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ORIGINAL PAPER

Developing and Testing a Spiritual Care Questionnaire in the Iranian Context

Sedigheh Iranmanesh · Batool Tirgari · Mohammad Ali Cheraghi

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Abstract As most research exploring nurses' perceptions on the topic of spiritual care was conducted in Western countries, these findings may not be applicable in Iran because of cultural and health system differences. Therefore, a new survey instrument was developed for the Iranian context. The study was conducted in two steps: (1) development and validation of items for perception scale and (2) distribution of the questionnaire among nursing students to determine scale reliability and construct validity. The preliminary scale consisted of 50 items designed to measure the participants' perception of spiritual care. Construct validity of the scale was examined on the remaining 33 items. On interpretation of the items, the following four components were identified: (1) meeting patient as a being in meaning and hope, (2) meeting patient as a being in relationship, (3) meeting patient as a religious being, and (4) meeting patients as a being with autonomy. The results in this paper showed that preserving dignity in the nurses' practice meant getting involved in interpersonal caring relationships, with respect for the involved peoples' religious beliefs and their autonomy. Proper education and professionally led supervision with reflection on past and recent experiences may develop student nurses' and nurses' perceptions as well as their attitudes toward spiritual care and to achieve a realistic view of the profession.

Keywords Spiritual cares · Nursing students · Questionnaire development · Iran

S. Iranmanesh · B. Tirgari (✉)
Razi Faculty of Nursing and Midwifery, Kerman Medical University, Kerman, Iran
e-mail: b_tirgari@yahoo.com

S. Iranmanesh
e-mail: s_iranmanesh@kmu.ac.ir

M. A. Cheraghi
Faculty of Nursing and Midwifery, Tehran University of Medical Sciences, Tehran, Iran
e-mail: Cheraghiali2000@yahoo.com

Introduction

Given that the spirit is the core of person's being, it is certainly essential to address spiritual care in nursing practice (Mauk and Schmidt 2004). The role of nursing as caring assumes the spiritual dimension of being and is thus a priority for nursing care (O'Brien 2004). Fundamentally, spiritual care seeks to affirm the value of each and every person based on nonjudgmental love (Wright 2002). According to Rumbold (2007) from a bio-medical perspective, in which health is implicitly defined as the absence of disease, spirituality lies beyond the scope of medical expertise; it is seen as the private concern of the patient. In spite of this perspective, nursing is becoming an increasingly important source of insight into the relationship between aspects of spirituality, health, and health care. However, certain aspects of the topic are contested, such as the conceptualization of spirituality and the nurses' role in providing spiritual care (Leeuwen et al. 2006). Providing spiritual care requires spiritual needs' assessments and meeting those needs. Carrying out spiritual assessments in a health care context clearly involves making assumptions about the relationship between spirituality and health (Rumbold 2007). According to Hodge (2001), a spiritual assessment consists of two parts and includes a spiritual or religious history as well as an inventory of the strengths and resources in a client's life. However, a qualified spiritual intervention requires well assessment.

The review revealed that different cultures place different values on spiritual intervention. Soerens (2001) reported that primary health providers need to be able to offer patients numerous nonreligious spiritual care interventions. Several studies found different interventions to provide spiritual care. These are active listening (Taylor 2003; Milligan 2004; Grant 2004), supportive talking (Taylor 2003; McGrath and Clarke 2003; Grant 2004), reminiscing (Bickerstaff et al. 2003), silence (McGrath and Clarke 2003), and ability to ask gentle probing questions (O'Brien 2003). McGrath (2002) agrees that spiritual care often involves the 'quintessential of the ordinary'. Other interventions are more ritualistic; they involve prayer and meditations or sacred and religious practices such as the last rites and communion (O'Brien 2003). Meraviglia (2002) concluded her study by saying prayer could lessen the effect of physical and psychological responses on cancer, and it was an expression of the human spirit in connection with God. Similarly, Albaugh (2003) reported that patients had shared that they received a sense of comfort from their spiritual belief and how a trust in God provided the means for them to get through the illness to either restoration of health or death. The patients also described they found strength from verses, prayers, scripture readings, and songs. They viewed the firm foundation of their faith in God would sustain them throughout the illness. The others found that spiritual care could be like meaningful connections such as touch (Brykczynska 1997), music (Salmon 2001; Hays and Minichiello 2005), and poetry reading (Charles 2004).

According to Grant (2004), there is no doubt that health care is concerned with providing the best care possible and the abundance of literature on the subject indicates that nurses affirm the 'efficacy of spiritual care' and they should be aware of these matters. Milligan (2004) also found that practitioners find it difficult to identify and attend to the spiritual needs of patients (Milligan 2004). However, McEwen (2004) asserts that despite ubiquity in the academic literature, spirituality as an important component of care is not well presented or taught as part of the nursing education. Based on the studies of Narayanasamy and Owens (2001) and Grant (2004), although most nurses feel that spiritual care is part of their role, many feel that they lack understanding of how to put this into practice. Additionally, Maclachlan (2004) claims that different cultures place different values on body images and people's self-evaluation. Examining nursing students'

perception of spiritual care is therefore important in the current Iranian context. Although Iranian people are believed to be religious, but their world views is a combination of magic, religion, mysticism, and theology, reflected in their poets and arts (Tabari 1970). According to Hunter (1990), Iranian Islam has been influenced by pre-Islamic philosophical, religious, and cultural traditions. Anyhow, Islam is the dominant religion in Iran and for Iranian there is no distinction between religion and spirituality. In fact, the concept of religion is embedded in the umbrella of spirituality.

As most research exploring nurses' perception on this topic was conducted in Western countries, these findings may not be applicable in Iran because of cultural and health system differences. Therefore, a new survey instrument was developed for the Iranian context.

Design

The study was conducted in two steps: (1) development and validation of items for perception scale and (2) distribution of the questionnaire among nursing students to determine scale reliability and construct validity.

Step 1. Development of the Instrument

A critical review of the literature, analysis of similar questionnaires (Narayanasamy 2004; McSherry et al. 2002; Anandarajah and Hight 2001; Burkhardt 1989) and key informant interviews were conducted to identify appropriate issues. Items were constructed to measure themes of personal and professional perceptions of spiritual care. Items were randomly distributed throughout the instrument. The preliminary scale consisted of 50 items designed to measure the participants' perception of spiritual care. The questions were graded from 0–5 (0 = strongly disagree, 5 = strongly agree). A questionnaire was designed to obtain background information that was assumed to influence spiritual care perception. It was based on the experiences of a pretest among students. It included questions about gender, age, marital status, and intrinsic as well as extrinsic religiosity. The original version was developed in English and, after initial validation, translated to Farsi for further validation.

Content Validity

The validity of scale has been assessed through a content validity discussion. Scholars of statistics and nursing care have reviewed the content of the scales from religious and cultural aspects of spiritual care and agreed upon a reasonable content validity. For translation of questionnaires from English into Farsi, the standard forward–backward procedure was applied. Translation of the items and the response categories independently performed by two professional translators and then temporary versions were provided. Afterward, they were back translated into English, and after a careful cultural adaptation, the final versions were provided. Translated questionnaires went through pilot-testing. Suggestions by nursing students were combined into the final questionnaire version.

Phase 2. Survey of Nursing Students

The ethical implication of the study was approved by the head of nursing faculty prior to the collection of data. The study employed a descriptive design and was conducted in

Kerman Medical University, Razi Faculty of Nursing and Midwifery. Accompanied by a letter including some information about the aim of the study, the questionnaires were handed out by the first author to 200 third- and fourth-year nursing students. Some oral information about the study was also given as well by the first author. Participation in the study was voluntary and anonymous. In total, 200 sets of questionnaires were distributed with no drop out. In all collected data, 98% of all questions were answered. Data from the questionnaires were analyzed using the Statistical Package for Social Scientists (SPSS, version 17). A Kolmogorov–Smirnov test indicated that the data were sampled from a population with normal distribution.

Validity and Reliability of Scale

To examine the context validity of the four identified components of the scale, a factor analysis (Rotated Component Matrix) on the results was done. The aim of principal component analysis was to evaluate the construct validity of the scale and to reduce the range of variables to a smaller number of components for interpretation. The steps carried out were as follows: (1) determining sample adequacy for principal component analysis by computing the Kaiser-Meyer Olkin (KMO) measurement of sampling adequacy; (2) determining the number of components to be extracted and rotated; and (3) interpreting the rotated factor matrix using factor loadings of 0.4 as the cutoff. To assess the reliability of scale, alpha coefficients of internal consistency and 3-week test–retest coefficients ($n = 20$) of stability were computed.

Results

Participants

A descriptive analysis of the background information revealed that about 80% of participants were females. All of them belonged to the age group of 20–29 years of age (mean = 25). About 88% were single. Considering religiosity, while 96.6% of respondents reported that they always experience God existence in their daily life, 65% claimed that they attended to the religious services daily. Of participants, 79.9% stated that they attended to the religious activities like pray daily. No significant correlation was found between background information and spiritual care items.

Reliability and Validity

The alpha coefficient of the scale was 0.78. The 3-week test–retest coefficient of stability was 0.80. Seventeen items were deleted as alpha coefficient was under 0.4. Alpha coefficient was reconducted on the remaining 33 items, resulting in increased internal consistency ($\alpha = 0.89$). Construct validity of the scale was examined on the remaining 33 items. The KMO measure of sampling adequacy was computed to determine the adequacy of the items for analysis within this sample. The KMO was 0.57. Four components with an eigenvalue >1 were identified. Mean and standard deviation for each item were shown in Table 1. Using latent root extraction, this was considered too high for 33 items. The screen test showed four strong components. These four components were shown in Table 2. In further examination and interpretation of the items, the following four components were

Table 1 Mean and SD in each component

Question	M	SD
Component1: meeting patient as a being in meaning and hope		
1.1: Being aware of patients' source of meaning and hope in life	3.77	1.153
1.2: Providing spiritual care by enabling a patient to find meaning in the good and bad events of life	4.42	0.741
1.3: Knowing what is truly important to the patient	4.41	0.698
1.4: Being aware of patients' perception of meaning and purpose in life	3.09	1.478
1.5: Assisting patient to have positive view on life	3.60	1.172
1.6: Being aware of things that patient is unable to do them in life	4.54	0.593
Component 2: meeting patient as a being in relationship		
2.1: Being available to listen to patients' feeling	3.97	1.068
2.2: Talking with patient to relive the sense of guilt	3.87	0.971
2.3: Giving support to patient and express empathy with him \her	3.87	1.041
2.4: Encouraging participation in interact with family members, friend, and others	3.60	1.172
2.5: Delivery of flower by visitors (family friends,…)	3.36	1.069
2.6: Staying with patient and being alongside him/her	3.89	1.100
2.7: Providing meeting with similar patients	3.78	1.124
2.8: Calling long-lost friend	4.04	1.072
Component 3: meeting patient as a religious person		
3.1: Jointing with patient in prayer and reciting the Quran, if desired	3.34	1.451
3.2: Reassuring the patient that God is listening, loving, and caring	3.61	1.302
3.3: Blessing for patient, if desired	3.61	1.510
3.4: Assisting patient who is unable to perform his religious worship	3.98	0.964
3.5: Providing radio or TV religious programs to the patient	3.86	1.092
3.6: Encouraging patient to do religious ritual	3.98	1.005
3.7: Encouraging patient to use religious worship and cultural tradition	3.78	1.097
3.8: Putting a prayer book within reach	4.14	0.899
3.9: Facilitating cultural practice that patients and their family find comforting	4.08	0.692
3.10: Giving information to the patient about how to do some worship at the time of disease	4.22	0.970
Component 4: meeting patients as a being with autonomy		
4.1: Being not allowed to judge about patients' religious views	3.04	1.230
4.2: Providing peace of mind for patient	4.00	1.172
4.3: Accepting patients who are stick on their beliefs about spirituality	3.88	1.113
4.4: Respect for patients who have different religious views	4.49	0.659
4.5: Allowing patient to eat his/her favorite food	3.69	1.042
4.6: Providing opportunity for patient to meet his/her family to relief his/her spiritual pains	3.84	1.117
4.7: Respect for patient's willing to stay whether at home or at hospital	3.88	1.113
4.8: Being attention to patients' spiritual views	3.65	1.085
4.9: Talking about spiritual care, if patient desired	4.09	1.026

Table 2 Rotated factor matrix: revised 33-item version

Item	Content	Component			
		1	2	3	4
6	Being aware of patients' source of meaning and hope in life	**0.675**	0.086	0.170	0.033
7	Providing spiritual care by enabling a patient to find meaning in the good and bad events of life	**0.670**	−0.040	0.016	−0.119
8	Knowing what is truly important to the patient	0.**668**	0.167	0.350	−0.004
9	Being aware of patients' perception of meaning and purpose in life	**0.564**	−0.126	0.297	0.083
37	Assisting patient to have positive view on life	**0.556**	0.137	−0.023	0.058
11	Being aware of things that patient is unable to do them in life	**0.485**	−0.043	0.130	0.286
38	Being available to listen to patients' feeling	0.219	**0.805**	−0.044	0.069
39	Talking with patient to relive the sense of guilt	0.152	**0.787**	0.152	−0.024
35	Giving support to patient and express empathy with him \her	−0.243	**0.750**	0.373	0.205
45	Encouraging participation in interact with family members, friend, and others	−0.084	**0.698**	−0.114	0.292
44	Delivery of flower by visitors (family friends,…)	0.151	**0.694**	−0.131	−0.014
34	Staying with patient and being alongside him/her	0.021	**0.600**	0.297	0.243
42	Providing meeting with similar patients	0.277	**0.556**	0.171	0.009
29	Calling long-lost friend	0.137	**0.437**	−0.023	0.058
21	Jointing with patient in prayer and reciting the Quran, if desired	0.010	−0.048	**0.864**	−0.076
22	Reassuring the patient that God is listening, loving and caring	0.272	−0.123	**0.836**	−0.050
17	Blessing for patient, if desired	0.152	0.147	**0.834**	0.040
20	Assisting patient who is unable to perform his religious worship	0.298	−0.058	**0.762**	−0.035
24	Providing radio or TV religious programs to the patient	0.211	0.227	**0.670**	−0.001
19	Encouraging patient to do religious ritual	0.022	−0.011	**0.561**	0.035
50	Encouraging patient to use religious worship and cultural tradition	0.099	−0.094	**0.538**	0.460
16	Putting a prayer book within reach	0.216	0.176	**0.522**	0.061
4	Facilitating cultural practice that patients and their family find comforting	0.134	0.306	**0.475**	0.127
15	Giving information to the patient about how to do some worship at the time of disease	0.261	−0.035	**0.457**	0.253
48	Being not allowed to judge about patients' religious views	−0.042	0.186	−0.261	**0.680**
33	Providing peace of mind for patient	0.62	0.314	0.051	**0.671**
26	Accepting patients who are stick on their beliefs about spirituality	0.136	0.334	−0.284	**0.590**
2	Respect for patients who have different religious views	0.080	0.142	0.076	**0.571**
47	Allowing patient to eat his/her favorite food	−0.101	0.167	0.353	**0.513**
14	Providing opportunity for patient to meet his/her family to relief his/her spiritual pains	0.292	−0.052	0.356	**0.495**
28	Respect for patient's willing to stay whether at home or at hospital	0.107	0.093	0.165	**0.485**
30	Being attention to patients' spiritual views	0.339	0.118	0.148	**0.481**
1	Talking about spiritual care, if patient desired	0.110	0.254	0.190	**0.415**

Bold indicates the highest factor loading in each component

identified: (1) meeting patient as a being in meaning and hope, (2) meeting patient as a being in relationship, (3) meeting patient as a religious being, and (4) meeting patients as a being with autonomy.

Findings and Discussion

Component 1: Meeting Patient as a Being in Meaning and Hope

Student nurses perceived spiritual care as meeting patient as a being in meaning and hope. A significant number of participants (55%) believed that spiritual care is enabling a patient to find meaning in the good and bad events of life. Half of them perceived spiritual care as being aware of patients' source of meaning and hope in life as well as knowing what is truly important to the patient. In addition, 45% thought that being aware of patients' perception of meaning and purpose in life is spiritual care. Earlier studies indicated that many people with cancer and illness perceived spirituality as search for meaning. It is a search that takes on different expressions and an answer to the search may not always be found (Walton and Clair 2000; Daaleman et al. 2001; Taylor 2003; Murray et al. 2004; Narayanasamy 2004); McSherry et al. (2004) through a survey development also found that spiritual care is assisting patient to find meaning in their life. Several researches explored nurses' experiences of spiritual care (Wong and Yau 2009; Kociszewski 2004; Carroll 2001; Greasley et al. 2000). Based on their findings, assisting patients to find the meaning in life was one of the meaning nurses give to the spiritual care. The finding revealed that participants (50%) perceived spiritual care as assisting patient to have positive view on life. Walton and Clair (2000); Daaleman et al. (2001); Hermann (2001); Shirahama and Inoue (2001); Lang Dora et al. (2006); and Taylor (2003) also found hope and positivity as important aspect of spirituality and spiritual care. According to Iranmanesh et al. (2009), giving hope to the patients is one of the most important parts of Iranian nurses' care especially when they deal with terminally ill patients. According to the factor analysis, component 1 consists of both giving hope to the patients and finding meaning. Tutton et al. (2009) claimed that hope is focus on the future and the meaning that activities, events have for individuals. They go on that it may involve a cognitive process identifying goals or be based on feelings about life and what people would like to happen, as given in Table 3.

Component 2. Meeting Patient as a Being in Relationship

Most of participants (55%) believed that spiritual care is calling long-lost friends to hospital.

Murata (2003) asserted that to alleviate spiritual pain of persons as being in relationship, we must pay attention to those who connect the patients to others beyond death among various persons and events that are mentioned. Forty-nine percent of participants reported that staying with patient and being alongside him is spiritual care. Participants (40%) perceived spiritual care as talking with patient to relive the sense of guilt as well as giving support to patient and express empathy with him. Similarly, nurses in some researches described spiritual care as being there and presence (Kuuppelomaki 2001; Narayanasamy and Owens 2001; Narayanasamy et al. 2002; 2004). The others also reported that patients perceived spiritual care as being present (Grant 2004; Sellers 2001; Emblen and Halstead 1993). Spiritual care also perceived by students as talking with patient to relief the sense of guilt as well as giving support to patient and express empathy with him. Spiritual care

Table 3 Frequencies in each component

Question	SA (%)	A (%)	MA (%)	MD (%)	D (%)	SD (%)
Component1: meeting patient as a being in meaning and hope						
1.1: Being aware of patients' source of meaning and hope in life	50	34	1	8	6	1
1.2: Providing spiritual care by enabling a patient to find meaning in the good and bad events of life	55	34	9	2	0	0
1.3: Knowing what is truly important to the patient	50	43	6	0	1	0
1.4: Being aware of patients' perception of meaning and purpose in life	36	45	13	4	0	0
1.5: Assisting patient to have positive view on life	44	50	5	0	0	0
1.6: Being aware of things that patient is unable to do them in life	37	46	15	2	0	0
Component 2: meeting patient as a being in relationship						
2.1: Being available to listen to patients' feeling	36	38	19	1	6	0
2.2: Talking with patient to relive the sense of guilt	28	40	27	1	4	0
2.3: Giving support to patient and express empathy with him \her	29	44	16	7	4	0
2.4: Encouraging participation in interact with family members, friend, and others	19	39	30	6	6	0
2.5: Delivery of flower by visitors (family friends,…)	9	34	29	22	4	2
2.6: Staying with patient and being alongside him/her	29	49	16	5	2	0
2.7: Providing meeting with similar patients	36	24	14	0	0	0
2.8: Calling long-lost friend	55	34	16	0	0	0
Component 3: meeting patient as a religious person						
3.1: Jointing with patient in prayer and reciting the Quran, if desired	22	32	24	11	2	9
3.2: Reassuring the patient that God is listening, loving, and caring	54	32	10	4	0	0
3.3: Blessing for patient, if desired	36	24	26	2	3	9
3.4: Assisting patient who is unable to perform his religious worship	33	41	19	6	1	0
3.5: Providing radio or TV religious programs to the patient	31	38	23	4	4	2
3.6: Encouraging patient to do religious ritual	33	46	9	10	2	0
3.7: Encouraging patient to use religious worship and cultural tradition	27	28	11	10	12	12
3.8: Putting a prayer book within reach	38	46	10	4	2	0
3.9: Facilitating cultural practice that patients and their family find comforting	46	32	14	4	4	0
3.10: Giving information to the patient about how to do some worship at the time of disease	55	32	14	6	1	0
Component 4: meeting patients as a being with autonomy						
4.1: Being not allowed to judge about patients' religious views	24	47	16	5	7	0
4.2: Providing peace of mind for patient	32	35	16	13	4	0

Table 3 continued

Question	SA (%)	A (%)	MA (%)	MD (%)	D (%)	SD (%)
4.3: Accepting patients who are stick on their beliefs about spirituality	33	38	8	1	2	0
4.4: Respect for patients who have different religious views	39	20	24	10	6	1
4.5: Allowing patient to eat his/her favorite food	56	17	15	12	0	0
4.6: Providing opportunity for patient to meet his/her family to relief his/her spiritual pains	45	30	13	8	4	0
4.7: Respect for patient's willing to stay whether at home or at hospital	54	16	9	10	11	0
4.8: Being attention to patients' spiritual views	14	21	21	14	20	10
4.9: Talking about spiritual care if patient desired	41	39	15	3	2	0

Values are given as (%)

SA Strongly agree; *A* Agree; *MA* Moderately agree; *MD* Moderately disagree; *D* Disagree; *SD* Strongly disagree

consists of listening, laughing, or physical touching. These cares included communication skills such as listening and supportive talking (McGrath and Clarke 2003; Taylor 2003; Milligan 2004). Spiritual care is about doing, rather than being, and implies that the nurse is superior to the client. It involves a way of being (rather than doing) that requires a symmetric nurse-client relationship (Taylor and Mamier 2005).

Component 3: Meeting Patient as a Religious Being

This component consists of 10 items described that spiritual care as meeting patient as a religious being. According to Wong and Yau (2009), there is ambiguity between the terms spirituality and religion. It is suggested that spirituality is the experiential individual descriptor, whereas religion is the conceptual group descriptor (Harkreader and Hogan 2004). Religion is characterized as formal, organized, and associated with rituals and beliefs. Although many people chose to express their spirituality through religious practices, some of them find that spirituality should be manifested as harmony, joy, peace, awareness, love, meaning, and being (Chung et al. 2006). Additionally, Iran is a country that is ruled by the authority's theocrats and is regarded as a religious country. Almost all Iranians (99.4%) consider themselves as religious (Surveys 2000). According to the findings, 96.6% of respondents reported that they always experience God existence in their daily life and 65% claimed that they attended to the religious services daily. Of participants, 79.9% stated that they attended to the religious activities like pray daily. Through a research, Iranmanesh et al. (2008) found that majority of Iranian nurses reported that they always experience God existence in their daily life and attended to the religious activities like pray daily. Majority of nursing students (54%) strongly agreed that spiritual care is reassuring patient that God is listening, loving, and caring. Similarly, Taleghani et al. (2006) reported that Iranian patients who have cancer used interchangeably spiritual and religious coping activities. They go on that most patients believed their disease to be some form of test by God. They concluded that providing spiritual care demand nurses to pay more attention to the religious aspects of coping with the disease through worship and praying as an important cultural strategy in caring for Iranian patients.

Fifty-five percent of students strongly believed that nurses should inform patient how to do some worship at the time of disease. Participants (46%) also claimed that nurses should place a prayer book within reach. Many researches conducted to examine patients' perception of spirituality as well as spiritual care, and they concluded that religious beliefs is the main part of spirit (Cavendish et al. 2000; Walton and Clair 2000; Chiu 2001; Daaleman et al. 2001; Hermann 2001; Shirahama and Inoue 2001; Lowry and Conco 2002; Taylor 2003; Murray et al. 2004; Narayanasamy 2004). There are also some researches assessed nurses' perception of spiritual care, and they found that meeting religious needs is the main part of care of spirit (Hubbell et al. 2006; Milligan 2004; Musgrave and McFarlane 2004; McSherry and Ross 2002; and Narayanasamy and Owens 2001).

Component 4: Meeting Patients as a Being with Autonomy

This component included 10 items determined that spiritual care is meeting patient as a being in autonomy. Forty-five percent of participants stated that if the patient is comfortable with his family for eliminate the spiritual needs, nurses assigned to this duty to the family. Forty-one percent believed that spiritual care means that nurse can talk about spiritual care if patient desired. According to Murata (2003), spiritual pain of the person as a being with autonomy develops from the experience of heteronomy and dependence on others, that is, "becoming unable to do anything". He goes on that if the patient becomes aware that he/she still has enough freedom of self-determination in each dimensions of perceiving, thinking, speaking, and doing, that is, the perception, thoughts, expression, and activities through his/her talks with spiritual care workers, he/she is certain to recover the sense of value as a being with autonomy. The goal of respect for the patient's autonomy is to "empower" the patient to express the values he or she holds and to understand autonomy as one feature of the patient's integrity or wholeness (Thomasma 1995). Fifty-six percent of nursing students reported that spiritual care is allowing patient to eat his/her favorite food. Fifty-four percent stated that care of spirit means that nurses should respect patient's willing to stay whether at home or at hospital. Similarly, Iranmanesh et al. (2009) concluded that developing professional care demands nurses to support patients' well-being through positive stimulation of all means of perceiving the world through human senses e.g., offer beautiful views and good tastes. Milligan (2004) also explored nurses' perception of spiritual care and found valuing and supporting autonomy as one of the meaning nurses gave to their care of spirit.

Conclusion

The results in this paper showed that preserving dignity in the nurses' practice meant getting involved in interpersonal caring relationships, with respect for the involved peoples' religious beliefs and their autonomy. Professional caregivers must be sensitive and pay attention to the preferences of each unique person's perceptions through her or his senses. This includes views, tastes, sounds, smells, and bodily contact. These circumstances deserve attention in all educational programmes and especially in programmes dealing with end of life care. In order to implement holistic care, caregivers must pay attention to patients' spiritual needs. Student nurses and nurses should be offered opportunities to reflect on their experiences, feelings, actions, and reactions to spiritual care in order to enhance the possibilities to utilize personal experiences as a part of positive and constructive learning. This requires access to professional supervision for reinterpreting

their personal and professional experiences. Proper education and professionally led supervision with reflection on past and recent experiences may develop student nurses' and nurses' perceptions as well as their attitudes toward spiritual care and to achieve a realistic view of the profession.

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