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Spiritual Care Education and Its Impact on Clinical Competence, Confidence, and Caring Attitudes Among Healthcare Professionals: A Mixed-Methods Study

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A B S T R A C T

Introduction: Spiritual care is a vital component of nursing that meets patients' spiritual needs, particularly in palliative care. However, spiritual care education should be included in nursing curricula, especially in culturally diverse settings like Indonesia. **Objective:** This study aimed to evaluate the effectiveness of spiritual care education on nursing students' clinical competence, self-confidence, and caring attitudes during a four-week clinical rotation in a palliative care unit in Indonesia. **Methods:** A sequential explanatory design was used, combining quantitative and qualitative approaches. The quantitative phase involved 127 nursing students in a quasi-experimental design to assess changes in competencies. Data collection included questionnaires measuring self-efficacy, caring attitudes, clinical competency, and clinical judgment. The qualitative phase involved focus group discussions with ten purposively selected students to explore experiences and challenges in providing spiritual care. Quantitative data were analyzed using the Wilcoxon test, while qualitative data were analyzed through thematic analysis. **Results:** Quantitative findings significantly improved students' self-efficacy, caring attitudes, and clinical competence. Qualitative results revealed barriers to spiritual care, including communication difficulties, fear of errors, and cultural sensitivity. **Conclusion:** Integrating spiritual care into nursing education enhances nursing students' competence and caring attitudes. Addressing cultural and communication barriers is crucial for improving holistic patient care in diverse contexts.

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1. INTRODUCTION

Spiritual care is a core dimension of holistic nursing practice, particularly in palliative care, where patients frequently experience existential distress, loss of meaning, and spiritual suffering alongside physical symptoms (Lukovsky et al., 2021; Tarbi & Meghani, 2019). Within nursing practice, spiritual care involves the ability to assess patients' spiritual needs, engage in meaningful dialogue about values and beliefs, and provide culturally sensitive interventions that support patients' sense of meaning, hope, and connectedness. When effectively delivered, spiritual care contributes to improved quality of life, psychological well-being, and patient–nurse relationships, especially in end-of-life contexts (Goncalves et al., 2017; Quinn & Connolly, 2023).

Despite its recognized importance, spiritual care remains inconsistently integrated into nursing education worldwide. Existing evidence suggests that most spiritual care education models are derived from Western contexts, predominantly North American and European, often reflecting Christian or secular spiritual frameworks (Jones et al., 2021; Mthembu et al., 2016). While these studies demonstrate positive effects on students' spiritual awareness and attitudes, their findings may not be readily transferable to regions with distinct cultural, religious, and social norms. This imbalance limits the global applicability of spiritual care education and underscores the need for empirical studies situated in non-Western settings, including Muslim-majority countries such as Indonesia.

In Indonesia, spirituality and religion are deeply embedded in daily life and healthcare experiences. However, the integration of structured spiritual care education into nursing curricula remains limited and uneven. Previous Indonesian studies suggest that nurses' perceptions of spirituality and their ability to provide spiritual care are significantly influenced by prior educational exposure, clinical department, and institutional support (Sinaga et al., 2021). Among nursing students, spirituality has been shown to correlate with positive perceptions of spiritual care, yet students often report uncertainty and discomfort when translating theoretical knowledge into clinical practice (Arvianty Shafira Putri et al., 2023). Classroom-based approaches, including case-based and cooperative learning, have demonstrated promise in improving students' understanding of spiritual care processes (Popy Siti Aisyah et al., 2022), but these studies rarely examine how such learning is enacted during real clinical encounters, particularly in palliative care settings.

From an educational perspective, the gap between knowledge acquisition and clinical application highlights the importance of experiential and reflective learning processes. Drawing on experiential learning theory and caring science, spiritual care education can be understood as a mechanism that enhances clinical competence, self-confidence, and caring attitudes by allowing students to integrate cognitive understanding, emotional engagement, and reflective practice in authentic clinical contexts (Kang et al., 2021; Sharifi et al., 2024). Through guided bedside teaching, reflection, and culturally grounded interventions, students may develop not only technical competence but also the confidence and moral sensitivity needed to address patients' spiritual needs (Heydari & Beigzadeh, 2024; Shin et al., 2023). However, empirical evidence examining these mechanisms, particularly in culturally and religiously diverse contexts, remains scarce.

The absence of standardized spiritual care curricula and structured clinical learning models in Indonesia further contributes to gaps in competence and confidence among nursing students

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(Setiowati & Said, 2024). Without adequate preparation, students may perceive spiritual care as sensitive, taboo, or outside their professional role, which can undermine holistic patient care, especially in palliative settings where spiritual concerns are most pronounced (Davis et al., 2020; Hawthorne & Gordon, 2020). These challenges point to the need for educational models that explicitly integrate spiritual care into clinical learning, supported by culturally relevant pedagogical strategies and reflective supervision.

This study is guided by an integrated conceptual framework drawing on **holistic nursing theory, experiential learning theory**, and **caring science** (Kolb & Kolb, 2022; Murali, 2020). Holistic nursing positions spirituality as an essential dimension of professional care, particularly in palliative settings (Lukovsky et al., 2021; Quinn & Connolly, 2023). Experiential learning theory explains how nursing students develop competence through clinical experience, reflection, and active application of knowledge (Kolb & Kolb, 2022). Caring science provides the relational and moral foundation through which engagement with patients' suffering fosters empathy and authentic presence (Watson, 2008). Within this framework, spiritual care education, implemented through bedside teaching, reflection, and evidence-based spiritual interventions, is expected to enhance clinical competence, strengthen self-confidence, and cultivate caring attitudes, with cultural and religious context acting as a moderating influence (Sinaga et al., 2021; Taylor et al., 2023).

Therefore, this study aimed to evaluate the implementation of spiritual care education among nursing professional students during a four-week clinical rotation in a palliative care unit in Indonesia using a mixed-methods approach. Specifically, the study sought to: (1) assess the impact of spiritual care–focused clinical learning on students' clinical competence, self-confidence, and caring attitudes, and (2) explore students' reflections and perceived barriers when providing spiritual care in a palliative care context. By situating spiritual care education within a real-world clinical setting and a culturally specific context, this study addresses a critical gap in the literature and contributes evidence to inform the development of culturally sensitive spiritual care education models in nursing.

2. METHODS

Research Design

This study employed a sequential explanatory mixed-methods design, consisting of a quantitative quasi-experimental pre–post phase followed by a qualitative descriptive phase (Doyle et al., 2020). The quantitative component assessed changes in nursing students' clinical competence, self-confidence, and caring attitudes following spiritual care–focused clinical learning. The qualitative component explored students' experiences, perceived barriers, and reflections on providing spiritual care in a palliative care setting, thereby enriching the interpretation of the quantitative findings.

Setting and Participants

In Indonesia, undergraduate nursing graduates proceed to a one-year professional nursing program comprising clinical rotations across various healthcare settings. The study population included 127 first-semester professional nursing students enrolled in the Nursing Department, Faculty of Health Sciences, Universitas' Aisyiyah Bandung, during the 2024–2025 academic year.

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Total sampling was used for the quantitative phase to minimize selection bias. Inclusion criteria were willingness to participate and completion of a minimum four-week clinical rotation in a palliative care unit. Students who did not complete the full clinical rotation were excluded.

For the qualitative phase, ten students were selected purposively to ensure variation in self-confidence levels, caring attitudes, and clinical competence scores. Data collection continued until thematic saturation was achieved, as indicated by the repetition of themes and the absence of new categories emerging during analysis.

Intervention: Spiritual Care–Focused Clinical Learning

Spiritual care education was integrated into routine clinical learning activities during a four-week palliative care rotation. The intervention followed a structured yet progressive sequence combining bedside teaching (BST), reflective practice, evidence-based nursing (EBN), and supervised clinical assessment.

1. Week 1–3 emphasized guided bedside teaching and reflective discussions focused on spiritual assessment, communication, and culturally sensitive interventions.
2. Evidence-based spiritual interventions (e.g., spiritual-emotional freedom technique, prayer guidance, bibliotherapy, and Qur'anic healing) were introduced and practiced under supervision.
3. Week 4 emphasized independent implementation, clinical evaluation, and reflective synthesis.

Reflection sessions were conducted weekly to facilitate experiential learning and integration of theory into practice. This structure was informed by experiential learning principles, enabling students to move from observation to active clinical engagement. The research procedure proceeds in the following stages, presented in Table 1.

Table 1. Intervention Procedure

	1st weeks	**2nd weeks**	**3rd weeks**	**4th weeks**
	Case I	Case II	Case III	Case IV
1st days	Self-assessment CA and SC	BST	BST	Mini-Cex II
2nd days	BST	Mini-Cex I	BST	EBN implementation
3rd days	BST	BST	BST	EBN implementation
4th days	DOPS I	BST	DOPS II	EBN implementation
5th days	case report	EBN	Meet the expert	case report
6th days	Reflection	Reflection	Reflection	self-assessment CA and SC

CA (Caring Attitude); SC (Self-Confidence); BST (bedside teaching); DOPS (Direct Observational Procedural Skill); EBN (Evidence-Based Nursing); Mini-Cex (Mini Clinical-Examination). Institutions or clinical preceptors do all BST. All DOPS and Mini-Cex assessments by clinical preceptors.

Instruments and Measures

Three validated instruments were used to assess study outcomes, selected based on their psychometric strength and relevance to nursing education and clinical competence.

1. **Self-Confidence.** Self-confidence was measured using a modified version of the *Student Satisfaction and Self-Confidence in Learning* questionnaire (Alsadi et al., 2023). The instrument consists of 14 items rated on a Likert scale and demonstrated high internal consistency (Cronbach's α = 0.928). Scores were dichotomized into low and high self-confidence using the median as the cut-off point.

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2. **Caring Attitudes.** Caring attitudes were assessed using the *Caring Behaviors Assessment Tool– Nursing Version Short Form (CBAT-SF)* (Akgün et al., 2021). The instrument comprises 27 items, rated from "never" to "always," and demonstrated good reliability following Indonesian translation (Cronbach's α = 0.84). Scores were categorized as poor, good, or excellent based on established cut-offs.
3. **Clinical Competence.** Clinical competence was evaluated using the Mini-Clinical Evaluation Exercise (Mini-CEX) and Direct Observation of Procedural Skills (DOPS), both widely used workplace-based assessments with established validity (Ansari et al., 2013). Assessments were conducted by trained clinical preceptors.

To reduce potential observer bias, assessors were not informed of students' prior scores and used standardized checklists during evaluations.

Data Collection Procedures

Baseline assessments of self-confidence and caring attitudes were conducted at the beginning of the clinical rotation, with follow-up assessments completed during the fourth week. Clinical competence was evaluated progressively using Mini-CEX and DOPS during weeks two to four.

For the qualitative phase, focus group discussions (FGDs) were conducted after completion of the clinical rotation using a semi-structured interview guide. FGDs explored students' experiences with spiritual assessment, interventions, emotional responses, and perceived barriers to implementing spiritual care.

Data Analysis

Quantitative data were analyzed using univariate and bivariate analyses. Descriptive statistics summarized participant characteristics and the distributions of outcomes. The Wilcoxon signed-rank test was used to examine pre–post differences due to non-normal data distribution. Statistical significance was set at $p < 0.05$.

Qualitative data were analyzed using thematic analysis, following familiarization, coding, theme development, and refinement (Creswell, 2014). Two researchers independently coded the transcripts, and discrepancies were resolved through discussion to enhance the credibility of the findings. Trustworthiness was ensured through peer debriefing and the use of direct quotations.

The integration of quantitative and qualitative findings occurred at the interpretation stage, allowing qualitative themes to contextualize and explain changes in the quantitative outcomes.

Ethical Considerations

Ethical approval was obtained from the Institutional Review Board of Universitas Aisyiyah Bandung (No. 398/KEP.01/UNISA-BANDUNG/IV/2023). Written informed consent was obtained from all participants. Confidentiality and anonymity were maintained, and participation was voluntary with the right to withdraw at any time.

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3. RESULT

3.1 Participant Characteristics

The characteristics of the participants in this study included age, work history, and gender, as listed in Table 2.

Table 2. Characteristic Participants and Correlation with Self-Confidence, Caring Attitude, and Clinical Competencies

Characteristics	f	%	SC *p-value*	CA *p-value*	CC *p-value*
Work experience			0,414*	0,466*	0,218*
Yes	38	29,9			
No	89	70,1			
Gender			0,012*	0,315*	0,114*
Female	96	75,6			
Male	31	24,4			
Age			0,067	<0,001*	<0,001*

Mean age 25 years, *Lambda test, SC (self-confidence), CA (caring attitude),CC (clinical competencies)

Table 2 indicates that A total of 127 nursing professional students participated in the quantitative phase. Most participants were female (75.6%) and had no prior clinical work experience (70.1%), with a mean age of 25 years. As shown in Table 2, demographic variables such as gender and work experience were not significantly associated with self-confidence, caring attitudes, or clinical competence. Age demonstrated a significant positive association with caring attitudes and clinical competence, suggesting that greater maturity may support the development of relational and clinical skills. This is illustrated in Figure 1.

3.2 Changes in Self-Confidence, Caring Attitudes, and Clinical Competence

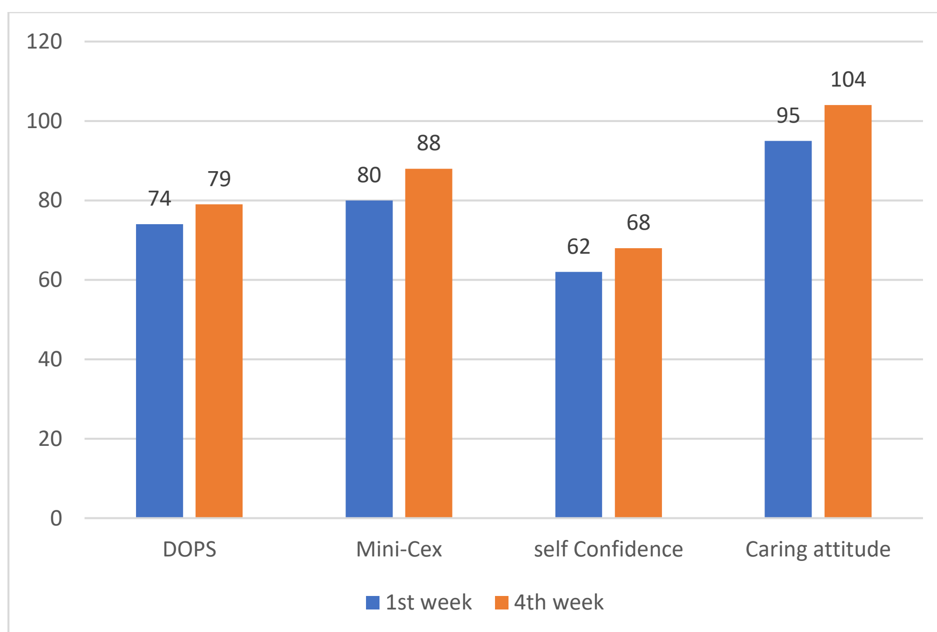

Figure 1. The Mean Values for Caring Attitudes, Self-Confidence, and Clinical Competencies

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Table 3 demonstrates that self-confidence increased modestly but consistently, with the proportion of students classified as having high self-confidence rising from 52.0% in the first week to 68.5% in the fourth week (Table 3). This improvement indicates greater perceived readiness to engage with patients' spiritual needs, although the magnitude of change suggests that confidence development may require sustained or longitudinal exposure.

Table 3. Categorization of Self-Confidence, Caring Attitude, and Clinical Competencies of Nursing Students (N=127)

Variables	1st week		4th week	
	f	%	f	%
Self-confidence				
low	61	48	40	31,5
high	66	52	87	68,5
Caring attitude				
poor	6	4,7	0	0
good	59	46,5	7	5,5
excellent	62	48,8	120	94,5
Clinical Competencies				
Mini-Cex				
below expectation	0	0	0	0
borderline	0	0	0	0
meet expectation	17	13,4	11	8,7
above expectation	110	86,6	116	91,3
DOPS				
below expectation	0	0	0	0
borderline	0	0	0	0
meet expectation	66	52	29	22,8
above expectation	61	48	98	77,2

Overall, nursing students demonstrated statistically significant improvements in self-confidence, caring attitudes, and clinical competence following four weeks of spiritual care–focused clinical learning (Table 4). Mean scores for all outcome variables increased from baseline to the final week, with p values < 0.001.

Table 4. Mean Difference between Self-Confidence, Caring Attitude, and Clinical Competencies

	Median (min-max)	Mean±SD	*p**
1st-week self-confidence	61(54-70)	62,17±5,62	<0,001
4th-week self-confidence	68(60-70)	67,67±2,67	
1st-week caring attitude	98(80-106)	94,94±5,77	<0,001
4th-week caring attitude	106(86-110)	103,98±5,81	
2nd-week mini-cex	79(58-93)	80,61±6,28	<0,001
4th-week mini-cex	89(73-98)	88,13±5,28	
1st week DOPS	75(57-88)	73,76±6,65	<0,001
3rd-week DOPS	80(57-91)	79,31±6,67	

*Wilcoxon test (CI, 95%)

Caring attitudes showed the most pronounced improvement. While a small proportion of students initially demonstrated poor caring attitudes (4.7%), by the fourth week, all participants were categorized within the good to excellent range, with 94.5% achieving excellent caring

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attitudes. This finding suggests that repeated engagement with spiritually sensitive patient care may particularly enhance affective and relational dimensions of nursing practice.

Clinical competence, as measured by Mini-CEX and DOPS, was consistently high throughout the rotation, with most students meeting or exceeding expectations even at baseline. Although statistically significant improvements were observed, the high initial scores indicate a potential ceiling effect, which may have limited the sensitivity of these instruments to detect larger changes over time. Nonetheless, the upward trend supports the contribution of spiritual care integration to refining clinical performance within palliative care contexts.

3.3 Qualitative results

Four themes emerged from the analysis of the answers to the open-ended questions about perceptions of the implementation of spiritual care in the palliative unit related to the positive and negative aspects of the activities. Sub-themes emerged from these themes according to the interview results.

Table 5 presents the characteristics of participants involved in the focus group discussion, where participants have a range of low to high self-confidence, a caring attitude that is good to excellent, and minimal clinical competence, ranging from meeting expectations to exceeding them.

Table 5. Participants Characteristics in the Qualitative Phase

No	Age	gender	SC	CA	DOPS	Mini-Cex
P1	23	male	less SC	good	74	71
P2	22	female	les SC	good	70	74
P3	23	female	High SC	good	88	76
P4	22	female	High SC	excellent	75	79
P5	21	female	High SC	excellent	75	78
P6	22	female	High SC	excellent	74	77
P7	23	male	less SC	good	73	75
P8	21	female	less SC	good	70	75
P9	22	male	les SC	good	72	75
P10	22	female	High SC	excellent	79	80

Spiritual Assessment

In the palliative care unit, nursing students perform spiritual assessments of patients. These assessments delve into the patients' beliefs, support systems, and religious practices to gain insight into their life's meaning and purpose, considering their current health conditions rather than solely focusing on their religious beliefs and practices. The results of the focus group discussion can identify the most difficult spiritual assessment holistically as follows:

1) Meaning: "The meaning of life is the most difficult part to study. The meaning of life is personal and subjective. Each person has a different meaning in life (P1). "*Assessing the meaning of life, the choice of words is sometimes difficult and afraid of offending the patient*" (P3). "*I also find it difficult when asking about how patients make meaning of their lives; sometimes my questions are not understood by patients*" (P4). "*The meaning of life and divinity is the most difficult to study. These two things are rarely discussed when the patient is hospitalized'* (P6). "*The meaning of life is the most difficult part to study, and I am confused about starting the first sentence when asking this*" (P9).

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2) Worship: "*Assessing a patient's worship habits is the most difficult part to assess. Worship habits such as prayer or others for me are sensitive things, worried about patient misperceptions*". (P5). "*Assessing the patient's worship habits is the most difficult part to assess. I am not used to it, and sometimes I am embarrassed to ask because I am still not good at worship*" (P8).
3) Negative emotion: "*when assessing the patient's negative emotions*" (P2). "*The difficulty is when assessing the patient's negative emotions*." (6)
4) Culture:' *I am confused about deciding the proper intervention if the patient has his own culture in how to heal; for example, there are sacred objects that the patient believes can protect him, whether I let it or I prevent it*. (P10)

The psycho-spiritual interventions given to patients during spiritual care

1) Spiritual-Emotional Freedom Technique (SEFT): "*I did SEFT on a breast cancer patient*" (P1). "After doing SEFT" (P2). "*giving SEFT intervention*." (P3) and (P9). "*I tried SEFT once on the patient*" (P6).
2) Qur'anic healing: "*Qur'anic healing by providing audio of reading the qur'an through a cellphone*"' (P3). "*Listening to the sound of the Qur'an through a cellphone*" (P4)
3) Bibliotherapy: "*Read a text about the reward of patience from God for the illness*" (P5). "*Giving readings about the struggles of terminally ill people and then discussing with patients*" (P7).
4) Prayer guidance: "*Prayer to relieve pain, while I rub the area of the leg that hurts*" (P4). "*Pray before and after the intervention*" (P5)

The barriers to the implementation of spiritual care

Nursing students mentioned several barriers to implementing spiritual care in palliative care units.

1) Communication problems: "*I am confused about how to start a conversation about spirituality or culture with the patient, choosing appropriate words for the patient'* (P6). "*I find it difficult to summarize the patient's words if she is too talkative*" (P7)
2) Afraid to make a mistake: "*I am afraid that patients will feel interrogated*" (P7). "*I am worried about the judgment of the lecturer or supervisor. I am afraid they will consider me incompetent in conducting nursing care as a whole*. (P8). "*I am afraid I will make a mistake*" (P10)
3) Taboo: "*I feel there is a negative stigma towards spiritual; spirituality is often seen as unimportant, or even as a taboo*" (P3), "*I feel that there are still nurses who consider spiritual assessment as unimportant, or even as a nuisance*" (P5).
4) Less competence: "*I also feel unskilled in conducting spiritual assessments or interventions, especially in an Islamic context*" (P2). "*I have not been trained to identify signs and symptoms of spiritual distress and to evaluate after implementation*" (P4). "*I also like to forget the order of the assessment and even miss some things*" (P3).
5) Less support: "*I need more guidance from my educational institution or place of practice*' (P2).
6) not sure or not understood yet about spirituality: "*I need to improve my understanding of spirituality and differentiate it from religion. I'm also unsure how to address my patient's spiritual needs.*" (P1).

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"*Many student nurses often overlook the importance of spirituality in palliative nursing care.*" (P3). "*I am unsure how to differentiate between spiritual distress and other mental disorders*" (P4). "*How to incorporate the spiritual assessment results into nursing documentation*" (P9).

7) Uncomfortable: "*I feel uncomfortable discussing spiritual matters*" (P1), "*I am worried that they will find me disrespectful*" (P2). "*I am afraid that patients will feel uncomfortable or even offended*" (P6). "*I feel uncomfortable with questions of a personal nature or culture*" (P7). "*I feel uncomfortable with spiritual matters, fearing that the patient will take offense*" (P9).

Insight from the delivery of spiritual care

Finally, the discussion on insight from the implementation of spiritual care has two themes:

1) Positive feeling: "*The patient's impression makes me happy to take care of him*" (P10). "*I am happy with this situation*" (P7). "*..so, I am happy*" (P1).
2) Spiritual awareness: "*reminds me of my parents, so I am more saying to them, SEFT can be very useful if done seriously* (P2). "*increasingly realizing that humans need to be supported spiritually* (P4). "*I believe the power of this prayer can heal*." (P4). "*I learned to be grateful for life from these patients*" (P5). "*Gave me the realization for myself, that life is short and we must do the best charity*" (P9).
3) Caring for awareness: "*I will better prepare the questions I will ask the patient. The questions should be open-ended and empathic*" (P4). "*I must exercise patience to listen attentively*" (P5). "*I will give the patient enough time to answer my questions*" (P6). "*I will respect the patient's beliefs and faith more, and I will avoid making judgmental or coercive statements*" (P7). "*I will seek feedback from the patient or family about my nursing care*" (P9)

Integration of Quantitative and Qualitative Findings

The qualitative findings provide contextual depth to the observed quantitative improvements, particularly in explaining how and why changes occurred. Students described increased awareness of patients' emotional and spiritual suffering, which aligned with the substantial gains observed in caring attitudes. Enhanced self-confidence was reflected in students' narratives describing greater comfort initiating spiritual conversations and responding empathically to patients' concerns.

However, qualitative data also revealed persistent challenges that help explain the more modest gains in self-confidence and competence. Students reported difficulties with spiritual assessment, fear of making mistakes, discomfort discussing sensitive topics, and uncertainty in distinguishing spiritual distress from psychological symptoms. These barriers underscore the complexity of translating spiritual care knowledge into confident clinical action, even when measurable competencies are improved.

4. DISCUSSION

This study examined the impact of spiritual care–focused clinical learning on nursing professional students' clinical competence, self-confidence, and caring attitudes during a palliative care rotation in Indonesia. Overall, the findings demonstrate that integrating spiritual care into clinical education is associated with significant improvements across cognitive, affective, and

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behavioral domains of nursing practice. These results underscore the importance of spiritual care as a vital component of holistic nursing education, particularly in end-of-life care settings.

Consistent with previous studies conducted in Western contexts, this study found that structured spiritual care education enhances nursing students' competence and caring orientation (Chiang et al., 2020; Martins et al., 2017). However, this study extends existing literature by situating these outcomes within a Muslim-majority, culturally diverse context, where spirituality is deeply embedded in everyday life yet often considered sensitive or taboo in formal clinical interactions. This contextual distinction is critical, as it highlights that the effectiveness of spiritual care education is not solely determined by curriculum content, but also by cultural norms, religious meanings, and institutional support.

The most substantial improvement was observed in caring attitudes, suggesting that repeated exposure to spiritually vulnerable patients may particularly strengthen empathic engagement and moral sensitivity. From a caring science perspective, sustained encounters with patient suffering foster authentic presence and compassion, which are central to caring behaviors (Kandula & Usha, 2019; Murali, 2020). In contrast, gains in self-confidence were more modest, reflecting the emotional and communicative challenges inherent in the delivery of spiritual care. Qualitative findings revealed that students frequently feared offending patients, making mistakes, or being judged by supervisors, concerns that may inhibit confidence despite adequate knowledge and skill acquisition.

Although clinical competence scores improved significantly, the consistently high baseline scores suggest a potential ceiling effect. This pattern indicates that while students demonstrated strong technical performance early in the rotation, spiritual care education may function more as a refinement and deepening process rather than a primary driver of technical skill acquisition. Alternative explanations for competence improvement, such as clinical maturation, repeated exposure to palliative settings, and increased familiarity with assessment tools, must therefore be considered. However, qualitative data suggest that spiritual care education uniquely contributed to students' ability to integrate psychosocial and spiritual dimensions into clinical decision-making, an aspect not captured by technical assessments alone.

Importantly, this study identified culturally specific barriers to spiritual care implementation, including perceptions of spirituality as taboo, uncertainty in differentiating spiritual distress from psychological symptoms, and discomfort addressing religious practices. These challenges contrast with Western-based studies, where spiritual discussions may be framed more openly or secularly (Mthembu et al., 2016; Willett et al., 2024). The findings underscore that spiritual care education cannot rely solely on universal models, but must be culturally adapted to align with local beliefs, communication norms, and religious practices.

The identification of culturally grounded interventions such as prayer guidance, Qur'anic healing, and spiritual-emotional freedom techniques further highlights the importance of contextual relevance in spiritual care education (I. P. Dewi et al., 2018, 2020, 2024; I. P. I. Dewi & Widiyanti, 2018; Inggriane, 2016; Inggriane et al., 2019). These interventions resonate with patients' belief systems and may enhance acceptability and effectiveness in Indonesian palliative care settings (Komariah et al., 2020). However, their use also requires clear ethical guidance, reflective supervision, and evidence-based framing to ensure professional boundaries and patient-centered care.

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Implications for Nursing Education, Practice, and Policy

The findings of this study have several practical implications. First, spiritual care education should be systematically integrated into nursing curricula, not limited to theoretical instruction but embedded within clinical learning experiences. Educators should employ experiential learning strategies, including supervised bedside teaching, guided reflection, and case-based discussions focused on spiritual assessment and intervention.

Second, faculty development is essential. Nurse educators and clinical preceptors require training to confidently model spiritual care, facilitate reflective dialogue, and address students' fears and uncertainties. Institutional support, including clear guidelines, documentation standards, and interprofessional collaboration with chaplains or spiritual leaders, can further normalize spiritual care as a legitimate component of professional nursing practice.

At the policy level, nursing education standards in Indonesia should explicitly recognize spiritual care competence as a key component of professional nursing outcomes. Aligning spiritual care education with national nursing competency frameworks would strengthen its legitimacy and sustainability within academic and clinical institutions.

Limitations

This study has several limitations that should be acknowledged. First, the research was conducted within a single cultural and religious context, which may limit generalizability to other regions or healthcare systems. Second, the absence of a control group restricts causal interpretation, as improvements may partially reflect clinical maturation or repeated exposure to palliative care environments. Third, the relatively short duration of the clinical rotation precludes assessment of long-term retention and transfer of spiritual care competencies. Finally, the high baseline competence scores suggest possible ceiling effects, which may have limited sensitivity to change.

5. CONCLUSION

This study demonstrates that integrating spiritual care education into palliative care clinical learning significantly enhances nursing students' clinical competence, self-confidence, and caring attitudes within the Indonesian context. Beyond measurable outcomes, spiritual care education fosters deeper spiritual awareness, empathy, and professional growth, supporting holistic nursing practice. However, culturally specific barriers—such as discomfort discussing spirituality and uncertainty in assessment—highlight the need for context-sensitive educational models. Future research should employ longitudinal designs to examine the sustainability of learning outcomes and comparative studies across cultural and religious settings to inform the development of standardized yet adaptable spiritual care curricula. By embedding culturally responsive spiritual care education into nursing training, educators and policymakers can better prepare nurses to deliver compassionate, holistic care aligned with patients' spiritual needs.

6. ACKNOWLEDGEMENT

We would like to express our sincere gratitude to all the nursing student participants for sharing their valuable insights and experiences. Our most profound appreciation goes to Universitas Aisyiyah Bandung for the support, guidance, and opportunity to conduct this study within its academic and research environment.

7. CONFLICT OF INTEREST

The authors declare no conflict of interest related to the conduct, analysis, or publication of this study.

8. REFERENCES

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