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Turkish nurses' perceptions of spirituality and spiritual care

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Aim. To explore Turkish nurses' perceptions of spirituality and spiritual care and to investigate the relationship between their perceptions and their demographic/independent variables.

Background. Nurses' perception of spirituality can directly affect how they behave, deal with their patients and communicate with them in regard to the provision of spiritual care.

Design. Survey.

Methods. This study employed a convenience sample of 348 staff nurses from the public hospitals in the west of Turkey. The data were collected with two tools; a 'sociodemographic data form' and the 'Spirituality and Spiritual Care Rating Scale' (SSCRS). The response rate was 92% (n = 319).

Results. The mean age of the nurses was 31·70 (SD 6·34) years and 22·9% of them had a Bachelor's degree. Among the nurses, 54·98% had ≥ 11 years of clinical experience. The mean score for the SSCRS was 3·21 (SD 0·63) which indicated that nurses' perceptions concerning spirituality and spiritual care were 'uncertain' or 'less clearly' defined. Significant differences were found between nurses' perceptions of spirituality and spiritual care and their ages ($p < 0·05$), marital status ($p < 0·05$) and education levels ($p < 0·01$).

Conclusion. The research findings suggest that Turkish nurses' perceptions were indecisive and inconclusive. Nurses' educational level, belief in the evil eye and department of employment appeared to have a positive impact on their perception of spirituality and spiritual care.

Relevance to clinical practice. These findings will enable nurses to consider the importance of spirituality and spiritual care. Grasping these concepts will enable nurses to become more sensitive in their daily practices of spiritual care.

Key words: nurses, nurses' perceptions, nursing, spirituality, spiritual care, Turkey

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Introduction

The holistic perspective in health care is not a recent development. Nurses have traditionally recognised that human beings are tripartite in nature, the three dimensions are interrelated and healing often occurs through restoring balance among mind, body and spirit (Stranahan 2001, Barnum 2003). The spiritual dimension of health care is increasingly becoming prominent. Spirituality and spiritual care are well known to be essential aspects of patient care (Wong *et al.* 2008). The International Council of Nurses' Code (1973) recognises the spiritual aspect of nursing care and identifies providing spiritual care as a required duty of all nurses (Stranahan 2001). Nurses should take an active role in meeting the spiritual needs of patients (Narayanasamy 1999). It is argued that if nurses are concerned with the whole person and holistic care, then caring is to deal also with the spiritual aspects of patients' lives (McSherry 2006, Ross

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2006). Research provides evidence on the lack of nurses' awareness of the spiritual dimension as an integral part of nursing care with the consequence of failing to deliver holistic care (Ross 1994b, Oswald 2004). Literature suggests various reasons for this neglect of the spiritual dimension in care such as, lack of time, nurses' feeling of inadequacy to deliver spiritual care and lack of education (O'Brein 2007, Baldacchino 2008). Nurses in practice are often confused about the nature of spiritual care and yet their understanding of spiritual care will influence how they deliver it. However, there is little discussion on practising nurses' perceptions of spirituality and spiritual care (Sawatzky & Pesut 2005, Chung *et al.* 2007, Wong & Yau 2009).

Background

Spirituality and spiritual care are not new to nursing and health care. The dimension of spirituality and related concepts of spiritual well-being and spiritual health have been relevant to nursing throughout history (Narayanasamy 1999, Kociszewski 2003). Nightingale emphasised the need for nurses to honour the psychological and spiritual aspects of patients to promote patients' health; furthermore, she has defined it as being a nursing task in patient care (Barnum 2003, Wong *et al.* 2008). Since the Nightingale's era, spirituality within the nursing field has received limited attention in the literature, research and practice setting (Oswald 2004, Miner-Williams 2006). In years past, spiritual care was generally not considered a dimension of nursing therapeutics. With the advance of the holistic health movement, however together with the notion of holistic nursing, assessment of an ill person's spiritual needs and in some cases the practice of spiritual care became recognised as legitimate activities within the domain of nursing (Barnum 2003, O'Brein 2007).

Nurses have the unique task of working with patients at various and multiple points throughout their life journeys (McSherry *et al.* 2004). Often, nurses encounter patients during 'rough parts of the trail' when spiritual care becomes one of the major components in holistic care. All nurses have the responsibility to be aware of and sensitive to their patients' spiritual needs as a dimension of holistic health care (Sawatzky & Pesut 2005). The nurse must consider spiritual needs as part of a comprehensive nursing assessment (Chan *et al.* 2006, McSherry 2006, O'Brein 2007). Nurses' perception of spirituality can directly affect how they behave, deal with their patients and communicate with them in regard to the provision of spiritual care. A spiritual nurse considers taking care of a patient's spiritual needs as a commitment but not just a 'job'. He or she listens to a patient's spiritual thoughts and concerns with spiritual feelings and views the patient as a whole person instead of fragmented parts (Narayanasamy 1993, McSherry 2006).

A review of the literature reveals that spirituality is a highly subjective concept dependent on one's world view with varying interpretations (Oswald 2004, Chung *et al.* 2007). Multiple definitions of spirituality exist in the literature. Three specific components reoccurred in the literature including: (1) a need to find meaning, purpose and fulfillment in life or illness; (2) a need for hope and will to live; and (3) the need for a belief or faith in self, others, or Higher Power or God (Ross 1994a, Oswald 2004, Chan *et al.* 2006, McSherry *et al.* 2008).

Spirituality is defined as a universal human phenomenon that recognises the wholeness of individuals and their connectedness to a higher being; it is the integrating factor in the quest for meaning and purpose in life (Barnum 2003, Cavendish *et al.* 2004, McSherry 2006). In addition to being broad and non-dogmatic, spirituality involves learning and changing: its energy flows from inward out in a process of subjective growth and connection (Cavendish *et al.* 2004). The literature continues to reflect the many theoretical and practical aspects of spirituality and spiritual care in the holistic delivery of nursing care (Nagai-Jacobson & Burkhardt 1989, Kociszewski 2003).

International studies have shown that there is a lack of knowledge and general confusion regarding nurses' perceptions and interventions related to spiritual care (Narayanasamy & Owens 2001, Christensen & Turner 2008). Research-based findings consistently suggest that nurses' knowledge and skills related to spiritual care is not adequate because of poor role preparation. A positive correlation exists between the ability of nurses who have received spirituality education and their ability to provide spiritual care (Narayanasamy 1999). Ross (1994b) studied 685 nurses in an attempt to identify factors associated with giving spiritual care. She discovered that spiritual care could be given at various levels of involvement with patients. Nurses who responded at the deepest levels were aware of their own spirituality, had experienced crisis in life and were sensitive people willing to get involved at a personal level with their patients. Research provides evidence on the lack of nurses' awareness of the spiritual dimension as an integral part of nursing care with the consequence of failing to deliver holistic care (Baldacchino 2006, Ross 2006, Chan 2009).

McSherry (2006) points out that spirituality is poorly defined and understood by nurses and a large proportion of nurses do not consider spiritual care part of their duty. They generally perceive that spirituality is limited to religious needs. Thus, the provision of spiritual care is inadequate and

there is a need to increase nurses' knowledge in this particular area.

McSherry and Draper (1997) suggested a definition of spirituality that is universal in its approach, taking into account the uniqueness of individuals and the relevance of this phenomenon to clinical practice. They argued that the knowledge of spirituality had been based on nurses' personal and intuitive opinions of the phenomenon for many years and cautioned that the phenomenon of spirituality was too important to be limited by the nurse's subjectivity.

Nursing education in Turkey

Formal nursing education in Turkey started in 1925 at the level of secondary education which was upgraded to two-year programs in 1985 and continued until 1996. The first Turkish school of nursing in a university opened in 1955 at Ege University. By 1986, Turkey was one of the only five European countries providing a basic university level nursing education. Hacettepe University initiated a MSc program (1968) and a PhD program (1972) in nursing (Yavuz 2004, Kukulu 2005). Although nursing education has been integrated with university levels since 1955, nursing education has not been standardised. As a result, there are presently two groups of trained and educated nurses; one from universities, the other from high schools. Nurses with two different educational backgrounds have to share the same title and responsibilities when they graduate (Yiğit *et al.* 2004).

Spirituality in Turkish nursing and culture

There are a limited number of studies on spirituality and spiritual care in our country. These concepts are still analysed on a theoretical basis (Ergül & Temel 2007, Kostak 2007). In the research conducted by Hakverdioğlu *et al.* (2007) with oncologic nurses, 66·7% stated that spiritual health had an impact on physical health and 54·2% of them partly believed that patients should be assisted in performing their religious functions while 41·7% completely supported this idea. In the study conducted by Yılmaz and Okyay (2009), it was determined that nurses' knowledge of spirituality and spiritual care was insufficient. It was stated that nurses were theoretically aware of the significance of both spirituality and holistic care; however, they had problems in putting these concepts into practice. Both spirituality and religiosity are features of cultural identity in Turkey. For Turkish people, cultural sensitivity requires spiritual understanding as a component of the cultural context (Karaırmak 2004). However, many nurses will express difficulty with understanding what spirituality is, or how it relates to nursing, never mind how to 'assess' and 'implement' it (Miner-Williams 2006).

Aims of study

This study aimed to explore Turkish nurses' perceptions of spirituality and spiritual care and to investigate the relationship between their perceptions and their demographic/independent variables. Three specific research objectives were formulated:

1 To identify nurses based on their demographic variables and their perceptions of spirituality and spiritual care.
2 To detect differences between independent variables and nurses' spiritual care perceptions and practices.
3 To identify the factors contributing to their perceptions of spirituality and spiritual care.

Methods

Design and sample

This study was a descriptive survey conducted at three local public hospitals in the city of Manisa, at the western part of Turkey. A convenience sample of 348 staff nurses was invited to participate in this study. The response rate was 92% (n = 319).

Instruments and data collection

A structured self-reported questionnaire was used to collect the data. The questionnaire consists of two tools; a 'sociodemographic data form' and the 'Spirituality and Spiritual Care Rating Scale' (SSCRS). The SSCRS was developed by McSherry (W. McSherry, The University of Hull, Hull, unpublished Master of Philosophy Thesis). The SSCRS measures spirituality by quantifying participants' perceptions of the extent to which they hold certain spiritual views and engage in certain spiritually related activities. The tool is composed of 17 items rated on a five-point Likert-type scale. The SSCRS is scored by calculating the arithmetic mean across all items, for a total score that ranges from 1–5. In general, higher scores indicate a higher level of perception of spirituality or provision of spiritual care. The Turkish version of SSCRS was used in this study. Validity and reliability study of the Turkish version of the scale was carried out by Ergül and Temel (2007) in Turkey. The Turkish version of SSCRS demonstrates satisfactory validity and reliability (Ergül & Temel 2007). The alpha coefficient reported for this study was 0·84.

The questionnaire was distributed to all nurses by researchers by means of a personal interview. Data collection

was carried out during March–June 2008 in different units of the hospital.

Ethical considerations

Ethical approval for conducting this study was obtained from the ethical committee of the Ege University School of Nursing and from the hospitals' administrators. Participants were informed of the purpose and procedure of the study. Oral consents were obtained from the informants.

Data analysis

Data were analysed using the SPSS for Windows, Version 13.0 (SPSS, Inc., Chicago, IL, USA) Descriptive statistics were used to describe nurses' demographic characteristics. Normality of the SSCRS score was examined by the Kolmogorov–Simirnov test and the SSCRS score did not demonstrate a normal distribution (The Kolmogorov–Smirnov statistics = 0·61, $p < 0·05$). Therefore, as non-parametric tests, Mann–Whitney *U* and Kruskall–Wallis tests were used to assess associations between scores and categorical variables. Multiple linear regression was used to identify the impacts of variables on their perceptions of spirituality and spiritual care.

Results

Demographic characteristics of nurses

All of the nurses were female and aged between 18–51, with a mean age of 31·70 (SD 6·34 years). More than half of the participants were married (64·0%). Nearly half of the nurses had an Associate degree (43·3%) and 22·6% of them had a Bachelor's degree. Among the nurses, 54·98% had ≥ 11 years of clinical experience. The mean length of clinical experience was 11·28 years (SD 7·42 years). Of the 319 participating nurses, 129 (40·4%) reported that they were employed in a surgical department and 201 (63·0%) worked in day shift, while 64 (20·1%) nurses worked in both night and day shifts. Most participants had ≥ 41 weekly working hours (61·4%). Only 137 (42·9%) reported their self experience of previous hospitalisation.

Nurses' perceptions of spirituality and spiritual care

When the nurses' 'the evil eye' and 'fate' beliefs – which are very widespread spiritual beliefs in Turkish culture- are considered; 83·7% expressed that they believed in 'the evil eye' while 89·7% believed in fate. When nurses' attitudes towards spiritual practices of patients (e.g. praying, wearing a blue bead against the evil eye or an amulet) were analysed, it was determined that 59·6% 'ignored it', 29·2% 'supported' such practices of individuals and 11·3% 'did not allow'.

The mean scores for the SSCRS are given in Table 1. The highest two mean scores for SSCRS were obtained by item 4; 'I believe spirituality involves only going to mosque/place of worship' (4·09 SD 0·97) and item 16; 'I believe spirituality does not apply to Atheists or Agnostics' (3·76 SD 1·06) which are both related with the perception of 'spirituality'. The two highest mean scores related with spiritual care were obtained by item 14; 'I believe nurses can provide spiritual care by having respect for privacy, dignity as well as religious and cultural beliefs of a patient' (3·13 SD 1·42) and item 7; 'I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need' (3·11 SD 1·18). The items that received the lowest mean scores were item 1; 'I believe nurses can provide spiritual care by arranging a visit by the religious official or the patient's own religious leader if requested' (2·76 SD 1·23) and item 15; 'I believe spirituality involves personal friendships, relationships' (3·02 SD 1·17) (Table 1). The mean score for the SSCRS was 3·21 (SD 0·63) with a median of 3·00 (min–max: 1·94–4·88). This score fell within the 'uncertain' category identified by the SSCRS to the presented spirituality statements and indicated that nurses' perceptions concerning spirituality and spiritual care were uncertain or less clearly defined.

Relationships of independent variables with SSCRS

The relationships between the total mean perception scores and independent variables were analysed by Mann–Whitney *U* and Kruskall–Wallis tests (Table 2). Statistically significant differences were found between nurses' perceptions of spirituality and spiritual care (and their age groups (KW $x^2 = 24·32$, $p < 0·01$), education level (KW $x^2 = 10·94$, $p < 0·05$), department of employment (KW $x^2 = 14·37$, $p < 0·01$), marital status ($U = 9·94$, $p < 0·01$), length of clinical experience ($U = 9·69$, $p < 0·01$) and nurses' belief in the evil eye ($U = 5·36$, $p < 0·01$). Those in the youngest age group, those with a Master's degree, singles, those employed in departments except for medical and surgical units (pediatrics, psychiatry) and those with a length of clinical experience less than 10 years had higher scale scores. Moreover, nurses who believe in the evil eye reported higher scores. No statistically significant difference was determined between the scale mean score and belief in fate, weekly working hours and experience of hospitalisation. However, the nurses who believed in fate, whose weekly working hours

Table 1 Mean scores of spirituality and spiritual care rating scale items (n = 319)

Items	Mean	SD
1. I think that nurses can provide spiritual care by inviting a religious official to the hospital on patient's demand	2·76	1·23
2. I think that nurses can provide spiritual care by acting in a compassionate, concerned and positive manner while giving care	3·20	1·65
3. I think that spirituality is only concerned with a need to forgive and be forgiven	3·56	1·02
4. I think that spirituality involves only going to a place of worship (mosque/church)	4·09	0·98
5. I think that spirituality is not concerned with belief in God or a supreme power and worship	3·12	1·34
6. I think that spirituality is concerned with finding meaning in the good and bad events of our lives	3·08	1·13
7. I think that nurses can provide spiritual care by allocating time for patients to support them in time of need	3·11	1·18
8. I think that nurses can provide spiritual care by helping patients in finding the meaning and causes of their illnesses	3·03	1·14
9. I think that spirituality is concerned with having hope for life	3·08	1·16
10. I think that spirituality is about living one's life 'here and now'	3·05	0·94
11. I think that nurses can provide spiritual care by giving patients enough time to explain and discuss their fears, worries and sorrows, and listening to them	3·10	1·21
12. I think that spirituality is a unifying force which enables one to be at peace with oneself and his or her environment	3·09	1·30
13. I think that spirituality does not involve areas such as art, creativity and self-expression	3·54	1·05
14. I think that nurses can provide spiritual care by showing respect for the privacy, dignity, religion and cultural beliefs of a patient	3·13	1·42
15. I think that spirituality involves personal friendships and relationships	3·02	1·17
16. I think that spirituality does not apply to those who do not have a belief in God/Supreme Power	3·76	1·06
17. I think that spirituality is a concept that includes morality	3·04	1·25

were ≤ 40 and who had a previous experience of hospitalisation received higher mean scores.

Influential factors on nurses' perception of spirituality and spiritual care

We used multiple linear regression analyses to determine the influential factors on nurses' perception of spirituality and spiritual care. As a result of the multiple linear regression analysis; education level (β = 0·17, $|t|$ = 4·27, $p < 0·01$), department of employment (β = 0·15, $|t|$ = 3·86, $p < 0·01$) length of work experience (β = -0·28, $|t|$ = 3·98, $p < 0·01$) and belief in the evil eye (β = 0·22, $|t|$ = 2·42, $p < 0·01$) were found to be -determinant- influential factors -at 16% (R^2 = 0·156) on nurses' perception of spirituality and spiritual care (Table 3). While educational level, belief in the evil eye and department of employment are considered positive influential factors on nurses' perception of spirituality and spiritual care, length of work experience is considered a negative influential factor.

Discussion

Spirituality may be influenced by culture (McSherry *et al.* 2004, Baldacchino 2008). A spiritual practice is the enactment of the spiritual beliefs (Armer & Conn 2001). In Turkish culture, the 'evil eye' and belief in 'fate' are widespread beliefs that are associated with psychological and physical illnesses as well as failures in life and personality problems. In accordance with these beliefs; praying, wearing blue beads or amulets are widely used as therapeutic tools by Turkish people in the culture context (Minas *et al.* 2007). Our study demonstrated that more than half of the nurses ignored these practices that patients develop with the purpose of finding spiritual support. In other words, they indirectly allow them to realise these practices. The fact that a great majority of nurses believe in the evil eye and fate themselves could explain this attitude. In other words, they indirectly allow them to practice these which could be explained by the fact that a large majority of nurses believe in the evil eye and fate themselves. McSherry (2006) asserts that nurses who are spiritually active are more sensitive to their patients' spirits. Research suggests that the individual person of the nurse may influence spiritual care by the personal beliefs and values, willingness to give of themselves, their level of sensitivity and spirituality and culture (Kociszewski 2003, Baldacchino 2006, Chan 2009).

The nurses' two highest mean scores for SSCRS were obtained by the items related with their perception of spirituality to which they responded as 'I agree' in a certain manner. When these items are considered, it is seen that nurses relate spirituality mainly with religious elements. Previous

Table 2 SSCRS scores and selected independent variables (n = 319)

Variables	n	Mean (SD)	Kruskall–Wallis-test x^2	p
Age				
18–26	70	3·41 (0·06)	24·32	0·000*
27–35	172	3·18 (0·04)		
36–44	60	3·09 (0·09)		
≥ 45	17	3·04 (0·14)		
Education level				
High school level	99	3·12 (0·05)	10·94	0·012**
Associate degree	138	3·10 (0·05)		
Bachelor of science in nursing	72	3·45 (0·07)		
Master degree	10	3·77 (0·22)		
Perceived income level				
Low	108	3·25 (0·59)	0·92	0·630
Middle	165	3·20 (0·48)		
High	46	3·15 (0·10)		
Department				
Medical	121	3·15 (0·53)	14·37	0·001*
Surgical	129	3·12 (0·60)		
Others (pediatrics, psychiatry)	69	3·46 (0·69)		
			U	p
Marital status				
Married	204	3·15 (0·45)	9·94	0·002*
Unmarried	115	3·31 (0·56)		
Length of clinical experience (years)				
≤ 10	144	3·34 (0·47)	9·69	0·000*
≥ 11	175	3·09 (0·49)		
Weekly working hours				
≤ 40	123	3·29 (0·58)	1·06	0·062
≥ 41	196	3·15 (0·44)		
Hospitalisation experiences				
No	182	3·19 (0·48)	1·21	0·693
Yes	137	3·22 (0·53)		
Belief in the Evil Eye				
No	52	3·16 (0·37)	5·36	0·009*
Yes	267	3·42 (0·49)		
Belief in fate				
No	33	3·19 (0·37)	4·15	0·261
Yes	286	3·35 (0·12)		

*Significant at $p < 0·01$, **significant at $p < 0·05$.
U, Mann-Whitney U-test.

researches also demonstrate that nurses tend to equate spirituality with religion (Narayanasamy & Owens 2001, McSherry *et al.* 2004, Oswald 2004, Chan 2009). Similarly, in the study of Wong and Yau (2009), nurses defined spirituality as mostly related with religion. In another study conducted in Turkey, where Yılmaz and Okyay employed the same scale (2009), it was seen that nurses associated spirituality and spiritual care generally with religion.

When the items in the scale that are related with spiritual care and that the nurses received the highest mean scores are evaluated, it is seen that nurses' perception of spiritual care is 'uncertain'. Ross (2006), in a literature review, found that nurses' awareness of patients' spiritual requirements were quite limited and that they tended to focus on religious requirements related with spiritual care and they had difficulty in defining spiritual care. International studies have shown that there is a lack of knowledge and general confusion regarding nurses' perceptions and interventions related to spiritual care (Narayanasamy & Owens 2001, Christensen & Turner 2008).

The high mean scores of the SSCRS indicated that, these nurses were spiritually minded nurses. Nurses appreciated providing spiritual care to patients (Wong *et al.* 2008). In this study, the mean score of the scale was uncertain. That

Table 3 Multiple linear regression analysis of factors potentially influential on the SSCRS scores

Factors	*n* = 319 Beta 2·84	| *t* | -statistics 17·02	*p*-value 0·000*
Length of clinical experience years ≤ 10	−0·28	3·98	0·000*
Education level	0·17	4·27	0·000*
Department (employment in pediatrics, psychiatry department)	0·15	3·86	0·000*
Belief in the evil eye	0·22	2·42	0·016**
$F(4,314) = 14{\cdot}497$; $p < 0{\cdot}01$.			

*Significant at $p < 0{\cdot}01$; **significant at $p < 0{\cdot}05$.

result demonstrates that nurses are confused about what spirituality and spiritual care is.

Previous studies have reported that nurses who were older (Tuck *et al.* 2001), married (Cavendish *et al.* 2004), of higher education level (Oswald 2004, Wong *et al.* 2008, Yılmaz & Okyay 2009), with longer work experience (Oswald 2004), hospitalisation experience (Chan 2009) and profound spiritual beliefs (Stranahan 2001, Cavendish *et al.* 2004) had higher spirituality and spiritual care scores. In this study, it was seen that as the level of education increased, nurses' scale mean scores also increased significantly. In addition, the scale mean scores of those who had hospitalisation experience were higher. Contrary to the findings of previous studies (Tuck *et al.* 2001, Cavendish *et al.* 2004, Oswald 2004), in this study, younger nurses as well as those who worked fewer than ten years and singles had high scale mean scores. In other words, the mean scores of married nurses and nurses with working experience for eleven years and above were relatively lower. This finding could be interpreted as nurses' lack of focus on patients' requirement of spiritual care and spirituality as a result of the intense working conditions and the responsibilities as mothers and housewives in the cultural structure in Turkey.

In the study, it was seen that nurses who worked in pediatric and psychiatric departments had higher perceptions of spirituality and spiritual care when compared with other departments. This may be due to the fact that nurses employed in such clinics use more therapeutic and communication skills (e.g. active listening, being nonjudgmental, building support, spending time talking with patients, etc.) for children and psychiatric patients (Chapman & Grossoehme 2002, McEvoy 2003).

As emphasised in the literature, it is expectable of nurses who believe in the evil eye and fate to have high perceptions of spirituality and spiritual care as a result of their spiritual sensitivity (Stranahan 2001, McSherry 2006, O'Brein 2007). The increased workload, lack of time, lack of knowledge and insufficient resources were considered as the obstacles in the provision of spiritual care by nurses (McSherry 2006, O'Brein 2007, Chan 2009). In the research, it was found that nurses' educational level, belief in the evil eye and department of employment appeared to have a positive impact on their perception of spirituality and spiritual care.

Limitations

The current study was limited by the use of convenience sampling. Thus, generalisation of the study findings is weakened.

Conclusion

The research findings suggest that Turkish nurses' perceptions of spirituality and spiritual care were indecisive and inconclusive. The cultural themes such as belief in the evil eye and fate may also have played an important role in nurturing the spirituality of the nurses in this study. Nurses' educational level, length of work experience and department of employment are determinant on their perceptions of spirituality and spiritual care.

Relevance to clinical practice

The study findings provide preliminary insights on nurses' perception of spirituality and spiritual care in Turkey. Although this study examined the issues in a local context, it has provided valuable information for international and cross-cultural comparisons. These findings will enable nurses to consider the importance of spirituality and spiritual care. Understanding these concepts is beneficial in efforts to improve the care offered to patients. The indicative content of educational programmes should incorporate and adequately address the spiritual dimension of nursing care. Nurses should take the initiative in increasing their knowledge of spiritual care and give priority to reflection in and on their clinical practice to enhance patient care. In addition, it is suggested that a thorough evaluation of nurses' perception of spirituality be made through qualitative studies.

Contributions

Study design: FO, SE, ABT; data collection and analysis: GGA, AC, SE and manuscript preparation: FO, SE, ABT, GGA, AC.

Conflict of interest

None of the authors have any conflict of interest.

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