritual care had higher spirituality perspectives and spiritual care attitudes. Students who believed they had the ability to provide spiritual care had higher spiritual care attitudes. One of the fundamental elements affecting the students' perspective on spiritual care was whether they saw spiritual care as included in their field of care.

Spirituality is raising awareness regarding the essence of being, who we are, what we are, our life goals, our power, and our lives. The notion is abstract and has only one definition, preventing us from interpreting spirituality. However, if people discover their spiritual side, they can describe the meaning of life easier (Lovanio, 2007). Students who could not provide spiritual care because of their problems in defining spiritual care had significantly lower score on defining spiritual care subscales.

Students who think spiritual care was not included in the field of nursing had significantly lower scores on the spiritual caregiving scale and its subscales. Previous studies stated that one of the biggest obstacles in spiritual care was nurses' thinking spiritual care does not concern nurses but are problems to be solved by the patients themselves (McEven, 2005; Callister et al., 2004).

Students stating that they could not give spiritual care due to workload had significantly lower spiritual care practices subscale scores. Even if students had high spiritual perspective, the workload was an obstacle for spiritual care practice. Similarly, Yong et al. (2008) found that nurses' time is limited, and they cannot practice spiritual care because of their workload.

Students experiencing personal uneasiness had lower scores on the spiritual caregiving scale and its subscales. While talking about spirituality, nurses' personal problems such as their being embarrassed, getting annoyed, experiencing spiritual uncertainty, and being uncomfortable with speaking about death, pain, and grief prevent spiritual care practices (McEwen, 2005; Callister et al., 2004). Study results showed that students' personal uneasiness was a variable creating differences in their spirituality perspective.

Limitations: The study was conducted at the nursing department of just one faculty. In addition, personal uneasiness was broad in scope. The source of uneasiness here was not defined, which is also a limitation.

Conclusions: The most applied spiritual care practice was talking with the patient and devoting time to the patient. The primary reason for not giving spiritual care was being unable to identify spiritual problems easily. Students had high spirituality and spiritual care perspectives. The education received regarding spirituality and conversation with patients regarding spiritual problems positively affected spirituality perspectives and spiritual care. Students who could not identify spiritual problems had difficulty

defining the spiritual care subscale. Personal uneasiness and thinking that spiritual care is included in the professional field affected spirituality and spiritual care perspectives. Spiritual care education and raising awareness regarding the properties of spiritual problems by creating simulation-based education may increase spiritual care perspectives. In addition, devoting time to solving personal uneasiness in the simulation-based educations may increase students' self-awareness. Students need to be prepared for their professional lives, which includes guidance in spiritual issues in the clinical environment.

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