Araştırma makalesi

Research article

Attitudes Towards Death and Perceptions of Spiritual Support of Nurses Caring for Patients in the Terminal Period: A Descriptive and Correlational Study

Yurdagül SELVİ[1], Figen İNCİ[2], Zehra ÇALIŞKAN[3]

ABSTRACT

Aim: This descriptive and correlational study was conducted to analyze the attitudes towards death and spiritual support perceptions of nurses who care for patients in the terminal period and their relationship.

Material and Methods: The population consisted of 378 nurses. The study sample was calculated according to the sample size of a specific population and included 198 nurses. The data were collected with the Personal Information Form, Attitude towards Death Scale, and Perception of Spiritual Support Scale. Data were analyzed using Kruskall Wallis Analysis of Variance, Correlation Analysis, and Mann-Whitney U Test.

Results: The nurses' gender and education level caused a difference in terms of their attitudes towards death. Fear of death and death avoidance scores of women were higher than those of men. As the educational level of nurses increases, their attitudes towards death change positively. As the perception of spiritual support increases, the positive attitude towards death also increases.

Conclusion: It can be said that paying attention to variables such as gender, education level, and attitude towards death while planning the nurse workforce in inpatient units where end-of-life care is provided will increase the quality of nursing care.

Keywords: End-of-life care, death anxiety, nursing, spiritual care

ÖZ

Terminal Dönemdeki Hastalara Bakım Veren Hemşirelerin Ölüme Karşı Tutumları ve Manevi Destek Algıları: Tanımlayıcı ve İlişki Arayıcı Çalışma

Amaç: Araştırma, terminal dönemdeki hastalara bakım veren hemşirelerin ölüme karşı tutumları, manevi destek algıları ve bunlar arasındaki ilişkinin incelenmesi amacıyla tanımlayıcı ve ilişki arayıcı türde yapılmıştır.

Gereç ve Yöntem: Evreni 378 hemşire oluşturmuştur. Örneklem ise, evreni bilinen örneklem büyüklüğü yöntemine göre hesaplanmış ve 198 hemşire örnekleme alınmıştır. Veriler Kişisel Bilgi Formu, Ölüme Karşı Tutum Ölçeği ve Manevi Destek Algısı Tespit Ölçeğiyle toplanmıştır. Veriler Kruskall Wallis Varyans Analizi, Korelasyon Analizi ve Mann-Whitney U Testiyle değerlendirilmiştir.

Bulgular: Hemşirelerin cinsiyetleri ve eğitim düzeyleri ölüme ilişkin tutumları açısından farklılığa neden olmuştur. Kadınların ölüm korkusu ve ölümden kaçınma puanları erkeklere göre daha yüksektir. Hemşirelerin eğitim düzeyi arttıkça ölüme ilişkin tutumları olumlu yönde değişmektedir. Ölüme ilişkin olumlu tutum arttıkça manevi destek algıları da artmaktadır.

Sonuç: Yaşam sonu bakımın verildiği kliniklerde hemşire işgücü planlanırken cinsiyet, eğitim düzeyi ve ölüme ilişkin tutum gibi değişkenlerin dikkate alınmasının hemşirelik bakımının niteliğini artıracağı söylenebilir.

Anahtar kelimeler: Hemşirelik, manevi bakım, ölüm kaygısı, yaşam sonu bakım

[1]Science Specialist, PhD Student, Department of Mental Health and Diseases Nursing, Erciyes University, Kayseri, Turkey, e-mail: yurdagulselvi@gmail.com, Phone: +90 5552895853, ORCID: 0000-0001-6095-8956
[2]Assoc. Prof. Dr, Department of Psychiatric Nursing, Niğde Ömer Halisdemir University, Niğde, Turkey. e-mail: figeninci@gmail.com, Phone: +90 5335445374, ORCID: 0000-0002-9977-4297
[3]Assoc. Prof. Dr, Department of Child Health and Diseases Nursing, Nevşehir Hacı Bektaş Veli University, Nevşehir, Turkey, e-mail: zcaliskan26@gmail.com, Phone: +90 5362381138, ORCID: 0000-0002-4726-5052
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INTRODUCTION

The most compatible action with human consciousness is to continue one's existence. Therefore, it is not easy to accept the disappearance of human consciousness, in other words, the fact that our existence has an end[1]. Every situation that reminds us of human mortality, such as diseases and old age, causes anxiety.

The improvements in the field of health, thanks to rapidly developing technology, make it possible to treat most life-threatening diseases and prolong people's lives. However, the number of chronic diseases and patients who need terminal care continues to increase[2,3]. During the terminal period, no treatment options are left, symptoms become more difficult to control, challenging questions are asked by the patients and their relatives, and emotional and spiritual needs increase, making caregiving difficult[3]. Additionally, the fact that "the patient is dying" means a loss for the nurse who provides care for them[4]. Like the patients' relatives, nurses may give emotional reactions such as fear, anger, or depression. These challenges may negatively affect the standard of care, which is a right of the terminally ill patient[2,3,5-7].

A holistic approach should be adopted, and patients' all biopsychosocial needs should be evaluated and met to provide terminally ill patients with quality care. For this to happen, first, the healthcare professionals working in this area should exhibit positive attitudes towards death[2,3,8].

The International Council of Nursing Ethics Committee states that "nurses should respect the spiritual beliefs, values, traditions, and human rights of individuals, families, and society". Nurses should provide appropriate care for patients' bio-psycho-socio-cultural and spiritual needs[9-10]. Studies showed that nurses were insufficiently aware of patients' spiritual needs, and the patient care plan included very limited information about the patients' spiritual needs[11,12]. Nurses' attitudes towards death may be effective in determining the spiritual needs of terminal patients. A limited number of studies on the subject have shown that one of the reasons for nurses' poor perception of spiritual support is their negative, non-accepting, and anxious attitudes towards death[9,13,14]. It is important to determine nurses' death attitudes to provide standard terminal care[1,3,15,16]. In order to improve the limited literature in the field and to provide quality terminal care, there is a need for more studies in different samples evaluating nurses' attitudes towards death, perceptions of spiritual support, and the relationship between them.

Aim

This research was conducted to analyze the attitudes towards death and the spiritual support perceptions of the nurses who provide care for terminally ill patients and the relationship between them**.**

MATERIAL and METHODS

Study Design

This study is a descriptive and correlational study.

Study Sample

The population consists of 378 nurses from two hospitals (one public and one private) in a city in the Central Anatolia Region of Turkey. The study sample was calculated according to the sample size of a specific population and included 198 nurses. The 131 nurses who participated in this study work in public hospitals and 67 nurses work in private hospitals. All nurses worked in inpatient units where terminal care was provided and agreed to participate in the research by choice. The units where end-of-life care is provided were determined as intensive care units, oncology units, and palliative care units. In a public hospital, there are 38 nurses working in general intensive care (adult), 16 in general intensive care (pediatric), 20 in oncology intensive care, 17 in palliative care, 36 in anesthesia intensive care, and 4 other (specialty nurses). In a private hospital, there are 16 nurses in general intensive care (adult), 7 in general intensive care (pediatric), 11 in oncology intensive care, 5 in palliative care, 8 in cardiovascular surgery intensive care, 16 in anesthesia intensive care and 4 other (specialty nurses). (131 in a public hospital, and 67 in a private hospital). The inclusion criteria included nurses working in intensive care units, oncology units, palliative care units and nurses who agreed to participate in the study.

Data Collection Tools

The data was collected using a personal information form created based on a literature review, the Death Attitudes Profile (DAP), and the Spiritual Support Perception Scale (SSPS). The personal information form consisted of nine questions on the participants' sociodemographic and professional characteristics[3,17]. The DAP is a 7-point Likert-type scale including 26 questions. It was developed to measure individuals' attitudes towards death. The scale consists of three subscales: Neutral Acceptance and Approach Acceptance (Subscale 1), Escape Acceptance (Subscale 2), and Fear of Death and Death Avoidance (Subscale 3). High mean scores in the subscales indicate a negative attitude. In the validity and reliability study, Cronbach alpha coefficients of the scales were determined as 0.86, 0.74, and 0.76, respectively[15]. The SSPS is a 5-Point Likert-type scale with 15 items. The scale has no subscale. It was developed to measure individuals' perceptions of spiritual support. High scale scores indicate good spiritual support perception and attitude. Cronbach alpha value of the scale was determined as 0.94[17].

Data Collection

The data collection forms were administered between August and October 2017 after written permissions were obtained from the required institutions. The data were collected through face-to-face interviews in the inpatient units where the participants worked during business hours (8:00 a.m. and 4:00 p.m.). Each interview lasted an average of 20 minutes.

Data Analysis

Statistical evaluations were carried out using the IBM SPSS Statistics 22 package program. The independent variables were the nurses' sociodemographic and professional characteristics, such as age, gender, education level, duration of time working as a nurse, and duration of time working in the clinic. The dependent variables were the

participants' scores on the DAP subscales and SSPS. For statistical significance, a p-value of less than 0.05 was accepted.

While the statistics were analyzed using numbers, percentages and averages, the relationship between the scales was analyzed using Spearman Correlation analysis since the data were not normally distributed. The differences between the scale scores according to the independent variables regarding the nurses' sociodemographic and professional characteristics were analyzed using the Mann-Whitney U test for binary groups and the Kruskal-Wallis test for more than two groups. Bonferroni correction was used for further analysis in more than two groups.

Ethical Dimension

The ethical conformity of the study was evaluated by the Ethics Committee of a university (2017/03-01) and the study was ethically approved. The required written permissions were obtained from the public hospital affiliated with the Turkish Public Hospitals Union, the General Secretary of a public hospitals union, and a private hospital. The participating nurses in the study were informed of the purpose of the research, and their verbal and written consent was acquired.

Limitations

Public hospitals are health institutions with higher capacity than private hospitals. Therefore, the number of nurses employed in public and private hospitals is not equal. This difference constitutes the limitation of the study.

RESULTS

Table 1 shows that the average age of the nurses was (31.01±6.65) years, and the average duration of employment was eight years (8.64±6.29). Approximately half of the nurses (52.5%) were undergraduate graduates. It is seen that they mostly worked in intensive care (adult) units (38.4%) and oncology services (19.2%).

Table 2 shows the participant scores on the scales. The nurses' positive death attitudes (Neutral Acceptance and Approach Acceptance/DAP Subscale 1) yielded the highest mean score; 63.45±9.87. The mean scores of the nurses' Escape Acceptance Attitudes (DAP Subscale 2) were 19.47±6.48, and Fear of Death and Death Avoidance (DAP Subscale 3) were 31.42±9.49. Their total SSPS score was 50.98±7.98.

Table 3 shows a statistically significant association connecting the nurses' scale scores according to their ages, duration of time working as a nurse, and duration of time working in their unit. The nurses' age (r= -0.145, p<0.05) and years of working (r= -0.160, p<0.05) had a negative, weak, and statistically significant association with the Escape Acceptance Attitudes (DAP Subscale 2). A negative, weak, and statistically significant association was found connecting the nurses' duration of time working in the unit and the Neutral Acceptance and Approach Acceptance (DAP Subscale 1) (r= -0.154, p<0.05). In addition, a positive, moderate, and statistically remarkable association was found between the nurses' SSPS scores and the Neutral Acceptance and Approach Acceptance (DAP Subscale 1) (r= 0.305, p<0.05).

Table 1. Nurses' Sociodemographic Characteristics (n= 198)

Characteristics	**X̄±SD**	
Age	31.01±6.65	
Duration of time working as a nurse (years)	8.64±6.29	
Duration of time working in the unit (month)	45.82±39.91	
	Number	**%**
Gender		
• Female	143	72.2
• Male	55	27.8
Marital Status		
• Single	79	39.9
• Married	119	60.1
Education Level		
• High School	46	23.2
• Associate's Degree	34	17.2
• Bachelor's Degree	104	52.5
• Postgraduate	14	7.1
The Unit They Worked in		
• Intensive Care (adult)	54	27.3
• Intensive Care (pediatric)	23	11.6
• Oncology	31	15.6
• Cardiovascular Surgery Intensive Care	8	4
• Palliative Care	22	11.2
• Anesthesia Intensive Care	52	26.3
• Other (Special Branch)	8	4
The Hospital Worked in		
• Public Hospital	131	66.2
• Private Hospital	67	33.8
Total	**198**	**100.0**

X̄: Mean, SD: Standard Deviation

Table 2. The Nurses' Mean Scores on the DAP and SSPS

SCALES	**X̄±SD**	**Med (Min-Max)**
Death Attitude Profile		
Neutral Acceptance and Approach Acceptance	63.45±9.87	63.00 (12.00-84.00)
Escape Acceptance	19.47±6.48	19.00 (5.00-35.00)
Fear of Death and Death Avoidance	31.42±9.49	31.00 (9.00-63.00)
Spiritual Support Perception Scale	50.98±7.98	52.00 (19.00-60.00)

X̄: Mean, SD: Standard Deviation, Med: Median (median value), Min: Minimum, Max: Maximum

Table 3. The Relationship between Nurses' Sociodemographic Characteristics and Mean Scores on the DAP and SSPS and between the DAP and SSPS Scores

Correlation	SSPS Total Score	Neutral Acceptance and Approach Acceptance (DAP Subscale 1)	Escape Acceptance (DAP Subscale 2)	Fear of Death and Death Avoidance (DAP Subscale 3)
Age				
Spearman's Correlation (r)	0.071	-0.045	-0.145	-0.034
Sig (p)	0.32	0.52	**0.04**	0.63
Years of Working				
Spearman's Correlation (r)	0.099	-0.040	-0.160	-0.037
Sig (p)	0.16	0.57	**0.02**	0.60
Duration of Working in the Unit				
Spearman's Correlation (r)	-0.113	-0.154	-0.111	-0.21
Sig (p)	0.11	**0.03**	0.12	0.77
SSPS Total Score				
Spearman's Correlation **(r)**	-	0.305	0.03	0.27
Sig (p)		**0.00**	0.67	0.07

DAP: Death Attitudes Profile, SSPS: Spiritual Support Perception Scale

Table 4 shows the distribution of nurses' DAP and SSPS scores according to some of their characteristics. A statistically significant difference was found between the Fear of Death and Death Avoidance (DAP Subscale 3) scores of the nurses according to gender; the mean Fear of Death and Death Avoidance scores of female nurses were significantly higher than male nurses ($p<0.05$). A statistically significant difference was found between the mean scores of Neutral Acceptance and Approach Acceptance (DAP Subscale 1) according to the educational level of the nurses. The nurses with a postgraduate degree had a statistically significantly higher mean score on the Neutral Acceptance and Approach Acceptance (DAP Subscale 1) compared to those who had a high school, associate's, or bachelor's degree ($p<0.05$).

The nurses working in the oncology unit had statistically significantly higher total mean SSPS scores compared to those working in the (pediatric) critical care, cardiovascular surgery intensive care, end-of-life care, and anesthesia intensive care units ($p<0.05$). No statistically significant difference was found between their mean scores on the Neutral Acceptance and Approach Acceptance (DAP Subscale 1), Escape Acceptance (DAP Subscale 2), and Death Avoidance (DAP Subscale 3) ($p>0.05$).

In the comparison made according to the hospital (Public Hospital, Private Hospital) where the nurses work, no statistically significant difference was found between their mean scores on Neutral Acceptance and Approach Acceptance (DAP Subscale 1), Escape Acceptance (DAP Subscale 2), and Death Avoidance (DAP Subscale 3) ($p>0.05$).

DISCUSSION

Nursing is a profession that is involved in the entire human life from birth to death. Accordingly, this study focuses on the relationship between death and perception of death, one of the most important phenomena nurses face, and nurses' perception of spiritual support.

The participant nurses' mean scores on the scales were analyzed, and it was found that they had the highest mean score on the positive death attitudes (Table 2). This shows that the nurses perceived death, which they frequently encounter, as a phenomenon that is natural and should be experienced and accepted. The literature includes studies with similar results[1,6,16,18-22]. A study reported that the nurses had the highest mean score on the positive death attitudes, which was not consistent with the finding of the present study[23]. This can be attributed to nurses' defense mechanism of avoidance against their fear and anxiety of death. A positive, moderate, and statistically significant difference was found between the SSPS and Neutral Acceptance and Approach Acceptance in the present study ($p<0.05$) (Table 3). As nurses' positive/accepting death attitude increased, their level of perceiving patients' spiritual support needs also increased. A study conducted with nursing students found that 17.2% of the students felt 'sad' and 10.2% 'continued to provide care without knowing what they felt[24], that most of the students did not want to care for the dying patients[21] and that spiritual care was ignored. Braun and Gordon (2010) found that nurses with a high fear of death and death avoidance had less positive attitudes while giving care to dying patients[25]. In a study, it was stated that nurses were afraid to care for the patient as death approached, they avoided communicating about death, they coped with the phenomenon of death by crying, and the care they provided could also be negatively affected[26]. İnci and Öz (2012) reported that nurses with awareness and positive attitudes towards death would have lower levels of anxiety of death, and in parallel, their negative attitudes towards caregiving to terminal patients would change[3]. In the present study, the nurses who regarded death as a natural and inevitable part of life had better spiritual support perceptions and were better at detecting spiritual needs.

The participant nurses' age had a negative, weak, and statistically significant association with the Escape Acceptance Attitudes ($p<0.05$) (Table 3). This means that as the age of the nurses increases, their death-avoidance attitudes decrease. The literature indicates studies with similar results[27-29].

Table 4. Distribution of the Nurses' Mean Scores on the DAP and SSPS according to their Sociodemographic Characteristics (n = 198)

Nurses' Characteristics	SSPS Total Score		Neutral Acceptance and Approach Acceptance (DAP Subscale 1)		Escape Acceptance (DAP Subscale 2)		Fear of Death and Death Avoidance (DAP Subscale 3)	
Gender	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**
• Female	51.66±7.06	52.00 (28.00-60.00)	63.26±9.99	64.00 (12.00-84.00)	19.43±6.63	19.00 (5.00-35.00)	32.56±9.58	32.00 (12.00-63.00)
• Male	49.22±9.87	51.00 (19.00-60.00)	63.96±9.62	64.00 (35.00-80.00)	19.58±6.16	20.00 (6.00-31.00)	28.45±8.69	29.00 (9.00-53.00)
p*	0.209		0.482		0.817		**0.015**	
Education Level	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**
• High School	51.17±7.86	52.50 (28.00-60.00)	64.28±7.38	64.00 (49.00-81.00)	19.54±7.43	19.00 (5.00-33.00)	32.54±10.20	32.50 (16.00-57.00)
• Associate's Degree	49.21±8.73	50.00 (22.00-60.00)	62.76±7.46	63.00 (43.00-75.00)	19.50±5.65	18.50 (8.00-30.00)	29.29±8.29	29.50 (9.00-51.00)
• Bachelor's Degree	51.19±7.90	52.00 (19.00-60.00)	62.43±11.31	64.00 (12.00-81.00)	19.08±6.21	18.00 (6.00-35.00)	31.64±9.69	32.00 (12.00-63.00)
• Postgraduate	53.07±7.18	55.50 (40.00-60.00)	70.00±8.65	70.50 (53.00-84.00)	22.14± 7.6	25.00 (9.00-31.00)	31.21±8.50	31.50 (17.00-43.00)
p**	0.430		**0.050**		0.374		0.647	
The Unit They Worked in	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**
• Intensive Care (adult)	49.49±9.27	52.00 (19.00-60.00)	62.41±11.20	63.50 (12.00-81.00)	19.71±6.49	20.00 (7.00-35.00)	30.14±9.26	31.00 (9.00-63.00)
• Intensive Care (pediatric)	50.96±8.08	50.50 (28.00-60.00)	66.21±5.94	65.50 (54.00-77.00)	19.83±7.80	20.00 (5.00-35.00)	36.25±11.24	36.00 (10.00-57.00)
• Oncology	53.92±7.45	56.00 (26.00-60.00)	62.92±10.47	64.00 (34.00-81.00)	17.18±6.35	16.50 (8.00-32.00)	32.79±10.19	31.00 (12.00-55.00)
• Cardiovascular Surgery Intensive Care	48.83±7.70	49.50 (31.00-60.00)	64.78±11.48	65.00 (40.00-80.00)	21.05±6.79	19.00 (6.00-31.00)	30.89±10.69	28.00 (14.00-53.00)
• Palliative Care	50.38±6.63	51.50 (40.00-60.00)	68.38±7.80	70.50 (53.00-78.00)	20.50±8.57	22.50 (8.00-30.00)	26.63±8.47	27.50 (17.00-38.00)
• Anesthesia Intensive Care	51.28±3.73	51.00 (44.00-60.00)	62.45±6.43	62.00 (53.00-77.00)	20.38±4.54	19.00 (11.00-27.00)	31.24±6.00	32.00 (15.00-47.00)
• Other (Special Branch)	58.40±1.67	58.00 (56.00-60.00)	63.40±11.78	60.00 (54.00-84.00)	19.00±4.64	19.00 (14.00-25.00)	27.80±5.76	31.00 (19.00-33.00)
p**/ p***	**0.045**		0.109		0.210		0.072	
The Hospital They Worked in	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**	**X̄±SD**	**Med (Min-Max)**
• Public Hospital	50.52±7.63	51.00 (19.00-60.00)	63.73±8.84	64.00 (34.00-84.00)	19.31±5.95	19.00 (6.00-32.00)	31.43±8.66	32.00 (10.00-54.00)
• Private Hospital	51.88±8.64	54.00 (26.00-60.00)	62.93±11.68	64.00 (12.00-81.00)	19.81±7.46	20.00 (5.00-35.00)	31.40±11.03	29.00 (9.00-63.00)
p*		0.058		0.897		0.742		0.455

X̄: Mean, SD: Standard Deviation, Med: Median (median Value), Min-Max: Minimum, Maximum Value, *Mann Whitney U Test, **Kruskall Wallis Test, *** Bonferroni Correction, DAP: Death Attitudes Profile, SSPS: Spiritual Support Perception Scale

On the other hand, some studies found no association between the anxiety of death and age[28,30-33]. Youth may lead nurses to perceive death as a remote possibility and think less about death. In conclusion, facing the truth of death may increase nurses' anxiety[3,28].

A negative, weak, and statistically significant association was found between the nurses' years of working and the Escape Acceptance Attitudes ($p<0.05$) (Table 3). Escape Acceptance, Subscale 2, is explained as believing that death will save people from the psychological and physical damages of life. Regarding death as avoidance or salvation is a negative attitude towards death. The literature includes studies with similar results[34,35]. Professional experience may lead nurses to face death more and develop a more realistic attitude towards death. Unlike the present study, a study on nursing students' perceived death attitudes[36] and a study on nurses' spirituality and understanding of spiritual care[35] found that the duration of time worked had a negative weak relationship with death acceptance and positive death attitudes. Chen et al. (2006) conducted a study with nursing students and found that the students with more experience had higher death anxiety levels than the students with less experience[37]. This difference can suggest that experienced students who provided care for dying patients for a longer period, experienced losses due to death, were unaware of their feelings, and could not effectively cope, which increased their death anxiety.

A negative, weak, and statistically significant association was found between the nurses' duration of time working in the unit and the Neutral Acceptance and Approach Acceptance ($p<0.05$) (Table 3). This indicates that as the duration of time working with terminally ill patients increased, the nurses' positive and accepting death attitudes decreased. Similar studies in the literature have reported that nurses who encountered terminal patients exhibited more positive attitudes and that experienced nurses had more neutral and positive death attitudes[38,39]. The discoveries of the present study were different from those in the literature. This can be attributed to the intense emotional burden and compassion fatigue created by providing long-term care for terminal patients and losing many patients they had provided care for.

A statistically significant difference was found between nurses' Death Avoidance scores according to their gender; female nurses' mean score was statistically significantly higher than that of male nurses ($p<0.05$) (Table 4). Unlike the present study, some studies have shown that death anxiety had no relationship with gender[40] and that females' death anxiety was lower than that of males[41,42].

However, there are a more significant number of studies which reported that females' death anxiety was higher than that of males[27,38]. Females' higher death anxiety can be attributed to the fact that they can more clearly notice and express their feelings and that females' overall anxiety levels are higher than that of males. In addition, males may express their feelings regarding death in this way to look strong and fearless due to gender roles. In Turkish society, men are expected to show no fear during frightening situations, while it is accepted that females are more emotional during such situations[38,43].

According to their education level, a statistically significant difference was found between the nurses' mean scores on the Neutral Acceptance and Approach Acceptance. The nurses who had a postgraduate degree had a statistically significantly higher mean score on the positive death compared to those who had a high school, associate's, or bachelor's degree ($p<0.05$). Neutral Acceptance and Approach Acceptance shows positive attitudes towards death. While the literature includes similar studies which have indicated that nurses' death attitudes positively changed as their education level increased[40,44-46]. Some other studies found no relationship between education level and death anxiety[47-50]. These findings suggest that further studies should be conducted on how education level affects nurses' death anxiety. In addition to education level, the content of education should also be evaluated in terms of being rich in death and providing care to dying patients[3].

The literature includes various results regarding nurses' perceptions of spiritual needs. The present study, in line with some other studies in the literature[12,13,17,50-54], found that the participant nurses had a high level of perception of spiritual needs. Nursing is based on protecting and maintaining the integrity of individuals' physical, psychological, social, and spiritual needs. Accordingly, determining and meeting individuals' spiritual needs is a significant part of nursing care. A study found that nurses volunteered to provide patients with spiritual care[55]. On the other hand, unlike the present study, other studies have reported that patients' spirituality is ignored and spiritual needs are insufficiently provided[11,55-57]. These studies have reported that nurses are unable to realize their patients' spiritual needs sufficiently.

A statistically significant difference was found between the participant nurses' mean total SSPS scores according to the unit they worked in. With advanced analysis, it was determined that the difference was due to the oncology department. The nurses working in the oncology unit had statistically significantly higher total mean SSPS scores compared to those working in the (pediatric) intensive care, cardiovascular surgery intensive care, palliative care, and anesthesia intensive care units ($p<0.05$). Unlike the present study, the literature has reported that the unit where nurses work does not affect their mean spirituality score[9,12-14]. The units caring for terminally ill patients encounter death and dying patients more frequently. Thus, since the nurses working in these units had more experience with death, it is expected that their perception of death would be more positive, their death anxiety would be lower, and their spiritual support perception would be higher. In intensive care and palliative care units, patients are usually able to establish limited or no communication or are unconscious. Since death and spiritual needs, which are abstract concepts, cannot be discussed with children in pediatric clinics, accurate statistics cannot be obtained on these subjects. Oncology clinics, on the other hand, provide care for patients who are more open to communication and are conscious, with whom nurses spend longer times due to

their treatments, and who can share their opinions on death, the afterlife, their beliefs, and spirituality—which can explain the findings of the present study. In addition, this finding also shows that even though the frequency of encountering the truth of death is high, this situation may not disturb when accurately coped with. Different characteristics between the units and nurses and the fact that nurses work focused on patients may also have contributed to this finding.

CONCLUSION

According to the findings of this research:

- As nurses' positive/accepting death attitude increased, their level of perceiving patients' spiritual support needs also increased. As the education level of nurses increases, their positive attitudes towards death also increase. Additionally, a holistic approach and spiritual care to terminal patients should be given during nursing education and in-service training for effective spiritual care.
- This study shows that positive attitude towards death is lower in young nurses. Therefore, attention should be paid to educating young nurses on the subject and raising their awareness.

This study showed that the nurses perceived the patients' spiritual support needs. However, this does not indicate how much they met the spiritual needs they perceived. Future studies should analyze the status of terminally ill patients' spiritual support needs being met in order to reveal all aspects of the subject.

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