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ORIGINAL PAPER

Nursing Students' Perception Levels of Spirituality and Spiritual Care in Turkey

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Abstract

The present study was conducted to determine nursing students' perception levels of spirituality and spiritual care and the factors affecting these levels. The study was carried out in the nursing faculty of a university located in eastern Turkey between April and June 2019. The study population was made up of students studying within a department of nursing ($n = 1250$), and involved a sample size of 420 students, determined by power analysis. Data were obtained from an 'Introductory Information Form' that included students' sociodemographic characteristics and questions related to spiritual care and the Spirituality and Spiritual Care Rating Scale (SSCRS). Students scored, on average, 59.8 ± 9.7 on the SSCRS. Gender, year of undergraduate education, father's education level, knowledge of spiritual care, beliefs on the relationship between spiritual care and nursing care, and the ability to meet patients' spiritual needs were variables with an impact on the total SSCRS scores ($p < 0.05$). The findings show that spiritual care perception levels of nursing students were high.

Keywords Spirituality · Spiritual care · Nursing · Students

Introduction

It has been emphasised that individuals' physical, emotional, mental, socio-cultural and spiritual aspects must be considered when providing holistic care, which is considered the building block of today's general health systems (Boztilki & Ardıc,

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2017; Dastan & Buzlu, 2010; Ramezani et al., 2014). Health is no longer perceived as a passive state of existence; instead, it is a process of reaching higher health levels in every dimension (Chan et al., 2006). Spirituality and spiritual care are not new concepts to nursing and health care (Wong et al., 2008). From the past to the present, nurse leaders and international codes and standards have emphasised the spiritual aspect of practicing holistic care (Ergül, 2010). The European Commission (2010) also emphasises the importance of the spiritual, religious and cultural aspects of people's lives, in terms of feelings of welfare, and recommends that care professionals be trained in this respect.

Spirituality refers to the inborn instincts that make people's lives meaningful and give them hope (Narayanasamy, 2014). It makes it easier to connect with others and to find meaning and purpose in life (Oldnall, 1996; Uğurlu, 2014). Spirituality has a powerful impact, not only during times of sickness, but also in times of health, as it ensures that people recognise themselves and their strength. It gives them hope and a sense of peace by supporting their strengths and positive life perceptions (Ergül & Temel, 2004; Hall, 2006). Many studies in the literature show the positive contributions of spirituality to patients' lives (Bediako et al., 2011; Jim et al., 2015; Koenig, 2012; Moadel et al., 2000).

Spiritual care involves specific interventions to address the spirituality of patients which may involve assessment, support, guidance, counselling and the conduct of, or assistance with, ritual practices appropriate to a patient/client's needs (WHO, 2017). Accordingly, spiritual care involves standing by the individuals, being supportive in terms of religion and belief, being effective in solving problems and answering questions, showing ways to practice customs and worship, helping patients to find a sense of meaning for their existence and life during their painful, troubled, sad, and frightening periods and during times of crisis, such as the sudden onset of disease (Erişen & Sivrikaya, 2017). Scholars agree that nurses must be ready to provide spiritual care when needed, including the evaluation of spiritual needs, as patients may suffer from spiritual discomfort at any time during their treatment (Giske & Cone, 2015). If nurses evaluate patients' spiritual needs and develop interventions that help them to meet these needs, they can help patients improve their quality of life and, in some instances, decrease their pain (Barber, 2008). Nevertheless, many studies have revealed that nurses lack knowledge of how to practice spiritual care and that spiritual care is the most-neglected field when practicing care (Chan, 2010; Lundmark, 2006; Taylor, 2008). The reason for this is that nurses are not adequately conscious of patients' spiritual needs and are insufficiently informed of patients' spiritual needs during their nursing education; thus, they are not well prepared to provide spiritual care (Ergül, 2010). A recent systematic review by Lewinson et al. (2015) confirmed that nurses are aware of their lack of information, understanding, and skills in the field of spiritual care, but they are willing to be further informed and made capable.

When spirituality and spiritual care education are integrated into the nursing curriculum, or when training is provided on this subject, information and awareness about spirituality and spiritual care will increase, attitudes towards spirituality will improve, and the use of these techniques in patients' care will increase (Kazer et al., 2008; Meyer, 2003; Van Leeuwen et al., 2008). In Turkey, the concept of spiritual

care in nursing education is included in the holistic care philosophy in the dimension of human needs. It is of great importance that nursing educators know the spiritual care perspectives of their students so that they can make the connection between education and practice and evaluate students' awareness of the subject of spiritual care. The present study was conducted to determine nursing students' perception levels of spirituality and spiritual care and the factors affecting them.

Materials and Methods

Design and Sample

The descriptive study was conducted between April and June 2019 and included on the students in the nursing faculty of a university located in eastern Turkey. The population pf the nursing faculty included 1250 students. The sample of the study was 420 students, determined by power analysis with a 0.05 error rate, a 95% confidence interval, and 99% representation power.

Data Collection and Instruments

The data were collected using two different forms: an 'Introductory Information Form', which included students' socio-demographic characteristics, and the Spirituality and Spiritual Care Rating Scale (SSCRS). Data were collected during face-to-face interviews. The researcher visited classes before the students were informed about the study, and then received students' verbal/written consent to participate. Thereafter, the researcher distributed the survey forms to the students and gave them time (10–15 min) to complete them.

The Introductory Information Form

This form included 12 questions about students' socio-demographic characteristics and experiences related to spiritual care.

The Spirituality and Spiritual Care Rating Scale (SSCRS)

McSherry et al. (2002) developed the SSCRS and the validity and reliability of the Turkish versions were assessed by Ergün and Temel (2007). The SSCRS uses a 5-point Likert-type scale with 17 questions and 3 sub-scales. The questions in the scale were scored as '1', I strongly disagree; '2', I disagree; '3', I cannot decide; '4', I agree; and '5', I fully agree. Questions 3, 4, 13 and 16 were scored in reverse. The highest possible score on the scale is 85, while the lowest possible score is 17. A high score on the scale indicates that the respondent's spirituality and spiritual care perceptions are positively high. The scale includes sub-scales of Spirituality and Spiritual Care, Individual Care, and Religiosity. The validity and reliability for the

Turkish version have a Cronbach's alpha coefficient of 0.76 (Ergül & Temel, 2007). The present study's Cronbach's alpha was 0.80.

Study Variables

The students' demographic characteristics were the dependent variables in the study, while their perception levels of spirituality and spiritual care were the independent variables.

Statistical Analysis

The data were evaluated using SPSS 22.0 packet program and the *t* test, ANOVA, and Kruskal–Wallis H tests to determine percentage, mean, and correlation in independent groups. Tukey's HSD test was used in the advanced analysis to determine which group caused differences. The appropriateness of the data for normal distribution was evaluated using the Kolmogorov–Smirnov test. Nonparametric tests were used for the variables that were not appropriate for normal distribution. Cronbach's alpha was calculated to evaluate the internal coherence of the scale. The significance level in the interpretation of the results was set at $p < 0.05$.

Ethical Approval

Written permission to conduct the study was obtained from the Dean of the Nursing Faculty of the relevant university, and ethical approval was obtained from the University Health Sciences Scientific Research and Publication Ethics Committee (Decision number: 20656). Prior to obtaining students' verbal/written consent, the aim of the study and the purposes of the results were explained. Students were informed that they were free to participate in or withdraw from the study at any time.

Results

The mean age of the students who participated in the study was 20.8 ± 1.6. In all, 60.5% of the students were women, and the most (77.9%) identified as middle-income earners. One third (33.6%) were in their freshman year of undergraduate education. Most of the participants had parents with an elementary-level education (mothers: 43.8% and fathers: 31.2%) and 52.9% willingly chose to study nursing (Table 1).

Most (64.5%) of the students already had information about spiritual care; 51.7% of them stated that spiritual care was partly related to nursing care, 52.1% of them stated that they partly met their patients' spiritual care needs, and 68.9% of them said that their own lack of knowledge was the reason for only 'partially' meeting these

Table 1 Socio-demographic characteristics of the students

Socio-demographic variables	*N*	%
Age	$X \pm$ SD	
	20.8 ± 1.6	
Gender		
Female	254	60.5
Male	166	39.5
Year of undergraduate education		
1 (freshman)	141	33.6
2 (sophomore)	84	20.0
3 (junior)	115	27.4
4 (senior)	80	19.0
Economic status		
Upper	78	18.6
Middle	327	77.9
Low	15	3.6
Mother education level		
Illiterate	70	16.7
Literate/primary education	184	43.8
Secondary education	55	13.1
High school	60	14.3
University	51	12.1
Father education level		
Illiterate	13	3.1
Literate/primary education	131	31.2
Secondary education	65	15.5
High school	103	24.5
University	108	25.7
Did you choose the nursing department willingly/ voluntarily?		
Yes	222	52.9
No	198	47.1

needs. In response to the question, ‘What do you think spiritual care is?’, 50.7% of the students defined spiritual case as ‘helping patients fulfil their spiritual needs’. A total of 26.7% of the students described a spiritual case as ‘directing patients to other professionals when they want to see a spiritual consultant’, such as an imam. The students’ level of connection between religion and spirituality was found to be somewhat low (Table 2).

Students scored 59.8 ± 9.7 on the SSCRS, 25.6 ± 5.9 on the Spirituality and Spiritual Care sub-scale, 14.3 ± 3.3 on the Individual Care sub-scale, and 12.8 ± 2.7 on the Religiosity sub-scale. The total mean scores of the student nurses (59.8 ± 9.7) indicated that the students had a positive perception of their spirituality and spiritual care (Table 3).

Table 2 Students' thoughts on spiritual care

Do you have any information about spiritual care?		
Yes	271	64.5
No	149	35.5
Do you think spiritual care is related to nursing care?		
It is not related	22	5.2
It is a little related	217	51.7
It is very related	181	43.1
Do you think you sufficiently meet your patients' spiritual care needs?		
Yes	143	34.0
Partially	219	52.1
No	58	13.8
If no, what is your reason for not practicing spiritual care?* ($n = 58$)		
Lack of information	40	68.9
Workload-lack of time	22	37.9
Lack of experience	20	34.4
Lack of communication	14	24.1
Importance given to medical treatment	18	31.0
What do you think spiritual care is? *		
Showing empathy and compassion	183	43.6
Acknowledging and listening without prejudice, sparing time for the patient	187	44.5
Helping patients fulfil their spiritual needs	213	50.7
Therapeutic touch, maintaining the family process	172	41.0
Directing to other professionals when they want to meet with a spiritual consultant (such as an imam)	112	26.7

*Percentages are calculated based on the *n* value, there is more than one answer

Table 3 Spirituality and spiritual care rating scale mean scores of nurses

	Min–Max	X ± SD
Spirituality and spiritual care	7.0–35.0	25.6 ± 5.9
Individual care	4.0–20.0	14.3 ± 3.3
Religiousness	5.0–20.0	12.8 ± 2.7
Total score of SSCRS	33.0–81.0	59.8 ± 9.7

Table 4 shows a comparison of demographic variables and the means of the scale scores. There was a positive weak correlation between the age of students and the Religiosity sub-scale score (r: 0.160**), which was statistically significant ($p < 0.05$). However, there was no statistically significant correlation between age and the other sub-scales of the SSCRS ($p > 0.05$). The difference between the students' gender and Spirituality and Spiritual Care sub-scale and total SSCRS score was significant ($p < 0.05$), and female students' scores were higher than males' scores. However, the difference between gender and the Religiosity sub-scale was not significant ($p > 0.05$), although the male students' religiosity mean scores were

Table 4 Comparison of socio-demographic characteristics of students and average scores of spirituality and spiritual care rating scale and sub-dimensions

Socio-demographic variables	Number	Spirituality and spiritual care $X \pm$SD	Individual care $X \pm$SD	Religiousness $X \pm$SD	Total score of SSCRS $X \pm$SD
Age	420	$r = -0.018$ $p = 0.709$	$r = 0.012$ p = 0..813	$r = 0.160$ ***p*** **=** ***0.001****	$r = 0.039$ $p = 0.420$
Gender					
Female	254	26.3 ± 5.6	14.6 ± 3.2	12.8 ± 2.7	61.1 ± 9.5
Male	166	24.3 ± 6.0 $t = 3.439$ ***p*** **=** ***0.001****	13.8 ± 3.4 $t = 2.512$ ***p*** **=** ***0.012****	12.9 ± 2.6 $t = -.139$ $p = 0.889$	57.9 ± 9.9 t = 3.280 ***p*** **=** ***0.001****
Year of undergraduate education $^{\mathcal{F}}$					
1 (freshman)	141	26.6 ± 5.1	14.9 ± 2.7	12.2 ± 2.5	60.9 ± 8.2
2 (sophomore)	84	26.0 ± 5.4	14.13.0	13.1 ± 2.8	60.7 ± 9.2
3 (junior)	115	22.7 ± 6.6	12.84.0	12.6 ± 2.3	58.6 ± 9.9
4 (senior)	80	27.5 ± 5.0 F = 14.60 ***p*** **=** ***0.000*****	15.62.7 F = 14.73 ***p*** **=** ***0.000*****	14.1 ± 3.0 F = 9.20 ***p*** **=** ***0.000*****	64.6 ± 9.3 F = 20.69 ***p*** **=** ***0.000*****
Economic level					
High	78	25.0 ± 6.8	14.0 ± 4.0	13.3 ± 2.7	59.5 ± 10.9
Middle	327	25.8 ± 5.6	14.4 ± 3.1	12.8 ± 2.7	60.0 ± 9.4
Low	15	24.2 ± 6.7 KW = .915 $p = 0.633$	14.3 ± 3.9 KW = .248 $p = 0.883$	12.2 ± 2.2 KW = .4.288 $p = 0.117$	57.3 ± 10.8 KW = .410 $p = .815$
Mother education level $^{\mathcal{F}}$					
Illiterate	70	26.3 ± 4.7	14.7 ± 2.4	12.9 ± 2.6	61.1 ± 8.7
Literate/primary education	184	26.4 ± 5.0	14.7 ± 2.7	12.5 ± 2.5	60.7 ± 8.6
Secondary education	55	24.9 ± 6.1	14.2 ± 3.6	12.8 ± 2.8	59.1 ± 9.9
High school	60	24.8 ± 6.8	14.2 ± 4.0	12.8 ± 3.0	58.6 ± 10.2

Table 4 (continued)

Socio-demographic variables	Number	Spirituality and spiritual care $X \pm SD$	Individual care $X \pm SD$	Religiousness $X \pm SD$	Total score of SSCRS $X \pm SD$
University	51	23.1 ± 7.7 F = 3.88 ***p = 0.004****	12.6 ± 4.5 F = 4.48 ***p = 0.001****	14.2 ± 2.5 F = 4.29 ***p = 0.002****	57.2 ± 13.2 F = 1.948 $p = 0.102$
Father education level [ℱ]					
Illiterate	13	27.7 ± 6.5	14.8 ± 2.6	12.9 ± 3.2	62.9 ± 10.4
Literate/primary education	131	26.7 ± 4.3	14.9 ± 2.2	12.6 ± 2.4	61.3 ± 7.8
Secondary education	65	26.7 ± 4.2	15.4 ± 2.2	12.6 ± 2.7	61.9 ± 6.9
High school	103	25.9 ± 6.1	14.5 ± 3.4	12.6 ± 2.5	60.0 ± 10.0
University	108	22.9 ± 7.1 KW = 18.73 ***p = 0.001****	12.7 ± 4.4 KW = 19.79 ***p = 0.001****	13.5 ± 2.9 KW = 11.83 ***p = 0.019****	56.2 ± 11.9 KW = 12.23 ***p = 0.016****
Do you have any information about spiritual care?					
Yes	271	26.7 ± 5.0	15.0 ± 2.7	13.0 ± 2.7	61.9 ± 8.8
No	149	23.5 ± 6.7	13.1 ± 4.0	12.6 ± 2.5	56.1 ± 10.2
		$t = 5.437$ ***p = 0.000*****	$t = 5.713$ ***p = 0.000*****	$t = 1.129$ $p = 0.260$	$t = 5.966$ ***p = 0.000*****
Do you think spiritual care is related to nursing care? [ℱ]					
It is not related	22	21.2 ± 6.8	12.0 ± 4.7	12.4 ± 2.3	52.2 ± 10.6
It is a little related	217	25.3 ± 5.5	14.2 ± 3.0	12.7 ± 2.5	59.3 ± 8.6
It is very related	181	26.4 ± 6.0 KW = 16.12 ***p = 0.000*****	14.7 ± 3.4 KW = 11.86 ***p = 0.003****	13.1 ± 2.9 KW = 1.59 $p = 0.451$	61.4 ± 10.4 KW = 18.11 ***p = 0.000*****
Do you think you sufficiently meet your patients' spiritual care needs?					
Yes	143	27.9 ± 4.5	15.5 ± 2.6	12.6 ± 3.1	63.1 ± 8.4

Table 4 (continued)

Socio-demographic variables	Number	Spirituality and spiritual care $X \pm SD$	Individual care $X \pm SD$	Religiousness $X \pm SD$	Total score of SSCRS $X \pm SD$
Partially	219	25.2 ± 5.7	14.2 ± 3.1	12.8 ± 2.4	59.4 ± 9.2
No	58	21.3 ± 6.6	11.8 ± 4.2	13.6 ± 2.4	53.5 ± 11.3
		F = 30.91	F = 28.71	F = 2.65	F = 22.83
		p* = 0.000*	***p* = 0.000****	$p = 0.072$	***p* = 0.000****

* $p < 0.05$, ** $p < 0.001$, $\mathscr{F}$ = Tukey HSD, r = correlation

higher. The difference between the year of undergraduate education and the Spirituality and Spiritual Care, Individual Care and Religiosity sub-scales scores and the SSCRS total score was statistically significant ($p < 0.05$). Advanced analysis showed that the difference was caused by junior year level students. The difference between economic status and SSCRS and sub-scale mean scores was not statistically significant ($p > 0.05$). The difference between parents' education levels and the Spirituality and Spiritual Care, Individual Care and Religiosity sub-scale mean scores were statistically significant ($p < 0.05$). Advanced analysis revealed that the difference was caused by the students who were university graduates. The differences between knowledge about spiritual care, nursing care and practicing spiritual care and the SSCRS total scores and the Spirituality and Spiritual Care and Individual Care sub-scales were statistically significant ($p < 0.05$) (Table 4).

Discussion

The present study examined the perception levels of spirituality and spiritual care among nursing students and the factors affecting them. We found that gender, year in school, fathers' education levels, knowledge about spiritual care, the relationship of spiritual care to nursing care, and variables related to meeting patients' spiritual needs affected the students' perception levels of spirituality and spiritual care. The students scored an average of 59.8 ± 9.7 on the SSCRS, and their perception of spiritual care was high. Another study conducted on nursing students found that participants scored 64.9 ± 6.1 on the SSCRS and had a high perception of spiritual care (Celik & Utas, 2016). Other studies have found similar results (Lovanio & Wallace, 2007; Pour & Ozvurmaz, 2017). According to Nas (2018), nurses scored 62.5 ± 7.1 on the SSCRS, 27.2 ± 4.6 on the Spirituality and Spiritual Care sub-scale, 14.5 ± 2.4 on the Individual Care sub-scale, and 13.7 ± 2.6 on the Religiosity sub-scale. Kostak et al. (2010) showed that participants scored 60.97 ± 7.92 on the SSCRS. Similar results were obtained in other studies conducted to evaluate the perceptions of spiritual care, but the mean scores of working nurses were lower than those of student nurses. This may be because nurses working in clinical settings need to focus more on spiritual care through in-service training programmes and courses.

Although the students surveyed in the present study had a positive perception of spiritual care, a considerable number of them (35.5%) did not know about spiritual care. They were hesitant to define 'spiritual care' and often described it as 'helping patients fulfil their spiritual needs', which was a summarising expression. This is consistent with the findings reported by Kalkim et al. (2016) who conducted a study in Turkey on nursing students and found that more than half (53%) lacked information about spirituality and spiritual care. Other studies found that nursing students act based on their experiences and intuition when providing spiritual care (Lopez et al., 2015; Taylor et al., 2009).

Further, students who were knowledgeable about spiritual care and who believed that they met their patients' spiritual needs had significantly higher mean scores on the SSCRS than other groups did. Bulut and Meral (2019) found that students who knew about spirituality and spiritual care, who had received education, including

instruction on spirituality and spiritual care, and who practiced spiritual care during internships had higher SSCRS total and sub-scale scores than those who did not. A study by Celik and Utas (2016) revealed that 62.4% of the nursing students indicated that they did not receive information about spirituality and spiritual care, whereas 86.2% said that the information they received was insufficient. In the same study, 93.2% of the students stated that it was necessary to receive information about this subject. Studies that examined the impact of integrating spirituality into the undergraduate nursing curriculum showed that students responded positively to spiritual education and demonstrated competence in providing spiritual care (Cooper et al., 2013; Van Leeuwen et al., 2008). According to the results of the current study, it seemed that the subject of the 'spiritual approach to nursing care' has been included in the nursing curriculum as an elective, and that spiritual care was considered as possibly effective for achieving higher information levels in students.

The present study found a statistically significant difference between students' genders and scores on the SSCRS, Spirituality and Spiritual Care sub-scale, and Individual Care sub-scale ($p < 0.05$). Female students had higher levels of spirituality and spiritual care perception. Studies by Wong et al. (2008) and Shores (2010) demonstrated that gender has a significant effect on the spiritual care scale scores. Many studies conducted in Turkey have shown that gender has an impact on spirituality and spiritual care perceptions, and that women have higher levels of spirituality and spiritual care perceptions (Çelik & Utas, 2016; Daghan, 2018; Macit & Karaman, 2019; Nas, 2018; Yılmaz & Okyay, 2009). The literature emphasises that women are more successful in expressing their feelings, understanding others' feelings and that they are more compassionate and more sensitive to the needs of others (Coleman & Ganong, 1985). The results of the present study confirm these findings.

This study found a statistically significant difference between students' years of undergraduate education and SSCRS and sub-scale scores. The SSCRS mean scores of senior year students were the highest, whereas those of junior year students were the lowest. Some studies have reported that spiritual care scores increase as education status increases (Ozbasaran et al., 2011; Wu & Lin, 2011; Yılmaz & Okyay, 2009), while others have shown that education does not affect the perception level of spiritual care (Ercan et al., 2018; Genç & Durğun, 2018; Kostak et al., 2010; Macit & Karaman, 2019).

In this study, the perception of spiritual care among third-year students was lower than in other classes, perhaps because the subject was not adequately addressed in the courses 'Obstetrics and Gynaecology Nursing' and 'Paediatric Nursing'. Students need to become more competent in assessing the spiritual needs of mothers and children. Similar to the results of the present study, work by Erenoğlu and Can (2019) showed that third-year students had the lowest average SSCRS scores, whereas fourth-year students had the highest levels. However, no significant difference was found between students' year in school and total SSCRS scores. A study by Mermer et al. (2019) conducted on midwifery students found a significant difference between the students' year in school and their SSCRS mean scores, with fourth-year students showing the highest levels of spiritual care perceptions.

There was a significant difference between the participants' parents' education levels and perceptions of spirituality and spiritual care ($p < 0.05$). Those whose

parents had university level education showed the lowest scores on the SSCRS. A study conducted on nursing students found that the mother's education level affects the perception of spiritual support. However, unlike the results of the present study, the authors found that the spiritual support perception of the students whose mothers had university/college level education was quite high (Erenoğlu & Can, 2019). A few studies in the literature found that parents' education levels did not affect the participants' perceptions of spirituality and spiritual care (Bulut & Meral, 2019; Pour & Ozvurmaz, 2017). In this study, we suspect that social and cultural factors may have influenced the importance of parents' education levels on participants' spirituality and spiritual care perceptions. However, this subject needs further study and consideration.

Conclusıon and Recommendatıons

The present study, which was conducted to determine the perception levels of spirituality and spiritual care of nursing students and their associated factors, revealed that students' spirituality and spiritual care perceptions were positively high. Their perceptions were affected by variables such as gender, year of undergraduate education, father's education level, and knowledge about spiritual care, with most students believing that spiritual care was related to nursing care and practicing spiritual care. Based on the results, we argue that nursing students should pay more attention to this subject during their undergraduate education programmes to increase their knowledge of spiritual care. Beyond graduation, nurses' practical skills in spiritual care should be further enhanced through in-service training. Such nurses will have an increased awareness, knowledge, and skills of concepts related to spirituality and spiritual care that may be extended to better quality spiritual care for their patients.

Limitations

The study was conducted only with students studying in the nursing faculty of a university located in eastern Turkey, and thus, the results cannot be generalised to the entire society. The study was also limited by its use of a quantitative data collection method and only a small number of open-ended questions that allowed students to express their thoughts directly.

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Declarations

Conflict of interest The authors declare that they have no conflicts of interest.

Ethical statement All procedures in this research were performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. Ethical approval was obtained from the Bingol University Health Sciences Scientific Research and Publication Ethics Committee (Decision number: 20656).

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