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Spiritual well-being and attitudes toward caring for dying patients: a cross-sectional study in Iranian nursing students

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Abstract

Background The concept of death is one of the most significant issues in the nursing profession. To provide effective and comprehensive end-of-life care, nursing students, as future nurses, should have spiritual well-being (SWB) and a proper attitude toward the care of dying patients (ATCODP). The present study was conducted to investigate the relationship between the level of SWB and ATCODP of Iranian nursing students in 2019.

Methods This descriptive-correlational study was conducted on 139 nursing students at Bam University of Medical Sciences who were selected by the census method. To collect data, a three-part questionnaire consisting of personal information, the Paloutzian & Ellison SWB scale, and the Frommelt Attitude Toward Care of the Dying (FATCOD) scale were used. The data were analyzed by IBM SPSS version 20.

Results The mean age of the participants was 21.63 ± 3.23 years. The mean score of SWB in 98 (70.5%) nursing students was moderate, and 41 of them (29.5%) had a high score. The correlation coefficient between religious and existential health with a total score of SWB was 88% and 86%, respectively. According to Pearson's test, a significant relationship was observed between ATCODP, SWB, and its dimensions ($P < 0.05$).

Conclusion A significant relationship was observed between ATCODP, SWB, and its dimensions. Considering that most nursing students have a moderate level of spiritual well-being, measures should be taken to improve it during their studies. Because improving SWB in students will prepare future nurses for better quality care of dying patients and enhance their positive attitude toward death.

Keywords Spiritual well-being, Care, Death, Nursing students, End-of-life

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Introduction

Death and dying are natural aspects of life, and everyone will eventually face the experience of death [1]. The concept of death is one of the enormous issues within the nursing career [1, 2]. In a study conducted in Iran, the number of hospital deaths was recorded as 8270 cases, the most common causes of which were cardiovascular diseases, various types of cancer, and respiratory illnesses [3].

Nurses play a crucial role in end-of-life care, as they spend more time with dying patients compared to other healthcare professionals. This role is one of the most challenging nursing experiences, necessitating adequate training to ensure compassionate care [4, 5]. As a result, nurses need to have the essential and enough training to provide care to dying patients, due to the fact that the mindset toward dying is one of the most critical factors that affect human beings' behavior [4].

According to the American Association of Colleges of Nursing, one of the important competencies of nurses to offer quality care to dying patients is a positive attitude toward death and the ability to care for dying individuals [6]. A positive attitude toward death is essential for effective care, influencing how nurses approach dying patients and their families. These attitudes are shaped by cognitive, emotional, and behavioral responses, which can either facilitate acceptance of death or contribute to fear and avoidance [7].

To provide effective and comprehensive end-of-life care to patients, the attitude toward death and dying should be assessed in the final years of educational existence [8]. For nursing students, as future healthcare providers, developing positive attitudes and acquiring adequate knowledge about death and end-of-life care during their education is crucial [9]. Currently, nursing college students do not have the necessary knowledge about the concept of death and dying and caring for dying patients, and in a few studies, it has been found that nursing students have a poor attitude toward the concept of death and dying, and as a result, they are unable to provide appropriate care for dying patients [1, 10]. Iran is a religiously oriented society where spirituality and religious practices are deeply embedded in daily life and healthcare contexts. Islamic teachings emphasize the acceptance of death as part of divine destiny and encourage compassionate care for the dying. Such a cultural and spiritual context molds nursing students' perceptions and attitudes, making spirituality a salient aspect of their professional development [11]. It often instills a positive outlook on the care of terminally ill patients, emphasizing the moral and spiritual responsibilities of health providers [2, 4]. These cultural influences play a key role in shaping how Iranian nursing students perceive death and dying in both educational and clinical settings [8].

The limited previous studies on the knowledge and attitude of nursing students and nurses towards the care of dying patients in Iran showed almost identical results. Razban et al. (2013) reported that nurses working in both special care and oncology departments have been showing negative to neutral attitudes toward providing end-of-life care [11]. Another study conducted by Iranmanesh et al. (2008) to investigate the attitude of nursing students toward death and care for dying patients also reported that the nursing students who participated in their study did not have a positive attitude toward providing care for dying patients [12]. In contrast, the results of a study by Hojjati et al. (2015) indicated that the awareness and knowledge of nurses about the care of dying patients were desirable [13].

Another important issue in health care is spirituality and SWB, which should not be ignored [14, 15]. SWB includes two dimensions: religious well-being and existential well-being. The religious dimension describes the satisfaction resulting from communication with a higher power, and the existential dimension is about trying to understand the meaning and purpose of life [8].

The results of the study showed that although nursing service providers try to provide comprehensive care, in the evaluation of these services, we always encounter patients' dissatisfaction and neglect of their spiritual needs. Therefore, nurses must gain the necessary knowledge about spirituality and its role in comforting hospitalized patients [16]. The privacy rights and dignity of each patient should be respected, and their spiritual and religious diversity should be recognized [17].

Neglecting the spiritual dimension and its relationship with health can also have irreversible impacts on patients and the nursing profession [7]. Paying attention to spirituality affects the ability to adapt to illness, disease prevention, the ability to find meaning and purpose in life, and health and well-being in general [17]. Spiritual well-being (SWB) plays a crucial role in coping with death, helping individuals find meaning and purpose in life [17, 18]. With the advancement of technology, people's attitudes and expectations toward death have changed, and patients and their families demand quality care at the end of life [5].

Although the importance of SWB in nursing care is well-recognized globally, research focusing on the relationship between SWB and attitudes toward caring for dying patients among Iranian nursing students remains limited. Given the cultural and contextual differences in how spirituality and end-of-life care are perceived, it is essential to bridge this gap to better prepare nursing. Therefore, nursing students, as future nurses, need to evaluate their level of SWB and their attitude and awareness toward the phenomenon of death, which means educating them on these dimensions is a necessity. As a

result, the present study was designed to investigate the relationship between the level of SWB of nursing students and their attitude towards caring for dying patients.

Methods

This descriptive-correlational cross-sectional study was conducted in 2019 with a census sample of 139 nursing students from Bam University of Medical Sciences. All available nursing students during the study period were included, ensuring comprehensive data collection and eliminating the need for random selection.

The implementation method was as follows: After obtaining project approval, ethical permission (IR.MUBAM.REC.1395.5), and informed consent from participants, the questionnaires were distributed in person during class sessions. The research participants were fully informed about the study's purpose and how to complete the questionnaires. To minimize social desirability bias, participants were assured that their responses would remain anonymous and confidential. They were also informed that participation was voluntary, and they could withdraw from the study at any time without any consequences. These measures were implemented to ensure the integrity of the data and encourage honest participation.

The data collection tool was a three-part questionnaire including demographic characteristics, the Paloutzian & Ellison SWB scale, and the Frommelt Attitude Toward Care of the Dying (FATCOD) scale.

The demographic part of the questionnaire consisted of six questions related to participants' age, gender, marital status, education, place of residence, and place of origin (native or non-native). A Paloutzian & Ellison SWB scale consists of 20 questions, 10 of which measure religious well-being and the other 10 measure existential well-being. Also, each of them has a score range of 10–60. There is no level of assessment for religious and existential well-being sub-groups, and evaluation is based on the obtained scores. Higher scores are an indication of participants' higher religious and existential well-being. The score of SWB is the sum of these two subgroups, which ranges from 20 to 120. The answers to the questions were classified based on a six-point Likert scale (from completely disagree to completely agree). In the negative questions, scoring has been done in reverse (from 60 to 10), and the SWB scores have been divided into three levels: low (20–40), medium (41–99), and high (100–120). In the study of Rezaei et al., the validity of the SWB scale was determined through content validity, and its reliability was confirmed with Cronbach's alpha coefficient of 0.82 [19].

The Forumlet attitude scale toward the care of dying patients (FATCOD) was used to measure the attitude of nursing students toward providing care for patients who are in the last days of their lives. This tool has 30 items to evaluate the attitude of the participants toward the care of dying patients. 15 items are positive, and the other 15 items are negative. In the positive items, the questions are scored from 1 to 5 (1-completely disagree to 5-completely agree), and in the negative items, the way of scoring is reversed. The minimum and maximum scores of this test are 30 and 150, respectively. Thus, based on the above-mentioned scoring, if one gets a higher score from this questionnaire, he or she has a more positive attitude toward caring for dying patients. In previous Iranian research, the validity and reliability of this questionnaire have been determined to be optimal [20]. Additionally, the reliability of the FATCOD scale was determined through internal consistency analysis, with a Cronbach's alpha coefficient of 0.85.

After collection, the data were analyzed using SPSS statistical software version 20 using descriptive and inferential statistics, including the Pearson correlation test, one-way ANOVA, and independent t-test. A P value less than 0.05 was considered statistically significant.

Table 1 Demographic characteristics of study participants

variable		Frequency(%)
Sex	Male	47(33.8)
	Female	92(66.2)
Marital status	married	20(14.4)
	single	119(85.6)
Academic term	Term2	31(22.3)
	Term4	48(34.5)
	Term6	38(27.3)
	Term8	22(15.8)
place of residence	Dormitory	83(59.7)
	Private house	54(38.8)
	Rented house	2(1.4)
place of origin	Native	72(51.8)
	Non-native	67(48.2)

Results

Out of the total number of 154 participating college students, the handiest 139 completed the questionnaires (90% response rate). The results of the analysis showed that the mean age of the participants in the study was 21.63 ± 3.23 years. Other demographic characteristics of the study participants are provided in Table 1.

Based on the results, the SWB scores of 98 (70.5%) nursing students were reported as moderate (41–70) and 41 (29.5%) as high (100–120), and none of the students participating in this study got a low score (20–40). In general, the SWB scores of the female participants were higher than those of the other sexes. Also, the score of SWB turned out better in married and native students, although it was not statistically significant ($P < 0.05$). The comparison of scores of SWB dimensions among nursing

Table 2 Comparison of spiritual well-being and ATCODP scores of nursing students according to demographic variables

variable		Religious Health Mean ± S.D	Existential Health Mean ± S.D	Spiritual Well-Being Mean ± S.D	*P*-Value	ATCODP Mean ± S.D	*P*-Value
Age		49.76 ± 5.93	43.6 ± 23.51	92.99 ± 10.88	0.04	102.18 ± 8.2	*P* = 0.007
Sex	Male	49.23 ± 6.12	43.6 ± 12.73	92.36 ± 11.17	t=-0.48	103.42 ± 8.91	t = 1.26
	Female	50.30 ± 5.85	43.28 ± 6.42	93.31 ± 10.78	*P* = 0.8	101.55 ± 7.86	*P* = 0.46
Marital status	Married	50.7 ± 7.27	45.40 ± 6.72	96.12 ± 1.22	t=-1.38	104.30 ± 8.83	t = 1.24
	Single	49.5 ± 6.7	42.86 ± 6.43	92.47 ± 10.61	*P* = 0.78	101.83 ± 8.13	*P* = 0.59
Student's place of origin	Native	50.40 ± 6.33	43.61 ± 6.99	93.65 ± 11.81	t = 0.74	101.94 ± 8.86	t=-0.35
	Non-native	49.46 ± 5.5	42.82 ± 5.96	92.28 ± 9.83	*P* = 0.13	102.44 ± 7.59	*P* = 0.08
Academic term	Two	49.83 ± 5.78	43.38 ± 5.44	93.22 ± 10.18	F**=0.15	101.80 ± 6.22	*P* = 0.58
	Four	49.64 ± 5.72	43.79 ± 6.78	93.37 ± 11.03	*P* = 0.92	101. 41 ± 7.93	F** = 0.64
	Six	48.84 ± 6.36	43.13 ± 7.01	91.97 ± 11.78		103.76 ± 8.59	
	Eight	51.50 ± 5.86	42.09 ± 6.66	93.59 ± 10.52		101.68 ± 10.7	

*Results of the independent-sample t-test, ** Results of the One-way ANOVA

Table 3 Pearson correlation analysis results between spiritual well-being variables and other variables

variable	age	Religious health	Existential health	Attitude toward death and dying
Spiritual Well-Being	*r* = 0.16* *P* = 0/04	*r* = 0.88** *P* = 0.000	*r* = 0.86** *P* = 0.000	*r* = 0.41** *P* = 0.000

students according to demographic variables is supplied in Table 2.

Table 2. Comparison of spiritual well-being scores of nursing students according to demographic variables.

A statistically significant correlation was observed between age and the total score of SWB ($P < 0.05$). Accordingly, the better the age became, the higher the spiritual well-being was. However, no correlation was observed between the dimensions of SWB and other demographic variables ($P < 0.05$). The correlation coefficient between religious health and the total score of SWB was 0.88, which is an indication that "the higher the religious health, the higher the score of spiritual well-being." Additionally, the correlation coefficient between existential health and the overall score of SWB was 0.86, which indicates that the higher the existential health is, the higher the ratings of SWB are (Table 2).

Also, a statistically significant relationship was observed between age and students' place of origin (native and non-native) with the total score of attitude towards caring for dying patients ($P < 0.05$). As a result, with higher ages, we've got higher ATCODP scores. No statistically significant relationship between ATCODP and different demographic variables was found ($P < 0.05$). According to Pearson's statistical test, a statistically significant relationship was observed between ATCODP, SWB, and its dimensions, so with higher rankings of SWB and its dimensions, there is a higher ATCODP score (Table 3).

Discussion

Thinking about the significance of SWB and its supportive outcomes on other dimensions of health as well as the ATCODP, the present study aimed to examine the relationship between the level of SWB and the attitude toward caring for dying patients (ATCODP) among nursing students at Bam University of Medical Sciences. Consistent with the received results, most of the nursing students obtained a moderate rating of SWB, and not one of the participating students in this study acquired a low score. In the study Tavan et al., which was conducted to evaluate the SWB among nursing college students, most of the students were in the range of average to high rankings [8].

Likewise, by assessing nursing students' level of SWB, Hsiao et al. concluded that they had average SWB levels [21]. In the study of Mohammadi et al., who examined the SWB of nursing students, the level of SWB changed from reported average to high [22]. Some of these results are consistent with our study results. In contrast, the results of Khiyali et al. on paramedical college students in Fasa showed a low level of SWB [23], which is not consistent with the present study.

The reason for this distinction may be the use of different measurement tools. Therefore, although many medical students may additionally enter the university with an average level of spiritual well-being, their attitude toward spirituality should be bolstered and improved during their four-year academic studies. The higher SWB nursing students have, the better care they can provide for their patients.

According to the results of the present study, the SWB score of female students was higher than that of male students; that's consistent with Rehman, Syed, Hussain, & Shaikh (2013) [24]. However, in the study of Tavan et al. (2015) [8], SWB in men and women was at a moderate level, and there had been no significant differences between the scores obtained from each sex. Yet, in one

study, male students had higher SWB [25]. The observed differences could be attributed to cultural and psychological factors. Male students may be more inclined to engage in new experiences, whereas female students may approach issues like death and dying with greater sensitivity and caution.

In the present study, the scores of SWB became better in married and native students, but they were not significant, which is consistent with the results of Tavan et al. (2015) [8] on the spiritual health of nursing students. However, Chung et al. reported no significant relationships among SWB and marital popularity [26]. Although it is not an established reality, maybe the higher SWB rankings among the local participants in this study are the result of living in a familiar environment and with their households. In non-native college students, the enjoyment of being some distance from their home and family may initiate the fear of losing loved ones, which would cause a reduction in their SWB levels. Additionally, married humans are better able to manage difficult situations because of the belief and support they get from their spouses and the closeness they have with them, so they have a higher SWB than single people.

In the current study, a significant correlation was observed between age and the total score of spiritual well-being. Based on the consequences, it can be said that "the higher the age, the higher the spiritual well-being."

In this regard, the results showed that students who have been within the age group of 23 years had more spiritual well-being. Also, the age group of 18 to 19 years had the lowest SWB [8]. In other studies, no significant relationship was observed between age and spiritual well-being, which is not consistent with the present study [22, 26]. Perhaps the cause of this difference is that in this study, the average age was 20 years old, and this age group is more prompted by the attitudes of their peers, and they are nevertheless a way from spiritual maturity.

According to the results of the present study, there may be an advantageous and direct correlation between the score of the dimensions of SWB (religious and existential health) and the total score of spiritual well-being. That is, with higher existential and religious well-being, we've got a higher total score of spiritual well-being. In this regard, Hsiao et al. also found in their study that nurses who have a stronger religious dimension of SWB are more willing to recognize the spiritual needs of patients [21].

Also, the results of Untrainer et al. showed that SWB and religion have a significant relationship with diverse aspects of mental health and personality, and spirituality expresses essential aspects of human personality [27]. Within the study of Asaroudi et al., only the existential dimension had a direct correlation with SWB [28], which is not consistent with the present study. Perhaps the purpose is that the study by Asaroudi et al. was conducted on nurses, not nursing students. Considering that our society is a religious society and our behavior and beliefs are rooted in religion, religious measurement is an important dimension of spiritual well-being, and strengthening this dimension in students can improve their level of spiritual well-being.

Also, in keeping with the consequences of this study, a statistically significant relationship was located between age and the total score of attitude toward providing care for dying patients. Based on our results, in older participants, the score of attitude toward death was higher, which might be a demonstration of older nurses' positive attitude toward being concerned for death patients [4, 29]. Students who were born during the time of the Bam earthquake, and continue to reside in the city, may exhibit a more positive attitude toward caring for dying patients, potentially influenced by their personal experiences with loss and grief during that period.

According to the final results of the present study, a significant relationship was observed between attitude towards death and SWB and its dimensions, so the higher the score of SWB and its dimensions, the higher the score of attitude towards death. The results of the Korzebor et al. study showed that SWB can be effective on satisfaction, happiness, quality of life, a positive attitude towards death and dying, mental health, and the reduction of anxiety and depression, especially in nursing students [30]. The results of another researcher cleared that spiritual self-awareness and spiritual activities are, respectively, the best predictors of attitude toward death, which is in line with the present study [2]. Therefore, religion could have a high-quality effect on the process of effectively dealing with stressful events in life, such as death and dying.

The observed differences in the results of this study compared to others, especially with medical students such as nursing students. These discrepancies may stem from factors such as culture, religion, and the specific educational system in Iran. In a country like Iran, where religion and spirituality play a significant role in daily life and healthcare, nursing students may be more familiar with the spiritual aspects of medical care, which could contribute to higher SWB scores. Additionally, the educational approach in nursing may place greater emphasis on holistic care, including spiritual care. Future research should explore the influence of these cultural and educational factors to better understand the reasons for these differences.

Conclusion

Primarily based on the present study results, and since most nursing college students have a moderate degree of spiritual well-being, measures have to be taken to beautify it all through their studies. SWB improvement

in nursing college students will prepare future nurses to offer higher-quality care for dying patients, and it will also improve their high-quality attitudes toward death and dying. Considering the role of SWB on the attitude of caring for dying patients in nursing students, it is recommended to bolster this aspect with such courses in their educational program.

Implications for practice

There are inadequate spiritual care skills in Iran, and patients' spiritual issues are often overlooked or not fully addressed, especially for cancer patients who require more spiritual care than other patients. To address these gaps, nurse managers need to work closely with nurses and improve the competencies of those working in oncology and hematology wards. This study highlighted deficiencies in nursing students' spiritual care abilities, emphasizing the need for targeted interventions. Incorporating SWB-focused education into nursing curricula can help bridge this gap. Strategies such as adding courses or modules on spiritual care, conducting workshops and panels to enhance practical knowledge, and using simulation-based training for real-life application can be effective. Additionally, fostering interdisciplinary collaboration with spiritual care experts and implementing evaluation mechanisms will ensure nursing students are better equipped to meet patients' spiritual needs and improve their attitudes toward caring for dying patients.

Limitations

This study has several limitations that should be considered when interpreting the findings. One of the primary limitations is the lack of comparable studies in the existing literature, making it difficult to draw definitive conclusions. The study's small sample size and its geographical localization may also limit the generalizability of the findings. Additionally, the exclusion of participants who did not complete all questions in the questionnaire could introduce selection bias. As a result, future research is encouraged to include a larger sample size and to extend the study across a broader geographical area to increase its applicability. Another important limitation is the cross-sectional design of this study, which restricts our ability to establish causal relationships between spiritual well-being (SWB) and attitudes toward death and dying. Longitudinal studies would provide a deeper understanding of how these factors evolve over time. Moreover, the study only focused on nursing students, which may not fully represent the views and experiences of other healthcare students or professionals.

The reliance on self-reported data, particularly on sensitive topics such as spirituality and death, could lead to biases such as social desirability bias, recall bias, or personal subjectivity. Cultural and institutional factors specific to the participants' educational environment may also influence the results, limiting the generalizability of the findings to other settings.

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Author contributions
N.S and A.N conceived of the presented idea. A.A.S developed the theory and collected data from scientific resources.H.S and M.J collected the questionnaires, entered in statistical software and verified the analytical methods. MJ encouraged NS to investigate scientific resources and supervised. All authors discussed the results and confirmed the final manuscript.

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Data availability
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Declarations

Competing interests
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