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# Perceptions of Spirituality and Spiritual Care of Health Professionals Working in a State Hospital

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Received: 8 September 2018; Accepted: 11 October 2018; Published: 12 October 2018

**Abstract: Background:** The determination and fulfillment of the spiritual needs of the individual in times of crisis can be realized by the health care professionals having the knowledge and skills to provide individual-specific care. This research was conducted to determine the perceptions of health professionals about spirituality and spiritual care. **Methods:** The study of 197 health professionals working in a state hospital was performed. This study is a descriptive study which was conducted between December 2017 and January 2018. Data in the form of an "Introductory Information Form" and "Spirituality and Spiritual Care Grading Scale" was collected. In the analysis of the data, the Mann–Whitney U test, Kruskal–Wallis tests, frequency as percentage, and scale scores as mean and standard deviation were used. **Results:** It was determined that 45.7% of the health professionals were trained in spiritual care, but that they were unable to meet their patients' spiritual care needs due to the intensive work environment and personnel insufficiency. The total score averaged by the health professionals on the spirituality and spiritual care grading scales was 52.13 ± 10.13. **Conclusions:** The findings of the research show that health professionals are inadequate in spiritual care initiatives and that their knowledge levels are not at the desired level. With in-service trainings and efforts to address these deficiencies, spiritual care initiatives can be made part of the recovery process.

**Keywords:** health professionals; spirituality; spiritual care; health care

## 1. Introduction

The holistic care approach that treats the individual as a whole in all its dimensions has recently adopted the "patient-centered" approach from the "disease-centric" philosophy of treatment. In this approach, the individual has physical, mental, social, and spiritual dimensions and these dimensions affect each other (Daştan and Buzlu 2010; Kostak et al. 2010). Health is the harmonious work of mind, spirit, and body as an orchestra. For the protection and continuation of the individual's health, the importance of physical, mental, and social health, as well as spiritual health should be considered as a component of holistic care (Daştan and Buzlu 2010; Yılmaz and Okyay 2009; Uğurlu 2014; Karagül 2012). If all dimensions of a person are balanced, it can be said that they are healthy (Aştı and Karadağ 2013). In different healing processes, for example, those from different religions are affected in different ways. A study has been conducted on how Christian and Muslim individuals deal with difficult and stressful life events. In this study, it has been determined that in such cases, Muslims adopt more interpersonal and collective coping methods, and Christians adopt more individualistic and individual coping methods, such as cognitive restructuring and seeking social support (Fischer et al. 2010). In this context, this aspect of the individual according to the health teams should not be ignored.

In research, spirituality and spiritual care consists of three subdimensions. The first is spirituality, which means "*breathing*", or "*being alive*", coming from the Latin word "*spiritus*", and is a universal dimension (Uğurlu and Başbakkal 2013). It evokes feelings of meaning, faith, and hope to connect to a divine power, and a sense of trust (Ercan et al. 2017). Spirituality refers to religious tradition and faith in one way or another, but also to philosophical belief and human life. The spirituality that takes a power beyond religious belief is a dimension that is possessed by individuals who do not have religious beliefs (McSherry and Jamieson 2011; McEwen 2005). By helping the individual/patient and his/her family cope with illness or difficult times that may result in death, it can positively affect his/her behavior (Uğurlu and Başbakkal 2013). Individuals experience emotional distress, major losses, sadness, grief, serious illness, and fear of death, and they experience spiritual deprivation and need the fulfillment of their spiritual needs to support them. Trust, hope, love, forgiveness, experience, sensuality, speech, consolation, rituals, praying, and sanctuary are spiritual needs (Çınar and Eti Aslan 2017). However, the second dimension is spiritual care. The practices for the eradication of the spiritual distress of the individuals who struggle for existence have revealed the concept of spiritual care. The purpose of spiritual care is to reduce or eliminate the conflict between beliefs, values, and health care. In addition, the purpose of spiritual care is to guide individuals who are hospitalized to perform their sanctuary as far as possible without interfering with their medical treatment, and to provide spiritual inspiration (Baldacchino 2006). Spiritual care practices have a positive impact on the physical and mental health of patients (Wong and Yau 2010). The last dimension is religiousness. Religion affects the individual's way of interpreting and facilitates the individual to cope with difficulties. For example, the tragic situation is perceived by God as nonhuman. Religion can influence the coping process by shaping the process. For example, an individual's religious past can help him fight addiction. Religion can also be shaped by the coping process. Or, to come to the edge of death may lead the individual to seek a religion (Hiçdurmaz and Öz 2013).

Health professionals who work full-time in the health system have a responsibility to be aware of their patients' spiritual needs and to be sensitive in order to perform psychosocial care, which is an important part of care. However, the majority of health workers have difficulty in evaluating the spiritual aspect of individuals/patients due to lack of information about spiritual care, less time for spiritual care, lack of self-esteem, and multiple work places (Kalkim et al. 2016). It is imperative that the knowledge, skills, and attitudes of healthcare professionals are at the professional level. It is important to be able to assess the caregiver in this context and to be able to correctly identify the specific needs of this area in order to plan appropriate interventions (Kostak 2007; Eğlence and Şimşek 2014). Considering the spirit of healing of the patient in spiritual care, it is thought that this research will contribute to the literature by determining how spirituality and spiritual care is perceived by health professionals and how much knowledge the doctors, nurses, and midwives have about this issue.

## 2. Method

### *2.1. Purpose of the Research*

The purpose of this descriptive study is to examine the perception levels of health professionals on spirituality and spiritual care.

### *2.2. Place and Time of Research and Sample*

This descriptive study was carried out between December 2017 and January 2018. The study created a sampling pool of 400 health professionals working in a State Hospital operating on the European side of Istanbul province. It was aimed to reach the entire sampling pool, but the research sample was carried out with 197 people for reasons of voluntary participation and nonavailability.

### *2.3. Collection of Data*

In the collection of the data, the "Introductory Information Form" and the "Spirituality and Spiritual Care Grading Scale" (SSCGS) were used by the researchers. In the introductory information form, there were a total of 10 questions for assessing age, marital status, educational status, total years of work, and information and attitudes about spiritual care. The questionnaire on which it was based, developed by McSherry et al. in 2002, has 17 questions (McSherry et al. 2002). However, the validity and reliability study in Turkish has been finalized as a five-point Likert-type scale that was made by Ergül and Bayık in 2007; the "Spirituality and Spiritual Care Grading Scale" (Ergül and Temel 2007). It consists of three subdimensions: spiritual and spiritual care, spirituality, and individual care. The items in the scale are scored from 1 to 5, 1 being "absolutely agree" and 5 as the expression "I do not agree". The first item is scored in a straightforward way, and the last four items are scored in the opposite way. The highest score that can be obtained from the scale is 75 and the lowest is 15. A high total score indicates that the perception level of spirituality and spiritual care concepts is good. Cronbach's alpha ($\alpha$) coefficient was 0.76 in the study performed by Ergül and Temel (2007) within the scope of internal consistency. In this study, the Cronbach's alpha ($\alpha$) coefficient of the overall and subdimensions of the scale was calculated within the scope of internal consistency; the overall reliability of the spirituality and spiritual care grading scale was found to be 0.84; that for the subdimension of spirituality and spiritual care was 0.86 ($\alpha$), for the subdimension of religion was 0.77 ($\alpha$), and for the subdimension of individual care was 0.73 ($\alpha$).

### *2.4. Method of Data Collection and Ethical Aspects of the Research*

Before starting the investigation, the ethics committee granted permission to the senior management of the hospital where the study was conducted. Verbal and written consent was obtained from the health workers included in the scope of the research. The researchers filled out data collection forms and provided information about the research. Questionnaires were distributed to the health workers who agreed to participate in the survey under the control of the investigator and filled out at the end of the hour.

### *2.5. Limitations of the Research*

The study is limited to data obtained from 197 health care workers working in a State Hospital operating on the European side of Istanbul province in 2018.

### *2.6. Evaluation of Data*

Statistical analysis was performed using the SPSS (Statistical Package for the Social Sciences) 25.0 package program. Before the analysis of the difference, the Kolmogorov–Smirnov test was used to evaluate the distribution of normality. The differences between the two groups were analyzed using the Mann–Whitney U test and Kruskal–Wallis tests for differences between the two groups. The distribution of the questions in the data form was interpreted as frequency and percentage, and the scale scores were interpreted as the mean and standard deviation. Results were evaluated at the 95% confidence interval and $p < 0.05$ significance level.

## 3. Findings

In the study, the results of the analysis of the descriptive data of the participants who were included in the survey were evaluated. Overall, 29.4% of participants were nurses, 53.3% were women, 32.5% were graduates, 70% were between the ages of 31 and 40 years, 77.2% of them had professional experience between 11 and 15 years, and 25.9% worked in surgical clinics (Table 1).

**Table 1.** Introductory characteristics of health professionals (n = 197).

| Questions | Items | Frequency (n) | Percentage (%) |
|---|---|---|---|
| Profession | Physician | 35 | 17.7 |
| | Nurse | 58 | 29.4 |
| | Midwife | 22 | 11.1 |
| | Healthcare, Technician, Technician | 44 | 22.3 |
| | Other (Psychologist, social work specialist, medical secretary) | 38 | 19.2 |
| | Total | 197 | 100.0 |
| Age group (years) | 30 and below | 32 | 16.2 |
| | 31–40 | 138 | 70 |
| | 41–50 | 21 | 10.6 |
| | 51 and over | 6 | 3 |
| | Total | 197 | 100.0 |
| Gender | Female | 105 | 53.3 |
| | Male | 92 | 46.7 |
| | Total | 197 | 100.0 |
| Education status | High school | 31 | 15.7 |
| | Associate | 23 | 26.8 |
| | License | 64 | 32.5 |
| | Master's degree | 42 | 21.3 |
| | Doctorate | 37 | 18.7 |
| | Total | 197 | 100.0 |
| Years of experience | 1–5 years | 18 | 9.1 |
| | 6–10 years | 24 | 12.1 |
| | 11–15 years | 93 | 77.2 |
| | 16 years and over | 62 | 31.4 |
| | Total | 197 | 100.0 |
| Working unit | Surgical Clinic | 51 | 25.9 |
| | Internal Medicine Clinic | 42 | 21.3 |
| | Palliative | 10 | 5 |
| | Emergency | 17 | 8.6 |
| | Pediatrics Clinic | 23 | 11.6 |
| | Intensive care | 21 | 10.6 |
| | Operating room | 13 | 6.6 |
| | Other | 20 | 11.1 |
| | Total | 197 | 100.0 |

In this study, it was determined that 45.7% of the participants had received education about spirituality, 64.4% found that the education about spirituality and spiritual care was not adequate, and 41.1% of the educated people received this education from their own sanctuary. It was also found that 52.8% stated that the patients did not have their spiritual care needs met and 32.4% stated that this was due to personnel deficiency. When they evaluated their attempts to meet the spiritual needs of the patients, 31.4% of respondents stated that they provided psychological support for most patients (Table 2).

**Table 2.** Knowledge and attitudes of health professionals about spiritual care (n = 197).

| Statements | Items | Frequency (n) | Percentage (%) |
|---|---|---|---|
| Received training about spirituality and spiritual care | Yes | 90 | 45.7 |
| | No | 107 | 54.3 |
| | Total | 197 | 100.0 |
| Found training in spirituality and spiritual care to be adequate | Yes | 32 | 35.5 |
| | No | 58 | 64.4 |
| | Total | 90 | 100.0 |
| Place of training in spirituality and spiritual care | School | 18 | 20.0 |
| | In-service training | 7 | 7.7 |
| | Family | 28 | 31.1 |
| | Church, mosque, synagogue, etc. | 37 | 41.1 |
| | Total | 90 | 100.0 |
| Health professionals' ability to meet spiritual care needs of patients | It can be met | 93 | 47.2 |
| | It cannot be met | 104 | 52.8 |
| | Total | 197 | 100.0 |
| Interventions to meet spiritual care needs | Talking | 48 | 24.3 |
| | Listening | 35 | 17.8 |
| | Providing psychological support | 62 | 31.4 |
| | Attending church, mosque, synagogue, etc. | 53 | 27 |
| Reasons for health professionals failing to meet spiritual care needs of patients | Time inadequacy | 48 | 24.3 |
| | Information inadequacy | 43 | 21.8 |
| | Staff inadequacy | 64 | 32.4 |
| | Physical disability | 42 | 21.3 |
| | Total | 197 | 100.0 |

In the study, the average score of the total scores of the health professionals obtained from the spirituality and spiritual care grading scale was determined as 52.13 ± 10.13. "Spiritual and spiritual care" subdimension scores averaged 22.53 ± 5.74, the "religiousness" subdimension scores averaged 9.51 ± 2.68, and the "individual care" subdimension scores' average was found to be 11.39 ± 2.05 (Table 3). When the lower and upper scores were evaluated according to the dimensions of the scale, the mean scores of the SSCGS (Spirituality and Spiritual Care Grading Scale) obtained as a result of the research were interpreted as moderate. The moderate scores indicate that the level of perception of spirituality and spiritual care is good.

**Table 3.** Spirituality and spiritual care grading scalepoints average of health professionals (n = 197).

| Constructs | Mean | SD | Min. | Max. |
|---|---|---|---|---|
| Spirituality and spiritual care dimension | 22.53 | 5.74 | 7 | 35 |
| Religious dimension | 9.51 | 2.68 | 4 | 20 |
| Individual care dimension | 11.39 | 2.05 | 4 | 20 |
| Spirituality and spiritual care grading scale total | 52.13 | 10.13 | 15 | 75 |

When Table 4 was examined, it was found that the subscales of the Spirituality and Spiritual Care Grading Scale according to sex showed a significant difference between the groups ($p < 0.05$) and female participants' scores were higher than the subscales of Spiritual and Spiritual Care Grading Scale ($p < 0.05$) and higher in the group aged between 31–40 years ($p < 0.05$). According to the experimental results, the subscales of the SSCGS and the difference between the groups' mean scores for those with 16 years' or more experience were significantly higher ($p < 0.05$).

The subdimensions of the SSCGS and the mean of the total points showed significant differences, with the average score of those with language education being higher ($p < 0.05$) according to the educational status of participants. According to the professional group of the participants, for the subscales of the Spirituality and Spiritual Care Grading Scale and the total, the difference between the groups was significant and the average score of the nurses was higher ($p < 0.05$). The subscales of the Spiritual and Spiritual Care Grading Scale and the mean of the total points were significantly different between the groups and the scores of those who were in the surgical and general intensive care units were higher ($p < 0.05$). According to the status of spiritual education, the subscales of the Spirituality and Spiritual Care Grading Scale and the difference between the groups' mean of the total points were significantly different, and the average score of those who did not receive education was lower than the average overall scores.

**Table 4.** Comparison of demographic characteristics of health professionals and their responses to spirituality and spiritual care grading scale dimensions (n = 197).

| | SSC Dimension | | Religious Dimension | | Individual Care Dimension | | SSCGS Total | |
|---|---|---|---|---|---|---|---|---|
| **Gender** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** |
| Male | 21.37 | 5.31 | 9.42 | 2.61 | 11.93 | 2.12 | 53.72 | 5.01 |
| Female | 22.72 | 5.05 | 11.26 | 3.59 | 13.43 | 2.59 | 57.41 | 8.08 |
| **Z** | −0.174 | | −3.485 | | −3.280 | | −3.821 | |
| **p** | 0.861 | | 0.000 | | 0.001 | | 0.000 | |
| **Age group** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** |
| 30 years and under | 17.71 | 3.77 | 9.83 | 3.13 | 8.87 | 2.20 | 44.41 | 5.78 |
| Between 31–40 years | 20.95 | 1.67 | 11.20 | 2.19 | 6.30 | 2.34 | 46.45 | 2.86 |
| Between 41–50 years | 17.73 | 4.38 | 12.00 | 4.15 | 9.83 | 2.93 | 49.56 | 10.90 |
| 51 years and over | 15.82 | 1.24 | 9.88 | 2.06 | 9.00 | 1.00 | 44.71 | 2.34 |
| $\mathbf{X^2}$ | 21.930 | | 8.081 | | 19.404 | | 4.170 | |
| **p** | 0.000 | | 0.044 | | 0.000 | | 0.244 | |
| **Professional experience** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** |
| 1–5 years | 17.98 | 2.94 | 10.60 | 3.42 | 8.91 | 2.25 | 45.49 | 6.11 |
| 6–10 years | 16.53 | 3.58 | 12.08 | 2.83 | 8.08 | 1.70 | 43.69 | 4.90 |
| 11–15 years | 16.18 | 3.48 | 10.21 | 2.04 | 8.44 | 2.47 | 44.84 | 4.39 |
| 16 years and over | 18.41 | 5.11 | 12.76 | 4.73 | 10.34 | 3.23 | 51.52 | 12.01 |
| $\mathbf{X^2}$ | 6.116 | | 11.693 | | 7.579 | | 9.602 | |
| **p** | 0.106 | | 0.009 | | 0.056 | | 0.022 | |

| **Spiritual care training** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** |
|---|---|---|---|---|---|---|---|---|
| Yes | 17.11 | 2.38 | 20.39 | 2.06 | 7.94 | 2.05 | 45.44 | 3.98 |
| No | 15.82 | 5.02 | 20.68 | 4.59 | 10.04 | 2.61 | 46.54 | 10.13 |
| **Z** | −2.142 | | −0.595 | | −5.409 | | −1.115 | |
| **p** | 0.032 | | 0.552 | | 0.000 | | 0.265 | |
| **Education Status** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** |
| High school | 17.98 | 2.94 | 10.60 | 3.42 | 8.91 | 2.25 | 45.49 | 6.11 |
| Associate | 16.53 | 3.58 | 12.08 | 2.83 | 8.08 | 1.70 | 43.69 | 4.90 |
| License | 16.18 | 3.48 | 12.21 | 4.73 | 8.44 | 2.47 | 53.84 | 12.01 |
| Master's degree | 16.18 | 3.48 | 10.21 | 2.04 | 8.44 | 2.47 | 44.84 | 4.39 |
| Doctorate | 18.41 | 5.11 | 10.76 | 4.03 | 10.34 | 3.23 | 41.52 | 4.32 |
| **$X^2$** | 6.116 | | 11.693 | | 7.579 | | 9.602 | |
| **p** | 0.106 | | 0.009 | | 0.056 | | 0.022 | |
| **Profession** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** | $\overline{X}$ | **SS** |
| Physician | 17.71 | 3.77 | 9.83 | 3.13 | 8.87 | 2.20 | 44.41 | 5.78 |
| Nurse | 22.95 | 1.67 | 12.00 | 4.25 | 9.83 | 2.93 | 51.56 | 9.90 |
| Medical Officer | 16.73 | 4.38 | 12.00 | 4.15 | 8.83 | 2.03 | 49.56 | 10.90 |
| Technician, technicians, other | 15.82 | 1.24 | 9.88 | 2.06 | 9.00 | 1.00 | 44.71 | 2.34 |
| **$X^2$** | 22.930 | | 9.081 | | 18.404 | | 4.170 | |
| **p** | 0.000 | | 0.041 | | 0.000 | | 0.024 | |

**$X^2$**: Chi-square test; Z: Mann–Whitney U test.

## 4. Discussion

Recently, it has been emphasized that spiritual aspects of the individual have vital importance in maintaining and improving health and coping with crisis situations in which health is impaired (Büssing and Koenig 2010; Vincensi and Burkhart 2016). Individuals' spiritual values support life meaning and increase hope (Bhatnagar et al. 2016). It is important that spirituality, which has such positive effects on health, is used by health professionals in awareness and practice. However, many health professionals have inadequate knowledge of and ignore the spiritual dimension of the ill individual and fail to integrate it into primary care areas. In order for health professionals to care for their patients' spiritual needs, they need to know the nature of spirituality, its reflection in different individuals, and how individuals will evaluate and use spiritual coping strategies.

When examining the distribution of the descriptive attributes of participants involved in this research in a general framework, 29.4% were nurses, 53.3% were female, 32.5% were bachelor's degree graduates, 70% were between the ages of 31–40 years, 77.2% of them had professional experience between 11–15 years, and 25.9% worked in surgical clinics. According to these results, it can be interpreted that participants who have a special knowledge, skill, and experience and who are working in different units within the hospitals at the same time are experienced in terms of age and working time. It is seen that the largest proportion of the the health care workers in the survey group are nurses and doctors. It is thought that the higher participation of the nurse group in the survey compared to the other occupational groups is due to nurses having the greatest number of cadres among the hospital staff and the small number of physicians willing to participate in the study. In the literature, almost all of the studies on health workers and nursing students related to spirituality and spiritual care have a higher participation rate of the female gender group (Kavak et al. 2017; Kavas and Kavas 2015; Çelik and Akhan 2016; Midilli et al. 2017). In addition, Esendir and Kaplan (2018) found that a large majority of participants in the study of health workers were female, nurses, bachelor's degree graduates, and had professional experience of over 16 years. The results of the current study support the findings of the previous study (Esendir and Kaplan 2018). In this study,

54.3% of the participants said that they did not receive education about spirituality, 53.2% said that they did not find enough training on spirituality and spiritual care, and 36% of the participants received this training from the church, mosque, synagogue, etc. The results of the studies carried out in the literature are similar to the results of this study (Kalkim et al. 2016; Çelik and Akhan 2016; Midilli et al. 2017; Lopez et al. 2015; Lovanio and Wallace 2007; Wu et al. 2012).

In the current study, it was determined that 54.3% of the participants did not receive education about spirituality, 64.4% of them did not find enough education about spirituality and spiritual care, and 41.1% of the educated people received this education from their own sanctuary. The results of other studies on the subject are also similar to those of this study. It was also found out that 52.8% stated that the patients did not have their spiritual care needs met, and 32.4% stated that this was due to personnel deficiency. It was determined that 31.4% of the respondents who were able to meet patients' spiritual needs stated psychological support in their illnesses as being foremost when evaluating the interventions to meet the patients' spiritual needs. According to the study by Eğlence and Şimşek (2014), the nurses stated that the lack of time, lack of personnel, lack of knowledge, and the lack of opportunities were the reasons that the spiritual care needs of the patients were not met (Eğlence and Şimşek 2014). Van Leeuwen et al. (2006) showed a lack of time and lack of education among the reasons for the inability of nurses to meet the spiritual care needs of patients (Van Leeuwen et al. 2006).

In the study, it was determined that the total average score of the health workers received from the SSCGS was moderate when the maximum and minimum scores were taken into consideration. The perception of spiritual support of health professionals may be indicative of a moderate increase in the total point average level, which suggests that healthcare personnel in this group are positively approaching spiritual care work and that patients need this support. Findings of studies with nurses in the literature are similar to findings of our study (Yılmaz and Okyay 2009; Kostak et al. 2010; Özbaşaran et al. 2011; McSherry and Jamieson 2011; Eğlence and Şimşek 2014; Çelik and Akhan 2016). The difference between the subscales of the SSCGS and the mean of the difference between subscales of the Spiritual and Spiritual Care Grading Scale and the mean of the total points of the groups was significant ($p < 0.05$). Female participants' scores were found to be higher, suggesting that being a woman affected the perception of spiritual care. Çelik and Akhan (2016) also found a statistically significant difference between the mean of scale scores of the female gender group (Çelik and Akhan 2016). In contrast to our study, gender was found to have no effect on spirituality and spiritual perception levels in other studies (Kavas and Kavas 2015; Kavak et al. 2017; Esendir and Kaplan 2018). The number of nurses in our study was large and the majority of them consisted of females with varying levels of perceptions of spirituality and spiritual care.

The subscales of the SSCGS according to age were significantly different ($p < 0.05$) and higher in the group aged between 31–40 years ($p < 0.05$). The subscales of the scale and the mean of the total scores were significantly higher between the groups ($p < 0.05$) than the participants who had at least 16 years' experience. It can be said that the perception of spirituality and spiritual care is higher for those who are older in the study, because of the increase of professional experience together with age, and because they provide the awareness of the individuals themselves. It has been determined that age does not affect the perception of spirituality and spiritual care in other studies, contrary to the results of our study (Yılmaz and Okyay 2009; Kostak et al. 2010; Eğlence and Şimşek 2014; Kavas and Kavas 2015; Çelik et al. 2014). According to the educational status of the participants, the subscales of the Spirituality and Spiritual Care Grading Scale and the mean of the total points were significantly different between the groups and the average score of those with undergraduate education was higher ($p < 0.05$). The number of graduates among the groups suggests that this is the reason why, and it was also taken into consideration that, during undergraduate education, there was training about spirituality and spiritual care (Wong et al. 2008; Yılmaz and Okyay 2009). It was found that the level of education of nurses affected the perception of spirituality and that the level of education increased the nurses' perception of spirituality and spiritual care subdimensions, and total point averages were significantly different between the groups, with nurse averages being higher ($p < 0.05$). The subscales of the SSCGS were significantly different between the groups in terms of the

subscales of the participants, and the scores of those in the surgical and general intensive care units were higher ($p < 0.05$). According to the state of spiritual care education, the subscales of the Care Grading Scale and the differences between the groups' mean of the total scores were significant, and the average score of those who did not receive education was lower than the overall average scores. The high average score of those working in surgical and general intensive care units in the study suggests that the patients in this clinic have different needs caused by the specific and multiple processing environments and that the employees are, thus, more sensitive.

## 5. Conclusions and Recommendations

In this study, the health professionals (physicians, midwives and nurses, health officers, health technicians) were evaluated by the spirituality and spiritual perception survey questionnaire. As a result, it was determined that the level of total points received by the health professionals from the SSCGS was moderate (52.13 ± 10.13). This result showed that health professionals have a sense of spirituality and spiritual care, but they do not use it in practice, that is, while caring for the patient, due to lack of time and lack of knowledge. For health professionals who do not receive any training in spiritual care or do not find adequate training, it is recommended to provide supportive training and information about the subject after graduation as well as during undergraduate training. It is thought that the number of health workers will be increased to support the process of spiritual care by providing patient-oriented work plans complementary to their jobs.

**Author Contributions:** F.Ç. and K.T. conceived and designed the study; F.Ç. recruited participants; K.T. conducted data collection; F.Ç. analyzed the data; F.Ç. and K.T. wrote the paper; and K.T. edited and reviewed the paper.

**Funding:** This research received no external funding.

**Conflicts of Interest:** The authors declare no conflict of interest.

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