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NURSES' PERCEPTIONS OF SPIRITUALITY AND SPIRITUAL CARE AND THE CHALLENGES OF LEARNING SPIRITUALITY

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ABSTRACT

Background. Nurses face barriers both from the environment and from themselves in providing spiritual care. Their perception to the spirituality as well as the spiritual care may contribute into this situation. Aim. This study was to identify the Indonesian nurse's perception of spirituality and spiritual care. Methods. A cross-sectional survey investigated 273 nurses in Central Java, Indonesia recruited through a convenience sampling. The Spirituality Spiritual Care Rating Scale (SSCRS) Bahasa Indonesia version was applied to measure the nurses' perceptions. Six other questions related to nurses' prior knowledge, responsibilities and work experiences were added. To examine the differences in the nurse's perception of Spirituality (SP) and Spiritual Care (SC), independent t-test and One-Way ANOVA were applied. Findings. Obtained score means were Spirituality 20.0 (2.0), Spiritual Care 46.2 (4.3), and total SSCRS 66.1 (4.5). There was the significant different perception of spirituality and spiritual care as a total, and in subscale of spirituality based on the geographic location (p=0.006). Respondents felt well informed (52.2%), got training (4.8%), capable of delivering spiritual care (70%), mostly considered the patient spiritual need through listening and observing patients by themselves (67.9%). Conclusion. Nurse perception of spirituality and spiritual care were not different based on respondent characteristics, except the respondents' work geographical area. Challenges in teaching spirituality were confirmed. This study provided basic information in describing Indonesian nurses' perception on spirituality and spiritual care.

Keywords: spirituality, spiritual care, nursing education, administration

ABSTRAK

Latar Belakang. Para perawat menghadapi hambatan dalam memberikan asuhan spiritual baik dari lingkungan maupun mereka sendiri. Persepsi mereka terhadap spiritualitas dan asuhan spiritual kemungkinan berkontribusi terhadap permasalah ini. Tujuan. Penelitian ini untuk mengidentifikasi persepsi perawat terhadap spiritualitas dan asuhan spiritual. Metode. Penelitian survei cross-sectional sudah dilakukan untuk meneliti 273 perawat di Jawa Tengah, Indonesia yang diperoleh melalui teknik convenience sampling. Spirituality Spiritual Care Rating Scale (SSCRS) versi Bahasa Indonesia diimplementasikan untuk mengukur persepsi para perawat. Enam pertanyaaan lain berkaitan dengan pengetahuan sebelumnya, tanggung jawab, dan pengalaman kerja perawat ditambahkan. Untuk menguji perbedaan persepsi spiritualitas (SP) dan Asuhan Spiritual (SC), independent t-test dan One-Way ANOVA diaplikasikan. Temuan. Rerata skor Spiritualitas 20,0 (±2,0), Asuhan Spiritual 46,2 (±4,3), dan SSCRS total 66,1 (±4,5). Terdapat perbedaan yang bermakna pada persepsi spiritual dan asuhan spiritual baik secara total maupun sub-kategoriny berdasarkan variasi lokasi geografis perawat (p=0,006). Para responden menyatakan sudah terinformasi konsep spiritualitas dan asuhan spiritual dengan baik 52,2%, memperoleh pelatihan 4,8%, merasa mampu memberikan asuhan spiritual 70%, dan mereka menyadari bahwa pasien memiliki kebutuhan spiritual setelah mendengarkan dan mengamati sendiri keluhan dari pasiennya 67,9%. Simpulan. Tidak ada variasi persepsi perawat terhadap spiritualitas dan asuhan spiritual menurut karakteristik demografik, kecuali lokasi geografis. Selain itu, tantangan dalam mengajarkan konsep spiritualitas juga terkonfirmasi oleh temuan penelitian ini. Penelitian ini telah memberikan inforasi mendasar yang menggambarkan persepsi perawat Indonesia terhadap spiritualitas dan asuhan spiritual.

Kata kunci: spiritualitas, asuhan spiritual, pendidikan keperawatan, administrasi

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BACKGROUND

Addressing patient spirituality in the clinical setting is in challenging situation nowadays. Even though spirituality is an important need for patient, as well as the physical need; many patients complained lack of support to meet the spiritual need (Balboni et al., 2010). Nurse faced barriers in proving spiritual care in the clinical setting. Unsupportive environments, lack of the nursing guidelines, nurses' lack of time, and lack of training and education of the issue (Rushton, 2014; Stranahan, 2001) were responsible for lacking spiritual care in clinical setting. Moreover, nurses felt unconfident in separating personal belief and professional practice (McSherry & Jamieson, 2013).

This feeling comes from an inadequate knowledge or misperceives spiritual care as other profession responsibility might cause nurse reluctant to meet it (Ruder, 2013). Because nurse's educational level, the length of work experience and department of employment were determinants on the nurse's perceptions of spirituality and spiritual care (Ozbasaran, Ergul, Temel, Aslan, & Coban, 2011). The negative perception of providing spiritual care in clinical practice originate from low exposure to the spirituality concept in the prior nursing education.

In the nursing education, barriers of teaching spirituality came from teachers, students, and environment (Baldacchino, 2011). Student and teacher experienced discomforting with the spiritual issue during teaching learning process in the school (Boswell, Cannon, & Miller, 2013). Besides that, the abstractness of concept generated a demand for a clear guidance and definition from the nursing profession. Likewise, consistent approaches to teaching the spirituality concept were important too (Timmins & Neill, 2013). It shows that that the problem affects nearly every element of education systems.

On the other hand, Indonesian nursing education has been developing progressively recently. Bachelor level of nursing education growth significantly. Nowadays 288 institutions registered as a member of Association of Indonesian Nurse Education ("Daftar Anggota AIPNI," 2016). Books, mass media and training use the term of spirituality or spiritual massively. In the nursing curriculum, the religion course takes two credits. As cultural belief may also nurturing the spirituality (Ozbasaran et al., 2011), it will develop nurse perception of spiritual care. However, there is no publication in Indonesia discussing spiritual care and the nurse perception of spirituality. This study is an initial step for further investigation in developing spiritual in educational and clinical settings. The purpose of this study is to identify Indonesian nurse's perception of spiritual care and spirituality and any influencing demographic characteristics of nursing practice.

METHODS

Research Design

A descriptive survey of nurses in Province Central lava, Indonesia, was undertaken using convenience sample to determine their perception of spirituality and spiritual care. Nurses who practiced in hospitals and community agency across the province were invited to participate.

Population

The sample of the study is nurses who work who worked as nurses in hospital, and community health. A convenience sampling was applied to recruit respondents. Nurses who already worked in the nursing service in the area of Province Central Java, Indonesia considered eligible as respondent. Those who have worked as administration staff only and have never been exposed into direct nursing care were excluded.

Data Collection

Data were collected during July to September 2015, in Province Central Java. Tree hundreds respondent invited to the study. Two experienced and trained research assistants distributed questioners to nurses in hospitals and public nursing services around Central Java. First, we identified the most accessible health facility to visit while delivering the

questioner manually. After selecting the hospital, the research assistant contacted the person in hospital to help to distribute questioner. Then the research assistant visited the hospital in particular time after contacting the contact persons in the hospital to confirm the most comfortable time meet the nurses.

The research assistant then briefly explained the study purpose, a set of questioner was provided to fill. Respondents must sign the informed consent before filling the questioner. It took 30 minutes in average to complete the questioner before returning to the research assistant. If respondent had not finished the questioner, the questioner would be drawn back to the un-responded questioner.

Instruments

The Spirituality and Spiritual Care Rating Scale (SSCRS) (McSherry, Draper, & Kendrick, 2002) was applied in the measurement. The instrument consists of 17 item, five items (a, b, g, k, and n) represent spiritual care, and 12 last items represent spirituality (McSherry & Jamieson, 2011). An English expert from Jenderal Soedirman University translated the original SSCRS into Bahasa Indonesia. The translated SSCRS was reviewed by three faculties in the department of nursing who understand the spirituality concept to formulate the translated version scale through a consensus.

There was a small modification of wording in this Bahasa Indonesia version. The word church was translated into “tempat ibadah” instead of direct translation “gereja” that only represent Christian or “Masjid” that only represent Muslim term. Then, the word chaplain was also translated into “tokoh agama” instead of “pendeta or pastur” that only familiar for Christian or “ulama or imam” that particularly for Moslem. By changing these particular words into the most common term in Bahasa, we expected a wider application for the wider area in the future. The items tool were tested to 30 nurses who worked in Purwokerto (a town in Central Java). Cronbach Alpha on this study was 0.74.

Beside SSCRS we added six questions to assess exposure of the spirituality concept, perception of responsibility, and experience in encounter spiritual need, exposure to the spirituality and spiritual care concept during previous nursing education and work, experiencing spiritual care, the capability after training

Data analyses

IBM SPSS Statistic Version 21 was utilized for data analyses. Firstly, univariate analyses described demographic characteristics, spiritual care and spirituality score, knowledge and experience. Following that, the association of spirituality and spiritual care were tested among various demographic characteristic. The independent t-test and One-Way ANOVA were implemented to compare the mean of SP, SC, and SSCRS between the characteristic of respondents. Ten respondents who are Catholic and Protestant were excluded from further analyses because we needed a cleaner information as Islam respondents dominated 96.5 % (n= 273). We also conducted further analyses if the p-value is closely higher to 0.05 by adjusting the extreme value.

RESULTS

Responds Rate

From 300 distributed questioners, exactly 273 nurses responded the questioner. The responds rate reached 90 %.

Table 1. Demographic Characteristic (N=273)

No	Demographic Characteristics	n	Percent
1	Female	160	58.6%
2	Religion Islam	273	100%
3	Age		
	21-29	99	36.3%
	30-39	129	47.3%
	40-49	41	15.0%
	≥50	4	1.5%
4	Direct Care Provider	192	70.3%
5	Geographic Location		
	Southern	110	40.3%
	Center	77	28.2%
	Northern	86	31.5%

No	Demographic Characteristics	n	Percent
6	Current work in area		
	Medical-Surgical	138	50.5%
	Maternity	12	4.4%
	Pediatric	42	15.5%
	Emergency care and Critical	72	26.4%
	Community and Mental Health	9	3.3%
7	Work Experience		
	< 1 years	21	7.4%
	1-5 years	73	25.8%
	6-10 years	75	26.5%
	11-25 years	106	37.5%
	> 25 years	8	2.8%
8	Full Time	247	90.5%
9	Rotated Shift Nurse	215	78.8%

Table 2. Results of SSCRS (n=273)

Scale	Mean (SD)	Range *)
Spirituality	20.0 (2.0)	5-25
Spiritual Care	46.2 (4.3)	12-60
SSCRS	66.1 (4.5)	17-85

**) theoretical range score based on score range*

Demographic Data

Most respondents were 58.0% (n=160) female (Table 1). Age ranged between 30-39 years old 47.3 % (n=129). Respondents were direct care providers 70.3 (n=192), work as fulltime employ 90.5% (n=247) as rotated nurses 78.8% (n=215). Respondents reported over 11 years of nursing experience (40.3%, n=l 14). The majority reported their practice in medical surgical specialties area (50.5%, n=138 in Table 1).

The mean SP score and SC score were 20.0 (SD 2.0) and 46.2 (SD 4.3) respectively. In total score mean of SSCRS is 66.1 (SD 4.5). The score of Spiritual Care is more homogeny compare to spirituality and total SSCRS score (Table 2).

Spiritual Care Education and Training

We assessed the respondents' background knowledge with three questions (Table 4). First, we asked, "*Selama menjalani pendidikan perawat, pernahkan mendapatkan mata kuliah yang mencakup perawatan spiritual*? During the course of your nurse training, did you receive any lessons/lectures covering Spiritual Care?" This question was to investigate the exposure of spirituality and spiritual care concept in the respondent previous nursing education. Most respondents agreed that they got exposed to spirituality or spiritual care concept 143 (52.4%). The second question is "*Sejak bekerja sebagai perawat, pernahkan Anda memperoleh training atau pelatikan yang mencakup perawatan spiritual?* Jika ya, apakah Anda merasa mampu menjalankan perawatan spiritual/Since qualifying as a nurse, have you been on any training courses which covered spiritual care? If yes, after training, do you feel capable to deliver spiritual care?" This second question assessed the training during work as qualified nurses. Only 4.8% (n=13) respondents answered 'yes.' Surprisingly, most of the nurses who experienced spiritual care training 69.3% (n=9) felt still incapable of delivering spiritual care.

Table 3. Distribution of Mean Score of Spiritual Care (SC), Spirituality (S) and Sprituality and Spiritual Care (SSCRS) on Individual Characteristics (n=273)

Characteristics	Mean		
	SC	S	SSCRS
Gender			
Female	19.93	46.01	65.94
Male	20.02	46.40	66.42
Age Range			
21-29 Years Old	19.94	45.56	65.49
30-39 Years Old	19.79	46.35	66.14
40-49 Years Old	20.68	46.93	67.61
> 50 years old	18.75	48.00	66.75
Geographic Region			
Southern	20.15	47.24	67.38
Center	19.78	45.22	65.00
Northern	19.90	45.66	65.56
Work Experience	.	.	.
< 1 years	19.38	47.00	66.38
1-5 years	19.93	44.90	64.83
6-10 years	20.04	46.47	66.51
11-25 years	20.02	46.57	66.59
over 25 years	20.38	47.38	67.75
Qualification			
Diirect Care	19.87	45.89	65.76
Nurse Leader	20.19	46.84	67.02
Work Shift			
Days	20.05	46.43	66.48
Rotated	19.94	46.10	66.04
Working Time			
Full Time	19.98	46.19	66.17

Characteristics	Mean		
	SC	S	SSCRS
Part Time	19.85	46.00	65.85
Specialties	.	.	.
Med-Surgical	19.81	45.45	65.25
Maternity	20.08	45.83	65.92
Paediatric	20.12	46.64	66.76
Critical Emergency.	19.96	46.75	66.71
Community & others	21.00	49.23	70.23

Table 4. Exposed to Concept of Spiritual Care (N=273)

Question	n	Percent %
During the course of your nurse training, did you receive any lessons/lectures covering Spiritual Care?		
No	44	16.1%
Not Remember	86	31.5%
Yes	143	52.4%
Since qualifying as a nurse have you been on any training courses which covered Spiritual Care?		
No	260	95.2%
Yes	13	4.8%
Feel incapable to deliver Spiritual Care after Training (N=13)	9	70%

Experiencing Spiritual Care

We also explored the respondents' experience in delivering nursing care to respond patient spiritual need. We asked a question "*Selama bekerja sebagai perawat, pernahkah Anda menjumpai pasien dengan kebutuhan spiritual*/During nursing practice have you encounter patient with spiritual need?" Most of the respondent 90.1% (n=246) encountered patients with spiritual need in clinical practice. For those, who encountered spiritual need were asked how they became aware patient had the need (Table 5). In this question, respondents could choose more than one answer, so that the calculation of percentage base on the total sample for each option. Listening and observing the patient 67.7% (n=167) and patients themselves 38.5% (n=95) were the most common way that made them aware that the patient has a spiritual need. In contrast, NCP and other nurses were selected only by 5.5% (n=16) and 3.7% (n=9) respondents respectively. The religious leader, the patient's family-and-friends was also selected as resources that made them aware the patients' spiritual need.

Perception of Responsibility

Similar to the question to identify what/who opened nurses awareness to the patients spiritual need, we provide options to be checked by respondents to answer the question "Siapa yang menurut Anda bertanggung jawab terhadap perawatan spiritual?/Who do you feel should be responsible for providing spiritual care?". Most of responded quite similarly by nearly checked the options provided. The selected options included nurses, chaplains, patient's family-and-friends, and the patient themselves. It seemed nurses understood that the spiritual care is under their responsibility too. However, chaplain or religious leader are the most selected by respondents.

Table 5. How Nurse Aware Patient's Spiritual Need and The Perception of Who Responsible in (N =273)

Multiple Options Questioner	Selected by	Percent (%)
How did you become aware of patients' spiritual need?		
Chaplain/Religious Leaders	9	3.7%
Listening to and observing the patient	167	67.9%
Nursing Care Plan	16	6.5%
Other Nurses	9	3.7%
Patient her/himself	95	38.6%
Patient's relatives/friends	35	14.2%
Who do you feel should be responsible for providing Spiritual		
Chaplain/Clergy	263	96.3%
Nurses	262	95.6%
Patient themselves	261	95.6%
Patients Family and Friends	251	91.9%
Patients own spiritual/religious	255	93.4%

Table 6. The Result of Demographic Characteristics Variation of SSCRS (N=273)

Characteristics	Spiritual Care	Spirituality	Total SSCRS
Gender (t test)	0.707	0.464	0.478
Geographical Location	0.438	0.002*	0.006*
Age Range	0.051/0.048*(b)	0.232	0.223
Work Experience	0.679	0.064/0.041 *(b)	0.217
Qualification (t test)	0.249	0.094	081
Current Work Specialties	0.704	0.181	213
Working Time (t test)	0.754	0.830	0.777
Working Shift (t test)	0.706	0.604	0. 587

The Variation of SSCRS Score on Demographic Characteristic

The association each demographic characteristic to the score of SSCRS both wholly or based on each Spiritual Care and Spirituality scores were tested. Perception of respondents on Spiritual Care were not different significantly based on gender, geographic location, age, work experience, current job specialties, working time, and working shift. However, after adjusting the extreme value, there was a significant different of perception of spiritual care based on age (p=0.48). The perception of spirituality also had a different result. Geographic location was the only variable that has a significant different of spirituality score (p=0.002). However, after adjusting the extreme value, the spirituality scores also significant based on the geographic location (p:0.002). Geographic location had shown a different of total SSCRS as a whole score (p:0.006).

DISCUSSION

Findings of this study indicated SSCRS average score 66.1 (±4.5), was better than compared studies in other countries. For example, a study among Turkey nurses reported the SSCRS score was 62.43 (±7.54) (Çetinkaya, Altundağ Dündar, & Azak, 2013). So do the score among Iran nurses 63.40 (±4.57) (Mazaheri, Falahi, Sadat, & Rahgozar, 2009). Iran and Turkey were countries where Islamic values colorizes their cultural lives. While, even though Islam was a majority, the cultural lives was varies in each region. Since the majority of sample in this study was affiliated to Islam too, the similarity among these three countries was comparable.

Another finding also indicated that nurses characteristic might not contribute to their perception of spirituality and spiritual care except demographic characteristic. Analysis results showed the *p values* of each individual characteristics were higher than 0.5 except demographic factor (0.006) (Table 6). This finding was different with a study among Hongkong Enrolled Nurses. This study reported the higher education level of nurses (degree compared to certificate and diploma nurses) the better their perception of spirituality and spiritual care. Also, nurses affiliated to religion perceive spirituality and spiritual care better than ones were not affiliated to religion (Wong, Lee, & Lee, 2008).

While, the variation of SSCRS average score by geographic area showed uniqueness the finding of this study. Nurses in southern area of Central Java perceived spiritual care and spiritual care better than those who lived int the center and northern area by 20.15 and 47.24 respectively (Table 3).

Historically, Northern area of central java were more religious than other area. Because, Islam religion developed well on the northern side of Java Island. Life in the northern cities such as *Demak, Pati, and Kudus*, had been influenced by Islamic cultural and social life. In fact, the northern people were less sensitive to the need of spirituality.

Religious color was not guarantee the acceptability to the spiritual need. For example, in a study about nurse's organizational commitment, even though the hospital hold a strong religious background, most of nurses felt their spirituality were well-facilitated (Mulyono, 2011). In contrast, less religious tend to open to practicing the spiritual values. Therefore, citizen in Banyumas (a city in southern area) had different ways in

perception of religion and spiritual as well as how they interpreted the values for daily living (Mufid, 2006).

Changing of Spirituality

One-way ANOVA showed a significant variation of mean, among respondents. The nurse worked between 1-5 years tended to have a lower score compared to another group. Different of motive and job satisfaction in work seemed rational to explain this finding. Job satisfaction and tenure in work made a U-shape pattern. High in earlier, drop in age of twenty and increase again (Herzberg in Padmaja, Bhar, & Gangwar, 2013).

In the early of work mostly new nurse will experience the exciting moment and reflect it into religious or spiritual value they hold. Most nurses in this group came from young Indonesian religious group (Sallquist, Eisenberg, French, Purwono, & Suryanti, 2010). Following this, in the first five years of employment, they faced dynamic in work setting, unsatisfied with the work environment. Work situation criticizes their religious values and tends to be a rational person, because some person may question about God role and temporarily lost connection with the God (Penson in Agrimson & Taft, 2009). However, their level of caring behavior (Sulistyanto, 2009) prevent them from avoiding meeting patient with spiritual transformation. Supported by better and stable job position, wide opportunity to face complex and traumatic event in a relationship with patient and other, turn back their belief and hope. In such of the crisis in finding meaning and purpose of their life, they surrender to the Supreme Being they previously believed. Thus, promote spiritual development. Finally, they got benefit from the experience and continue to find meaning and purpose of their job (Agrimson & Taft, 2009; McBrien, 2006; Sallquist et al., 2010)

Learning Spirituality is challenging

Learning spirituality was reported very challenging by respondents. For example, only 52.4% (142) nurses remembered there were taught with spirituality concept during their education. Moreover, even though 13 percent have been trained with the spiritual care issue in work setting, 7 of 13 remained felt incompetence in delivering spiritual care. This study was relevant with previous study that only 25.4 % (15) nurses had a good spiritual competence (Arini, Susilowati, & Mulyono, 2015). This finding confirmed the difficulty level of learning and teaching spiritual care or spirituality in the school and the clinic.

Authors provided a number of argumentations in explaining how to learn spirituality and spiritual care. One argued that inclusion in the nursing curriculum be beneficial out of its limitation. The student can learn that the concept can be learned and transferable. The student also can follow the real nurse role modeling from the teacher (Taylor, Testerman, & Hart, 2014). On the other hand, other authors also reported positive benefit if providing spiritual care as separated course. Because it opened the opportunity to deliver the learning process in the various innovative strategies (Shih, Gau, Mao, Chen, & Kao Lo, 2001). However, adding content, or credit time will burden undergraduate nursing curriculum. Alternatively, advanced technology, great e-learning offered an alternative method to provide a course of spirituality and spiritual care as a continuing education. In fact, the online learning was not effective for working nurses as the learner (Feng et al., 2013). So that, developing an innovative learning design is a challenge to overcome the situation.

Nurses Performed Spiritual Care as a Caring Behavior but Undocumented

This study also indicated that teaching spirituality and spiritual care already affected the practice setting, however they were not well documented. Nurses sensitiveness to patient spiritual need through listening to the patients' statements, observing the signal, or family reports (Table 4) represented nurses' caring behavior. A study to in Surakarta confirmed that nurses caring behaviors were fairly good (Sulistyanto, 2009). Regrettably, nurses did not document their care well in their NCP. Consequently, the

were a communication gap as reported that respondent rarely considered the patients spiritual need from the NCP or other nurses (Table 4).

Nursing documentation might influence poor scores of SSCRS. A study reported that more than half nursing documents suffered from a lack of quality (Triyanto & Kamaluddin, 2008; Yanti & Warsito, 2013). This condition would be worse if the nurse thought that nursing documentation burdened their job. Because workload and limited guidelines were responsible for the lack of providing spiritual care (Rushton, 2014; Stranahan, 2001). Since then, the nurses perceived spiritual care negatively.

The nursing document is a valuable resource for clinical learning. Lack of information resulted in losing potential resources for further investigation. According to Benner (1982), to be an expert, nurses should pass every steps of professional development. Unavailability of learning resources paused the nurses to be expert. Consequently, a novice would not have a role model in provideng spiritual care.

The Spiritual Care Score was Low while Spirituality Score was High.

Nurses' SC score tended to low (mean 20.1), comparing to the theoretical SC's median score (21). Without supporting environment, the nurse might change the perception to spirituality and spiritual care even though already exposed to the concept. Because spirituality was not in the basic of human need that commonly learned in nursing education. Since the environment did not put spirituality as the main organization issue; there is no reason for the nurse to respond the spiritual issue among patient enthusiastically.

Religious based organization did not guarantee to put interest on spiritual care and make the spiritual care become undeliverable care. Spiritual need is not an attractive business matter. The previous study to assess nursing spirituality and their organizational commitment identified that the nurse spirituality was not well facilitated even though they worked in the religiously affiliated hospital (Mulyono, 2011). Without organization support, barriers become stronger. Even the post-registration nurses will feel difficult to provide spiritual care (Milligan, 2004). Therefore, the nurse perception of spiritual care is lower than the perception of spirituality.

In contrast to perception to SC represented in the score, the perception of spirituality was better. The S's mean score (46.18) was higher than the theoretical median (35.5). Since this study located in Java, the spiritual trait of Javanese (Wijayanti & Nurwianti, 2010) were involved in developing good perception of spirituality. This value and belief contribute in developing a positive correlation to the score of spirituality (Ozbasaran et al., 2011). Moreover, since 2000, the word 'spiritual' and 'spiritualties' have been extensively used in books, research publication, training, and other religious activities (Muttaqin, 2012). The combination of original spiritual belief and newly acquired concepts of spirituality may take part dynamically in developing nurse perception. As reported in Iran, the nurse perception in Iran, which mostly Muslim, emerged similar theme in defining spirituality with the western (Mahmoodishan, Alhani, Ahmadi, & Kazemnejad, 2010).

CONCLUSION

Nurses perceptions of spirituality was better than other compared countries. All nurses were similar in perceiving spirituality and spiritual care; except those who lived in the southern area in Central Java. Most nurses had a similar perception of spirituality and spiritual care. Only geographic characteristic has significant variation. This study also confirmed challenges in teaching spirituality and spiritual care.

LIMITATION

The power sample of this study was higher than 0.9 however, Javanese population dominated the sample that possibly could change the results on the various population. Moreover Central Java province was only a small part of the bigger Indonesia. Wider coverage and

more heterogeneous and representative sampling might refine the finding.

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