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RESEARCH ARTICLE
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Determining Spiritual Care And Anxiety Levels of Nursing Students in Southeastern Turkey

Türkiye'nin Güneydoğusundaki Hemşirelik Öğrencilerinin Manevi Bakım ve Kaygı Düzeylerinin Belirlenmesi

Ayse Şahin [1]
Nermin Kılıç Barmanpek [2]
Hasret Yağmur Sevinç Akın [3]
Seyhan Çıtlık Sarıtaş [4]

ABSTRACT

Determine spiritual care and anxiety levels of the nursing students. Personal Information Form, Spirituality and Spiritual Care Rating Scale, and State Anxiety Inventory were employed to gather the data. It was determined that the Spirituality and Spiritual Care Rating Scale mean score was 40.83±5.43 and the State Anxiety Inventory score average was 69.64±6.5. The mean anxiety score of those who do not practice spiritual care is 71.65±7.1, which is 68.42±5.89 statistically significantly higher than the mean score of those who practice spiritual care ($p<0.05$); The anxiety score average of those who do not know about spiritual care is 72.70±5.99. According to the mean score of those who know spiritual care 68.77±6.47 was found to be statistically significant ($p<0.05$).Spirituality and spiritual care are suggested to be included into the nursing curricula in order for nursing students to comprehend spiritual care. It is also suggested to provide holistic nursing care practices throughout their education, increase spiritual awareness of nurses by providing in-service trainings in work environments after graduation, and support them with practices reducing their anxiety.

Keywords: Spiritual care, Anxiety, Nursing, Student

ÖZET

Araştırma hemşirelik öğrencilerinin manevi bakım ile kaygı düzeylerinin belirlenmesi amacıyla yapıldı. Araştırma verileri; Kişisel Soru Formu, Maneviyat ve Manevi Bakım Dereceleme Ölçeği (MMBDÖ) ve Durumluk Kaygı Envanteri ile toplandı. Maneviyat ve Manevi Bakım Dereceleme Ölçeği puan ortalamasının 40.83±5.43, Durumluk Kaygı Envanteri puan ortalamasının ise 69.64±6.5 olduğu belirlendi. Manevi bakım uygulaması yapmayanların kaygı puan ortalamasının 71.65±7.1 manevi bakım uygulaması yapanların puan ortalamasına göre 68.42±5.89 istatistiki olarak önemli düzeyde yüksek olduğu ($p<0.05$); manevi bakımı bilmeyenlerin kaygı puan ortalamasının 72.70±5.99 manevi bakımı bilenlerin puan ortalamasına göre 68.77±6.47 istatistiki olarak önemli düzeyde yüksek olduğu belirlendi ($p<0.05$). Hemşirelik öğrencilerinin manevi bakımı kavrayabilmeleri için maneviyat ve manevi bakımın hemşirelik müfredatında yer alması önerilmektedir. Ayrıca eğitimleri boyunca bütüncül hemşirelik bakımı uygulamalarının verilmesi, hemşirelerin mezuniyet sonrası iş ortamlarında hizmet içi eğitimler verilerek ruhsal farkındalıklarının artırılması ve kaygılarını azaltan uygulamalarla desteklenmesi önerilmektedir.

Anahtar Kelimeler: Manevi bakım, Kaygı, Hemşirelik, Öğrenci

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INTRODUCTION

Philosophy of nursing is established on holistic care, including physical, social, psychological, and spiritual care, each of which is interrelated with one another (Daghan, 2018; Celik et al., 2014, Gallison et al., 2013). When people encounter with emotional stress, disease or death, they may experience mental, physical and mental problems and may need spiritual nursing care to cope with these problems (McEwen, 2005). Therefore, spiritual care is among the most important nursing care components (Ramezani et al., 2014). Spiritual care helps be by individuals' side during painful, troubled, sad and fearful periods, provide them with religious and belief support, be effective in solving their questions and problems if any, guide them in praying, and bring a new meaning to their existence and lives (Erisen & Sivrikaya, 2017). Spiritual nursing care enables to maintain the continuity, integrity and well-being of health along with the balance between biopsychosocial and spiritual aspects of the person (McEwen, 2005). On the other hand, spirituality is the individuals' attempt to figure out and accept their relations with each other and others, their place in the universe, and the meaning of life (Cetinkaya et al., 2007).

High spiritual well-being lowers anxiety level of individuals, as well (Ergul & Bayık, 2004). Being an important concept in explaining human behaviors, anxiety refers to one's psychological response to burst of energy caused by stress and also tension he feels as a response to an expected threat to self-integrity (Arabacı et al., 2015). Nursing students experience higher level of anxiety than those from other health-related disciplines (Wang et al., 2019). Stress causes nursing students to have high level of anxiety and this results in failure to meet patient expectancies,

[1] [1]Lecturer Dr., Harran University Viranşehir Health School, Department of Nursing, Şanlıurfa, Turkey, ORCID: 0000-0002-0112-2371
[2] Research Assistant, Bingöl University Faculty of Health Sciences Department of Nursing, Bingöl, Turkey, ORCID: 0000-0003-3985-0662
[3] Assist. Prof.Dr., Harran University Viranşehir Health School, Department of Nursing, Şanlıurfa, Turkey, ORCID: 0000-0002-3962-7113
[4] Assoc. Prof.Dr., Turgut Özal University Faculty of Nursing, Department of Nursing, Malatya, Turkey, ORCID: 0000-0003-2519-0261

fear of giving misinformation, making malpractice in hospital procedures, failure to observe patient's needs well, and losing the patient's trust (Arabacı et al.,2015; Hacıhasanoglu et al., 2008).

This information makes us suggest, that student nurses, who are healthcare professionals of the future, cannot provide holistic care to patients when they cannot comprehend spiritual care and have high levels of anxiety, and this may result in negative outcomes in the recovery process and patient care. For this reason, this study aims to detect nursing students' spiritual care and anxiety levels.

MATERIAL & METHOD

Design

This research was designed as a descriptive study.

Setting and Time

The study was carried out with nursing students studying in a public university located in Southeastern Turkey in September 2019.

Population and Sample

The population consisted of totally 189 nursing students (71 from 1st year, 76 from 2nd year, and 42 from 3rd year). For the study, it was intended to reach the whole population without using sample selection. However, the study was completed with 152 nursing students since 13 students declined to participate in the study, 16 students completed the data collection forms incompletely, and 8 students were absent in the school during the data collection.

Data Collection Tools

Personal Information Form, Spirituality and Spiritual Care Rating Scale (SSCRS), and State Anxiety Inventory were employed to gather the data.

Personal Information Form

The researchers prepared this form by reviewing the literature. It asks the participants about their socio-demographic characteristics (age, gender, marital status, grades, working status in the clinic, status of being trained on spiritual care, implementing spiritual care, and having knowledge about spiritual care and necessity of spiritual care (Ince & Akhan, 2016; Yilmaz & Okyay, 2009).

Spirituality and Spiritual Care Rating Scale (SSCRS)

Spirituality and Spiritual Care Rating Scale (SSCRS) was developed by McSherry, Draper and Kendric in 2002 (McSherry et al., 2002). Bayik and Ergul conducted its Turkish validity and reliability study in 2004. This five-point Likert-type scale has 17 items, which are rated from "1" (I strongly disagree) to "5" (I strongly agree) and three subscales (spirituality and spiritual care, religiosity, and personalized care). The last four items of the scale are scored reversely. The lowest score and highest scores of the scale are 17 and 85, respectively. High total score indicates a high perception level for spirituality and spiritual care. Cronbach's Alpha reliability coefficient of its original version is 0.76 (Ergul & Bayık, 2007). In this study, the Cronbach's Alpha reliability coefficient was determined as 0.52.

State Anxiety Inventory

State Anxiety Inventory (SAI) was developed by Spielberger et al., (1970). Its Turkish validity and reliability was conducted by Öner and Le Compte (1985). Several studies have revealed that its alpha reliability coefficient is between 0.94 – 0.96 (Oner & Le Compte, 1985). In this study, the alpha reliability coefficient of SAI was found to be 0.92. SAI determines feelings of individuals at a specific moment and under certain conditions. The scale includes 20 items. While direct statements express negative feelings, reversed statements (items 1, 2, 5, 8, 10, 11, 15, 16, 19, and 20) express positive feelings. They are rated using a 4-point scale (none, a little, a lot, and completely) (Cronbach's Alpha: 0.93). Total score varies between 20 and 80. High score signifies a high level of anxiety. The mean score level reported after the applications varied between 36-41 (Taslak & Isıkay, 2015; State and Trait Anxiety Scale).

Data Collection

Personal Information Form, SSCRS and State Anxiety Inventory were applied by conducting a face-to-face interview with the participants in the classroom during the breaks. It took 15-20 minutes to complete the data collection forms.

Data Analysis

SPSS 22.00 software was employed to analyze the data. Descriptive statistics as well as Anova and T test for normal distribution, and Mann Whitney U and Kruskal Wallis tests for independent groups were used in the data analysis. The data were regarded as statistically significant at the level of $p<0.05$.

Ethical Considerations

Before the study, ethics committee approval was taken from the related Directorate of the School of Health, and the Clinical Trials Ethics Committee (Ethics committee decision no: 29/07/2019-E.32071/ institution permission document no: 29/05/2019-E.23368). Once the participants were informed about the aim of the study, their verbal and written consents were obtained.

RESULTS

Results on Some Characteristics of the Students

The results of the study revealed that 66% of the participants were female, 75.8% were aged between 18-21 years, 93.5% were single, 41.8% were 1st-year students, 71.9% were unemployed, 64.7% were not trained on spiritual care, 62.1% provided spiritual care to their patients, 77.8% had knowledge about spiritual care, and 93.5% believed that spiritual care is necessary (Table 1).

Results on Distribution of SAI and SSCRS Mean scores of the Students

The mean scores of the participants were 40.83±5.43 for the overall SSCRS, 8.09±2.18 for personalized care subscale, 15.00±2.75 for religiosity subscale, 12.31±3.13 for spirituality and spiritual care subscale, and 69.64± 6.5 for SAI (Table 2).

Results on Comparison between the Socio-Demographic Characteristics and SSCRS and SAI Mean Scores of the Students

There was no statistically significant difference between the students' gender, marital status and working status and SSCRS mean scores ($p>0.05$). SSCRS mean scores of the 1st-year students aged between 18-21 years were statistically significantly higher ($p<0.05$). Spiritual care total mean scores were higher in single students (78.30±8.23) than the married ones (58.35±6.00). No statistically significant difference was detected between their gender, marital status, grade, and working status and anxiety scores ($p>0.05$). However, anxiety mean scores were statistically significantly higher in those aged between 18-21 years (70.87±6.25) than those aged between 22-25 years (65.81±6.07) ($p< 0.05$) (Table 3).

Results on Comparison of the Students' Knowledge about Spiritual Care with their SSCRS and SAI Mean Scores

The difference between the status of receiving spiritual care training, performing spiritual care practice, having knowledge about spiritual care, and believing that spiritual care is necessary and SSCRS total mean scores was not statistically significant ($p>0.05$). Any statistically significant difference was not detected between the students' status of receiving spiritual care training, believing that spiritual care is necessary and SAI scores ($p>0.05$) ($p=0.05$). Anxiety mean score was significantly higher in those who did not do spiritual care practice (71.65±7.13) than those who did (68.42±5.89) ($p<0.05$). Anxiety mean score was significantly higher in those who did not have knowledge about spiritual care (72.70±5.99) compared to those who had (68.77±6.47) ($p<0.05$) (Table 4).

DISCUSSION

Spirituality is not only affected by traditional cultures and religion, but also learned from education and personal life experiences. Being an important aspect of human existence, it brings a meaning to life and helps one cope with difficulties emerging especially during illness and crisis. Nursing practices for spiritual care include giving support to patients for their cultural and religious beliefs, respecting for their privacy, establishing an effective communication and interaction, and empathizing. Nurses help meeting the spiritual needs of patients. Holistic care of patients should be assessed by taking both spiritual care and daily nursing care into consideration. However, if nursing students are poorly knowledgeable about spiritual care and its importance and are insufficiently trained on spiritual care, this prevents the provision of holistic care. For this reason, nurses need to develop their spiritual care competencies in order to meet the spiritual needs of patients. When compared with other students in various disciplines, nursing students are known to suffer from very high stress levels which are affected by numerous factors. The high level of stress leads nursing students to experience the increased level of anxiety and impairs the quality of both nursing care and spiritual care. The healthcare system has become more complicated; therefore, in nursing departments, nursing students will enable to provide high quality care by enhancing quality of nursing care as a result of strengthening their skills of coping effectively with stressors encountered and being aware of spiritual care needs of patients (Wu et al., 2012; Khalajinia, et al., 2021; Kalkim et al., 2018; Labrague et al., 2018).

For this reason, results of this study revealed that the spirituality and spiritual care perceptions of the student nurses were moderate according to their SSCRS total mean scores, the highest score was obtained from religiosity and spirituality and spiritual care subscales, respectively and the lowest score was obtained from the personalized care subscale. The anxiety level of the participants was high according to their SAI mean score. SSCRS total mean scores of nurses and midwives in the study conducted by Gonenc et al., were similar with the scores detected in the present study. In their study, Kalkim et al. determined that perceptions of spirituality of nursing students were not at the desired level (Kalkim et al., 2016). SSCRS total mean score in other studies conducted with nursing students differed from the present study (Gonenc et al., 2016; Ince & Akhan 2016; Bulut & Meral, 2019; Celik, et al., 2014).

In this study, it can be asserted that the nursing students were aware of spirituality and spiritual care but not at the desired level. The nursing students' awareness about this subject was moderate. This may be associated with the fact that they had insufficient knowledge about spiritual care and spiritual care was not sufficiently involved in the contents of nursing education.

If spiritual care is included in nursing education programs, awareness and care quality about spirituality and spiritual care can increase and attitudes towards spiritual care can develop positively.

It was determined in the present study that SSCRS personalized care subscale mean score of the nursing students was 8.09±2.18. Likewise, the lowest subscale score was observed in the personalized care in the study by Gonenc et al,., Unlike, personalized care subscale mean score was higher in the studies by Celik et al., and Bulut et al., (Gonenc et al., 2016; Celik, et al., 2014; Bulut & Meral, 2019).

Results of the present study that SSCRS religiosity subscale score was 15.00±2.75. Religiosity subscale scores were 13.41±2.59 in the study by Ince et al., 13.04±2.21 in the study by Gonenc et al., and 13.57±2.62 in the study of Pour et al., (Ince & Akhan, 2016; Gonenc et al., 2016; Pour et al., 2017). Since spiritual care includes all nursing cares that respect for religious practices and personal faiths of patients; religion constitutes the basic part of the spirituality concept. It was believed that high score of the religiosity subscale in this study was associated with sociological and cultural structure and religious beliefs of the Southeastern Anatolia Region.

In this study, SSCRS spirituality and spiritual care subscale score was 12.31±3.13. Unlike spirituality and spiritual care subscale scores were higher in similar studies (Wu et al., 2012; Khalajinia, et al.,2021; Kalkim et al., 2018). The lowest and highest scores of the spirituality and spiritual care subscale are between 11 and 31, therefore, the spirituality and spiritual care subscale score was low in the present study possibly due to the fact that the participants had np knowledge about spiritual care and this subject was not sufficiently taught during their nursing education. In line with these results, it can be asserted that regulations aiming at increasing the awareness and knowledge of the students about spirituality and spiritual care help students integrate spiritual care into their clinical practices, thus when they understand the relationships between spiritual care and diseases, their perception and awareness on spirituality and spiritual care can increase (Bulut & Meral, 2019; Daghan, 2018).

In the study, no statistically significant difference was determined between the participants' gender, marital status, working status in the clinic and SSCRS mean scores but SSCRS mean score of the 1st year students aged between 18-21 was significantly high. Likewise, in their studies Babamohamadi et al., and Wong et al., determined that gender did not affect the perception level of spirituality and spiritual care. Yilmaz et al., and Ince et al., reported no statistically significant difference between the marital status and working in clinic and the spirituality and spiritual care perception level. They found that spiritual care was an important dimension in nursing education, knowledge and skills of undergraduate students about spiritual care were expected to improve from the first year to their final year; whereas, SSCRS total mean score of the 1st-year students was higher in this study (Babamohamadi et al., 2018; Wong, et al., 2008; Yilmaz & Okyay, 2009; Ince & Akhan, 2016). Unlike the present study, Daghan and Ince et al., found that gender was important, women had higher levels of spirituality and spiritual care perception and these levels did not differ according to years (Daghan, 2018; Ince & Akhan, 2016).

In another study investigating the views and practices of nursing students on spiritual care, that most of the female students stated that they could meet the spiritual needs of the patients and the marital status and working status as a nurse did not have any effect on meeting the spiritual care of patients (Midilli et al., 2017).

Results of the present study indicated no statistically significant difference between status of receiving spiritual care training, doing spiritual care practice, having knowledge about spiritual care and believing that spiritual care is necessary and SSCRS total mean scores possible because the students were not sufficiently trained on spiritual care, did not consider themselves enough to provide spiritual care and did not see themselves as being responsible for spiritual care (Yilmaz & Okyay, 2009). One study investigating the nurses' opinions about spirituality and spiritual care reported that based on views of most of the nurses, training was important to recognize spiritual dimensions, the majority of the participants did not receive information about spirituality and most of those who received information found such information insufficient (Baldacchıno & Draper, 2001; Ross, 2006).

Similar studies have reported that the spiritual care practices of the nurses who received training on spiritual care increased, but the nurses who received insufficient training on spiritual care had difficulties in providing spiritual care (Mamier et al., 2018; Milligan, 2004).

According to their SAI mean score, the participants had high anxiety level. A study investigating whether or not anxiety levels of nursing students are correlated with the time management skills reported that their anxiety level was high (Lafcı & Oztunc, 2015).

Numerous factors can influence the level of anxiety. Nursing as a profession has its own stressors. The hospital environment creates new stressors for nurses and nursing students. The mostly perceived stressors in nursing programs are theoretical courses and clinical practices. Clinical experience is also known to be one of the components that cause mostly anxiety in nursing students (Sharif & Masoum, 2005). In their study, Pryjmachuk et al., revealed that one-third of nursing students experienced stress which is severe enough to result in anxiety and depression (Pryjmachuk et al., 2009). Lack of confidence, lack of clinical experience, fear of making mistakes, difficult patients, fear of being evaluated by faculty members, and concern for harming patients with wrong information or drug administration are the most important stressors for nursing students (Pryjmachuk et al., 2009). Studies investigating the possible practices to be done to prevent anxiety in nursing students have revealed that music therapy and progressive muscle relaxation exercises applied before the first clinical practice experience effectively reduce anxiety levels, the anxiety level of the students who used computer-based virtual simulation method in intravenous catheter skill training was low and the anxiety level of the students about the clinic and the practices decreases as a

result of the professional skills laboratory practice they make before the basic nursing courses are applied in the clinic (Chang et al., 2002; Sut & Kücükkaya, 2020; Inangil, et al., 2020).

In line with these results, it is recommended for nurse educators to have knowledge about the presence of stress experienced by nursing students and generate related solutions in order to lower their stress and anxiety levels (Crary, 2013).

No significant difference was found between the students' gender, marital status, grade, and working in the clinic and their anxiety scores. Anxiety mean score of the students aged between 18 and 21 was statistically significantly higher compared to those aged between 22 and 25. Among the studies investigating the anxiety levels of nursing students, there was no significant difference between gender and anxiety level in the study by Taslak and Isikay and between the grade and anxiety level in the study by Bayar et al.,. and anxiety of students under 22 was higher in the study by Sevinc and Ozdemir (Taslak & Isikay, 2015; Bayar et al., 2009; Sevinc & Ozdemir, 2017).These results are compatible with the result of the present study. The result indicating that the anxiety mean score of the students aged between 18-21 was significantly higher compared to those aged between 22-25 in the present study was attributed to the fact that those aged between 18-21 just started their education and had fewer encounters with the patients.

The results of the present study indicated that the anxiety score of the nursing students who did not receive spiritual care training and believed that spiritual care is necessary was higher and the difference between them was not significant. Those, who did not do spiritual care practice and did not have knowledge about spiritual care, have statistically significantly higher anxiety mean score. Nurses are the most important healthcare professionals who take care of patients along with spiritual care. However, when examining the nursing studies conducted on anxiety and spiritual care, it was determined that nursing students having high level of anxiety and stress had difficulties in their relations with the healthcare professionals, they may experience a decrease in their ability to cope with problems and social relations, nurses had low spiritual care and spirituality perception, they had knowledge about the spiritual needs of the patients but only very few of them provided spiritual care for these needs. This is mainly associated with the fact that nursing education cannot make students ready to provide spiritual care, spirituality and spiritual care concepts are interpreted in a narrow frame and they are not competent in providing spiritual care. Some studies have highlighted that nurses should first discover their own spirituality in order to have knowledge about the spiritual needs of patients (Labrague et al., 2016; Arabacı et al., 2015; Ergul & Bayık, 2007; Tiew et al., 2013; Ergul & Bayık, 2004).

Limitations

Limitations of the study are that the study was carried out in a single center. Results can be generalized only to this group.

CONCLUSION

It was concluded that SSCRS total score of the nursing students was at moderate level, the highest score was obtained from the religiosity and spirituality and spiritual care subscales, respectively and the lowest score was obtained from the personalized care subscale, and their anxiety levels were high according to their State Anxiety Inventory score. Those who did not do spiritual care practice and did not have knowledge about spiritual care had higher anxiety mean score.

Implications for Nursing Practice

Spiritual care is the main component of holistic nursing care. When nursing students cannot determine the spiritual needs of the patients, they will not be able to provide holistic care, and as a result, the healing process of the patients will be adversely affected. Accordingly, it may be recommended to include spirituality and spiritual care subjects into the nursing curricula, to provide holistic nursing care practices throughout their education, to rise the spiritual awareness of nurses through in-service trainings in the work environments after graduation, and to support them with practices that will reduce their anxieties in order for nursing students to understand spiritual care.

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TABLES

Table 1: Distribution of Socio-demographic Characteristics and Spiritual Care-related Characteristics of the Students

Characteristics	**n**	**%**
Gender		
Female	101	66.0
Male	53	34.0
Age		
18-21	116	75.8
22-25	37	24.2
Marital Status		
Married	10	6.5
Single	143	93.5
Year		
1st year	64	41.8
2nd year	52	34.0
3rd year	37	24.2
Working Status		
Employed	43	28.1
Unemployed	110	71.9
Receiving spiritual care training		
Yes	54	35.3
No	99	64.7
Conducting spiritual care practice		
Yes	95	62.1
No	58	37.9
Knowing spiritual care		
Yes	119	77.8
No	34	22.2
Believing that spiritual care is necessary		
Yes	143	93.5
No	10	6.5

Table 2: Distribution of Mean Scores of the Scales

Scales	**Mean ± SD**
State anxiety	69.64± 6.5
Spiritual care	
Personalized care	8.09±2.18
Religiosity	15.00±2.75
Spirituality and spiritual care	12.31±3.13
Total	40.83±5.43

Table 3: Comparison of the Students' Socio-demographic Characteristics with their Mean Scores from the Spirituality and Spiritual Care Scale and State Anxiety Inventory

Socio-demographic Characteristics	**SSCRS X±SD**	**p**	**Anxiety inventory X±SD**	**p**
Gender				
Female	41.29±5.39	0.14	70.16±6.51	0.17
Male	39.94±5.45		68.63±6.60	
Age				
18-21	41.41 ± 5.40	0.02	70.87±6.25	0.01
22-25	39.02 ± 5.20		65.81±6.07	
Marital Status				
Married	58.35±6.56	0.16	62.15±5.43	0.27
Single	78.30±8.23		78.04±7.12	
Year				
1st Year	42.53±4.89	0.01	72.15±6.43	0.07
2nd Year	39.71±6.21		70.00±6.55	
3rd Year	39.68±6.40		69.92±6.72	
Working status				
Employed	40.00±4.20	0.23	69.55±5.71	0.91
Unemployed	41.16±5.83		69.68±6.88	

Table 4. Comparison of Students' Knowledge On Spiritual Care with Their Mean Scores from the Spirituality and Spiritual Care Scale and State Anxiety Scale

Characteristics	**SSCRS X±SD**	**p**	**Anxiety inventory X±SD**	**p**
Receiving spiritual care training				
Yes	40.57±6.62	0.66	69.25±6.72	0.59
No	40.97±4.69		69.85±6.49	
Practicing Spiritual Care				
Yes	40.85±5.63	0.96	68.42±5.89	
No	40.81±5.13		71.65±7.13	0.01
Knowing spiritual care				
Yes	40.77±5.65	0.78	68.77±6.47	0.01
No	41.05±4.67		72.70±5.99	
Believing that spiritual care is necessary				
Yes	76.61±5.43	0.69	75.10±6.56	0.05
No	82.00±6.02		72.10±4.40	