Exploration of the Association Between Religious Affiliation and Attitude Toward Spiritual Care in Clinical Nurses

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ABSTRACT

Background: Religion is an important cultural asset that is known to affect the thoughts, behaviors, and lifestyles of individuals. However, the impact of religious affiliation, religious activities, and religious beliefs on the attitudes of nurses toward providing spiritual care to their patients is an issue that has been inadequately explored.

Purposes: The aim of this study was to explore the relationship between religion (including religious affiliation, religious activities, and religious beliefs) and attitude toward spiritual care in clinical nurses.

Methods: This study used a cross-sectional correlation study design. Six hundred nineteen nurses were included as participants. The measurements used included a questionnaire on religious affiliation, religious activities, and religious beliefs; the Spiritual Health Scale-Short Form; the Spiritual Care Attitude Scale; and a sociodemographic datasheet. The study employed hierarchical regression modeling to establish the relationships between the aspects and degrees of religious belief and practice as well as the attitudes of participants toward spiritual care.

Results: Most of the participants participated infrequently in religious activities. After controlling for demographic variables and spiritual health, religious belief was found to be an important factor impacting participants’ attitudes toward providing spiritual care.

Conclusions/Implications for Practice: The findings indicate that religious belief is an important factor impacting the attitudes of nurses toward providing spiritual care and that the religious/spiritual beliefs of nurses may impact on their fitness to provide spiritual care to patients. Education on religion may be needed to improve the attitude of nurses toward providing spiritual care.

KEY WORDS:
religion, spirituality, nurse.

Introduction
Religion is an important cultural characteristic that is known to affect the thoughts, behaviors, and lifestyles of individuals. Around 90% of people worldwide are involved in some form of religious activities (Grim, Johnson, Skirbekk, & Zurlo, 2015). Previous studies have shown religious beliefs and practices to be associated with health conditions and to potentially assist people to cope with stress (Bonelli & Koenig, 2013; Medved Kendrick, 2017).

The hospital palliative care regulation issued by the Taiwanese legislature in 2000 emphasizes the importance of providing spiritual care to patients. The healthcare systems in Taiwan have started integrating the spiritual needs of patients into religious/spiritual cares. The hospital palliative care regulation requires hospitals to establish related facilities and provide mandated services. However, to date, only 50% of the hospitals in Taiwan have met these requirements (Liu & Wu, 2008; Tzeng & Yin, 2006). Nurses, who comprise the highest proportion of healthcare providers in Taiwan, will likely be the key providers of spiritual care in clinical practice settings.

Taiwan is home to more than 22 distinct religious faith traditions (Ministry of the Interior, Taiwan, ROC, 2018). Therefore, healthcare providers are frequently challenged to tend to the spiritual needs of patients of different religious faiths. The spiritual care training and personal religious/spiritual beliefs of healthcare providers potentially impact their ability to provide effective spiritual care. For example, one study found that nurses who were more spiritual provided better spiritual care to their patients than their less-spiritual peers (Chan, 2010; Wu & Hsiao, 2009).

Patients hope that healthcare providers will address their spiritual needs and desire to receive spiritual care during the healthcare process (Borneman, Ferrell, & Puchalski, 2010).
However, health professionals do not generally concern themselves with the religious/spiritual issues of their patients (Best, Butow, & Olver, 2016). It remains unclear whether the religious beliefs of healthcare providers affect their professional sensitivities in assessing the spiritual needs of their patients or in providing spiritual care. Moreover, it is particularly important that nurses in Taiwan be aware of patients' spiritual needs. Therefore, the aims of this study were to explore the association between religion (including religious affiliation, religious activities, and religious beliefs) and attitudes toward spiritual care among clinical nurses.

**Literature Review**

**The meanings of spirituality and religion**

Spirituality is the value system and worldview of an individual. Spirituality may be explained by the association between the self with the self as well as with others, nature, and God. When the relationships with the self, others, God, and nature are in communion and harmony, the individual has a rich, meaningful, peaceful, and hopeful love of life (Lin, Liou, & Chen, 2008; McSherry & Jamieson, 2011). Spirituality shares similarities with religion. For example, religion is usually viewed as an important way for people to express their spirituality (Burkhart & Solari-Twadell, 2001; Edwards, Pang, Shiu, & Chan, 2010). In the Oxford Dictionary, religion is defined as “the belief in and worship of a superhuman controlling power, especially a personal God or gods” (Soanes & Stevenson, 2006, p. 1487). Therefore, although similar, spirituality and religion are still different concepts. Religion is more objective and external and may involve ritual practices that one performs in a community, which guide an individual's behaviors, whereas spirituality is the subjective, internal, and unique experience of an individual with a super-being that imbues life with meaning (Barber, 2012).

Taiwan is a society of multiple religious faiths. Some Taiwanese do not clearly associate with a specific religious affiliation, although they participate in certain religious activities (Hsiao, Chiang, Lee, & Han, 2013). Religion has been defined as the belief in and awareness of a super-being (Koenig, King, & Carson, 2012). Several instruments are available that measure organized and private religious activities, motivation, involvement, belief, commitment, attitude, coping, affiliation, and faith development (Hall, Meador, & Koenig, 2008; Hill & Hood, 1999). These instruments may be classified into the three categories of religious affiliation, religious activities, and religious beliefs (Chiang, Lee, Chu, Han, & Hsiao, 2017; Hall et al., 2008; Koenig et al., 2012) and are typically used to assess people belonging to a specific religious faith such as Catholicism, Judaism, Taoism, or Buddhism. Religious activities may be defined as attending public or private religious activities, typified by variables such as church attendance, scripture reading, and praying. Religious beliefs may refer to the perception of the importance of religion and religious beliefs. Therefore, religious affiliation, religious activities, and religious beliefs may be applied as observable variables for religion. Moreover, as spirituality has been defined as an individual’s inner force and resource for giving unique meaning to life, spiritual health may be assessed using the Spiritual Health Scale (Hsiao et al., 2013).

**Spiritual care and its characteristics**

Activities that are intended to satisfy the spiritual needs of patients may be incorporated under spiritual care. Spiritual care has been defined as the care provided by nurses to help patients gain a harmonious connection with the self, others, nature, and higher beings (Lin et al., 2008). The content of spiritual care may include a healing presence, the therapeutic use of self, the intuitive sense, exploration of the spiritual perspective, patient-centeredness, meaning-centered therapeutic interventions, and the creation of a spiritually nurturing environment (Ramezani, Ahmadi, Mohammad, & Kazemnejad, 2014). From the experience of clinical practice, patients who are ill or in the terminal stages of disease typically have greater spiritual needs. In one study, almost 80% of patients with advanced cancer relied on religion to cope with their illness (Phelps et al., 2009). Religious support helps patients who are diagnosed with advanced cancer feel hope and peace and may equip them to better face death (Hsiao, Gau, Ingleton, Ryan, & Shih, 2011). Moreover, satisfying the spiritual needs of patients may influence their medical decision making and quality of life at the end of their life. For example, Balboni et al. (2010) reported that patients who received spiritual support from their healthcare provider had a better quality of life at the end of life than those who did not.

Both environmental and personal factors affect the provision by nurses of spiritual care to their patients. Related environmental factors include hospital policy, ward space, and nursing education and training (Edwards et al., 2010; Noble & Jones, 2010), whereas personal factors include demographic profile, self-spirituality, and perception of spiritual care. For example, Chan (2010) indicated that nurses holding religious beliefs who were married, had past hospitalization experiences, and had worked in obstetrics and gynecology departments tended to be more willing to provide spiritual care to their patients. Finally, previous studies indicate that the spirituality, interpretation of spiritual care, and attitudes toward spiritual care of nurses affect their provision of spiritual care (Chan, 2010; Edwards et al., 2010).

**Methods**

**Design**

A cross-sectional survey study design was used in this study, and data were drawn from the Survey of Religion, Spirituality, and Nursing (SRSN) study. The SRSN was a comprehensive study that was designed to explore the relationship between the spirituality and professional performance of nurses. The first part of the study was focused on instrument development,
and the second part was focused on exploring the predictors of spiritual care and professional behaviors. The data for the SRSN study were collected in 2012. Only the results of the SRSN related to religion and attitude toward spiritual care were adopted and used in this article.

Participants
A convenience sampling method was used to recruit 619 nurses from three teaching hospitals in Taiwan. The inclusion criteria were: nurses who (a) were full-time workers at a hospital, (b) had over 6 months of nursing experience, and (c) agreed to complete the questionnaire. The exclusion criteria were nurses who were not direct-care providers. The major purpose of this study was to explore the association between religion and attitude toward spiritual care in nurses. Calculating the desired sample size for this study was difficult (Cohen, 1988) because of the lack of existing studies on this topic. Therefore, the authors assumed a small effect size for the association between religion and attitude toward spiritual care, resulting in a partial $R^2$ (increased $R^2$) of .0196. Given an alpha level of 5% and a power of 95%, a minimum required sample size of 652 was estimated, and an additional 5% was added to compensate for the expected risk of participants dropping out before the end of the study. Six hundred ninety participants were initially invited, with 71 either declining to participate or failing to complete the questionnaire. Thus, the data for 619 participants were available for analysis (response rate: 89.71%).

Data Collection
The rules set by the hospital's institutional review board for the protection of participants' confidentiality (approval number: 98-4001B) were strictly followed for this study. All of the participants provided informed consent to participate in this study after receiving oral and written explanations of the study and its procedures. Data were collected using a self-administered questionnaire in six parts that covered the following: information on religious affiliation, religious activities, religious beliefs, the Spiritual Health Scale-Short Form (SHS-SF), the Spiritual Care Attitude Scale (SCAS), and sociodemographic details.

Religious affiliation
This scale, established by Chang and Lin (1992), distinguishes between the three religious affiliation categories of primary, secondary, and atheist. Participants proclaiming a belief in a higher spiritual power or god and who identified themselves as having a very clear perception of their religious affiliation and of the religion they practiced were categorized as “primary.” Participants who did not assert a firm religious affiliation but did claim belief in a higher spiritual power or god and participated in some religious activities were categorized as “secondary.” Finally, participants who did not believe in a god or higher spiritual power and who were not involved in any religious activities were categorized as “atheist.”

Religious activities
Religious activities were assessed using a five-item instrument that was developed by the research team of this study using a review literature and in-depth interviews with clinical nurses. Initially, seven original items of the instrument were assessed by seven specialists (including one PhD in religion, two nursing faculty members with PhD degrees, one head nurse, and three senior nurses currently working in hospitals). The content validity index of this instrument was .96, indicating it to have acceptable validity (Polit & Beck, 2006). This instrument is scored using a 4-point Likert scale ranging from 1 = never to 4 = often. Participants were asked to recall the frequency of involvement in religious activities over the past 6 months. The validity of this instrument was established by performing exploratory factor analysis on a calibration sample ($n = 310$), with the one extracted factor explaining 48.0% of the variance. In addition, the data from the exploratory factor analysis showed that all of the factor loadings were greater than .50, indicating good convergent validity (Hair, Black, Babin, Anderson, & Tatham, 2006). Furthermore, the research team used a validation sample ($n = 309$) to conduct a confirmatory factor analysis (CFA) to verify the validity of the factor structure. The results of the CFA revealed that the religious activities instrument had an acceptable construct validity with the model fit indices after the deletion of two items ($\chi^2/df = 6.47$, nonnormed fit index = .88, comparative fit index = .94, standardized root mean square residual = .045, and root mean square error of approximation = .133; Bentler, 1992). Therefore, the final instrument included five items, including participating in religion-related events, praying, reading the bible/religious texts, meditating on religious incantations, and seeking religious guidance to make decisions.

Religious beliefs scale
The Religious Beliefs Scale (RBS) was developed by Chiang et al. (2017) and was derived from in-depth interviews, a literature review, and expert recommendations. The 17 items of the RBS comprise four subscales, including “religious effects,” “divine,” “religious query,” and “religious stress,” which explain a combined 64.1% of the total variance. A 5-point Likert scale is used for scoring, with 5 indicating “strongly agree” and 1 indicating “strongly disagree.” Chiang et al. (2017) established the acceptable reliability and validity of RBS, calculated a Cronbach’s alpha of .87, and used CFA to establish construct validity with acceptable model fit indices. The Cronbach’s alpha of the RBS was .89 for this study.

Spiritual care attitude scale
The 15-item SCAS, developed by Chiang, Chiang, Lee, Han, and Hsiao (2014), is a Likert-type scale (1 = strongly disagree to 5 = strongly agree) encompassing the three subscales of spiritual growth, spiritual care concepts, and spiritual nursing. Chiang et al. (2014) indicated that the three subscales of the SCAS explained 71.06% of the total variance. The reliability of the SCAS was established with a Cronbach’s alpha of .96,
A CFA established its constructed validity (Chiang et al., 2014). The Cronbach’s alpha in this study was .94.

**Spiritual health scale-short form**
The SHS-SF was developed by Hsiao et al. (2013). CFA was used to establish the construct validity of the SHS-SF, with results confirming the model fit indices of the SHS-SF’s five-factor model as acceptable. Moreover, analysis showed acceptable reliability with a Cronbach’s alpha of .934. The SHS-SF is composed of 24 items in five subscales, including “connection to others” (four items), “meaning derived from living” (six items), “transcendence” (six items), “religious attachment” (four items), and “self-understanding” (four items). A 5-point Likert-type scale was employed for this scale, with scores ranging from “strongly disagree” (1) to “strongly agree” (5). The range of total possible scores was 24–120, with higher scores denoting a higher level of respondent spiritual health (Hsiao et al., 2013). The Cronbach’s alpha of the SHS-SF in this study was .93.

**Sociodemographic information**
This study gathered demographic data on age, marital status, educational status, seniority, and job position.

**Data Analysis**
The association between independent variables (religious affiliation, religious activities, and religious beliefs) and attitude toward spiritual care was investigated using the hierarchical regression model. Personal information and spiritual health were included in Model 1 and served as control variables. Religious affiliation, religious activities, and religious beliefs were further introduced into Models 2–4, respectively. Finally, the subscales of religious beliefs were incorporated into Model 5 in the presence of the variables included in Model 3. Data analysis was conducted using IBM SPSS Version 22 (IBM, Inc., Armonk, NY, USA).

**Results**

**Sociodemographic Characteristics of Participants**
All of the survey participants were female, with a mean age of 30.1 years and an average of 7.9 years of work experience as nurses. Most held bachelor’s degrees (74.0%), and 67.5% were single (Table 1).

**Descriptive Statistics for Research Variables**
Slightly over two thirds (68.7%) of the participants were in the primary religious category (Table 2), with the data in Table 2 showing that primary-category participants earned higher scores for religious activities and religious beliefs than their secondary- and atheist-category peers ($F = 62.36$, $p < .001$ and $F = 40.54$, $p < .001$, respectively). Furthermore, a Pearson correlation found a significant and positive relationship between religious activities and beliefs ($r = .451$, $p < .01$). Table 3 shows the descriptive data for religious activities, religious beliefs, spiritual health, and attitude toward spiritual care. The mean score for religious activities was 2.07 ($SD = 0.66$), indicating that most participants rarely participated in religious activities. “Seeking religious guidance

**TABLE 1.**

**Sociodemographic Characteristics of Participants (N = 619)**

| Variable                  | n  | %     |
|---------------------------|----|-------|
| Age (years; $M$ and $SD$) | 30.1| 5.6   |
| Seniority (years; $M$ and $SD$) | 7.9 | 5.6   |
| Educational level         |    |       |
| Baccalaureate             | 458| 74.0  |
| Associate degree          | 156| 25.2  |
| Missing                   | 5  | 0.8   |
| Religious affiliation     |    |       |
| Primary                   | 425| 68.7  |
| Secondary                 | 160| 25.8  |
| Atheist                   | 34 | 5.5   |
| Marital status            |    |       |
| Single                    | 418| 67.5  |
| Married                   | 201| 32.5  |
| Job position              |    |       |
| Nurse                     | 552| 89.2  |
| Supervisor                | 65 | 10.5  |
| Missing                   | 2  | 0.3   |

Note. Range of age is from 20 to 60 years; range of seniority is from 0.5 to 28.

**TABLE 2.**

**Differences Among Religious Affiliation, Religious Activities, and Beliefs (N = 619)**

| Variable          | n  | %     | Religious Activity | Religious Belief |
|-------------------|----|-------|---------------------|------------------|
|                   |    |       | $M$     | $SD$ | $F$/Scheff’s test | $M$    | $SD$ | $F$/Scheff’s test |
| Religious affiliation |    |       |         |     |               |       |     |               |
| Primary           | 425| 68.7  | 2.26    | 0.65 | 62.36*          | 3.33   | 0.45 | 40.54*         |
| Secondary         | 160| 25.8  | 1.70    | 0.45 |                | 2.97   | 0.51 |               |
| Atheist           | 34 | 5.5   | 1.57    | 0.51 |                | 2.99   | 0.39 |               |

*p < .001.
to help me make decisions” (M = 2.76, SD = 0.90; 61.2%, “sometimes” or “often”) was the highest-frequency activity, whereas “reading bible/religious texts” was the lowest-frequency activity (M = 1.42, SD = 0.81; 72.2%, “never”).

The mean score for religious beliefs was 3.22 (SD = 0.49), with the subscale “divine” earning the highest score (M = 3.81, SD = 0.58) and the subscale “religious query” earning the lowest score (M = 2.56, SD = 0.72). The mean score for spiritual health was 3.95 (SD = 0.47), with the subscale “connection to others” earning the highest score and the subscale “religious attachment” earning the lowest score. Finally, the mean score for spiritual care attitude was 3.93 (SD = 0.49), with the subscale “spiritual core concept” earning the highest score (M = 4.14, SD = 0.49).

**Predictors of Spiritual Care Attitudes**

The results for the predictors of spiritual care attitudes in nurses are shown in Table 4. Model 1 indicates that participants with a longer work experience (β = .18, p < .001) and a higher level of spiritual health (β = .44, p < .001) tended to have higher levels of spiritual care attitude. Models 2 and 3 indicate that religious affiliation and religious activities were not independently associated with spiritual care attitude, after adjustment for the control variables. Model 4 indicates that religious beliefs were positively associated with spiritual care attitudes (β = .16, p < .001). Finally, Model 5 indicates a positive relationship between spiritual care attitudes and the “divine” and “religious stress” subscales (β = .11, p < .01 and β = .11, p < .05, respectively) and a negative relationship between spiritual care attitude and “religious query” (β = -.10, p < .01).

**Discussion**

This study marks the first investigation of potential associations between the religious beliefs and attitudes toward spiritual care of nurses. The primary findings of this study are that religious beliefs impact the attitudes of nurses toward spiritual care significantly. This study is affected by two notable limitations. First, the results may not be generalizable to all nurses because of the convenience sampling approach used. Second, the theoretical reasoning for this research was limited by the paucity of previous studies on this subject.

The results of this study indicate that around 68.7% of nurses in Taiwan have a religious affiliation and seldom participate in religious activities. In general, the findings are consistent with previous studies conducted in Taiwan (Liu, 2010; Yeager et al., 2006). For example, Yeager et al. (2006) found that, although most of the Taiwanese population had religious affiliations, only 54% rated religious attendance as “never to rarely.” In comparison, a large-scale online survey conducted by McSherry and Jamieson (N = 4,054) indicated that 84.2% of nurses in Western countries hold a religious affiliation and that 67.2% practice religious activities regularly (McSherry &
The significantly lower rate of religious activity attendance in Taiwan highlights a cultural difference between East and West that may relate to the traditional Chinese Confucian ideals and the religious culture in Taiwan. First, in Confucianism, “The Master does not speak of prodigies, force, disorder, and gods,” with practitioners urged “to keep one’s distance from the gods” (Yang & Liu, 2009). Therefore, Taiwanese reticence in accordance with Confucian values to publicly express superstitious and nonscientific beliefs may decrease willingness to participate regularly in religious activities. Second, most Taiwanese (81%) believe in Buddhism, Taoism, and traditional folk religions (Grim et al., 2015). However, many Taiwanese find it difficult to clearly distinguish among these three religious faiths. Furthermore, their doctrines emphasize that individuals who believe in gods will be blessed everywhere and anytime. These religions do not stress the importance of regularly attending religious activities in a specific religious organization, which may result in Taiwanese tending to have relatively weak connections to specific religious organizations and to participate only infrequently in religious activities.

Furthermore, the results of this study show the religious beliefs of the participants to be neutral. This is consistent with Yeagar et al. (2006), who found a neutral religious beliefs score for Taiwanese (M = 5.1; 0–12 scale). This result may relate to the history of the development of the Western medical system in Taiwan, which was heavily influenced during its formative years on missionaries from Western countries. These missionaries helped provide Taiwanese good medical care during the 19th century while promoting Protestant and Catholic religious doctrines. This effort helped foster Taiwan’s modern landscape of multiple coexisting religious faiths and the general attitude of respect and acceptance that Taiwanese hold toward most religions.

Ellison and Levin (1998) initiated academic inquiry into the connection between religion and health in the 20th century. The possible mechanism that they proposed as underlying this connection was the improvement effect on individual health of the religious regulation of personal behaviors and lifestyle. Religion may provide coping resources such as praying and worshipping to help reduce perceived stress. In this study, associations were found among the three religious variables of affiliation, activities, and beliefs. The participants in the “primary” religious affiliation category attended religious activities more frequently than their peers in the secondary and atheist categories, and frequency of participation in these activities was shown to relate positively to the strength of religious beliefs (p < .01). These findings are similar to previous studies (Neyrinck, Vansteenkiste, Lens, Duriez, & Hutsebaut, 2006). The results of this study identified religious belief, after controlling for the variables of education, marital status, seniority, job position, and spiritual health, as an

| TABLE 4. Hierarchical Regression Model Predicting the Attitude Toward Spiritual Care |
| Block/Variable | Model 1 | Model 2 | Model 3 | Model 4 | Model 5 |
|----------------|---------|---------|---------|---------|---------|
| **Control variable** | | | | | |
| Education (Baccalaureate vs. associate degree) | .07 | .07 | .06 | .07 | .07 |
| Marital status (married vs. single) | .05 | .06 | .05 | .04 | .03 |
| Seniority (year) | .18*** | .19*** | .19*** | .17*** | .17*** |
| Job position (supervisor vs. nurse) | −.02 | −.02 | −.02 | −.01 | .005 |
| Spiritual health | .44*** | .43*** | .42*** | .39*** | .35*** |
| **Independent variable** | | | | | |
| Religious affiliation (ref: atheist) | | | | | |
| Primary | .05 | .02 | .01 | −.01 |
| Secondary | −.03 | −.03 | −.02 | −.02 |
| Religious activities | | | | | |
| Religious belief | .16*** | | | | |
| Religious effects | − | | | | |
| Divine | − | | | | |
| Religious query | − | | | | |
| Religious stress | − | | | | |
| **△ R²** | .264*** | .005 | .003 | .017*** | .040***,* |
| **Model summary** | | | | | |
| Total R² | .264 | .270 | .273 | .290 | .313 |
| Adjusted R² | .258 | .261 | .263 | .279 | .299 |

*Note. The values in cells not specified were standardized regression coefficients (β). △ R² denotes change in R².

*Compared with Model 3.

*p < .05. **p < .01. ***p < .001.
important factor influencing attitude toward spiritual care and religious affiliation and attendance as having minimal influence on this attitude. Two potential reasons for this finding are suggested. First, a previous study of nurses examining the impact of religiosity on the motivation to provide spiritual care found that the personal philosophies of the subjects, which reflected evangelical Christian religiosity, may have influenced their willingness to provide spiritual care (Taylor, Park, & Pfeiffer, 2014). The religious doctrines of Buddhism and Taoism teach people to view helping others as an opportunity to grow spiritually. This may be a reason why the participants with stronger religious beliefs held more positive attitudes toward spiritual care in this study. Second, the minimal effect of religious affiliation and attendance on the attitude of participants toward spiritual care may relate to the low percentage of participants who self-identified as belonging to a specific religious organization and the high percentage who seldom participated in religious activities.

The results of the hierarchical regression model in Model 5 indicate the need to further examine which subscales impact attitude toward spiritual care in nurses. The divine and religious stress subscales were significantly and positively associated with attitude toward spiritual care, whereas the subscale of religious query was negatively associated with this attitude. This may be a result from the items in the subscale of “religious query” including negative views of religious belief, such as “I feel that God is unfair to me,” “I feel that religion is related to superstition,” and “the impressions of religion include negative perspectives, passive attitudes, and a tendency to escape from reality.” Therefore, the participants with higher scores in the subscale of religious query may exhibit decreased willingness to provide spiritual care. A strong relationship has been identified between religion and spirituality (Balboni, Puchalski, & Peteet, 2014; Rykkje, Eriksson, & Raholm, 2013). A possible reason is that religious query, which conveys a negative aspect of religion that is similar to spiritual struggle, was defined as expressions of conflict, questioning, and doubt regarding matters of faith, God, and religious relationships (Abu-Raiya, Pargament, & Exline, 2015). As the participants who earned higher scores for religious query may be inferring that they are in conflict with gods or think that gods are treating them unfairly during suffering events, they may not perceive serving the spiritual needs of patients as a good way to help.

The spiritual health of nurses was treated in this study as a control variable in the hierarchical regression model predicting attitude toward spiritual care. The reason for this treatment is that previous studies (Chan, 2010; Chiang, Lee, Chu, Han, & Hsiao, 2016; Wu & Hsiao, 2009) have shown results in the Hierarchical Regression Model 1 that also indicate that nurses who exhibit more spirituality tend to have a greater ability to provide spiritual care to patients. Furthermore, van Leeuwen and Cusveller (2004) pointed out that the ability to face their own spirituality is a competency of nurses that is necessary to providing spiritual care. Therefore, the spiritual health of nurses should be regarded as a significant value and a factor that affects the attitude of nurses toward spiritual care and that should be controlled when exploring its predicting factors.

Conclusions

A cross-sectional correlational study design was used in this study to explore the association between religion (including religious affiliation, religious activities, and religious beliefs) and attitude toward spiritual care in clinical nurses. The results found that 68.7% of participants reported having a religious affiliation but participated only rarely in religious activities. In addition, after controlling for education, marital status, seniority, job position, and spiritual health, the religious beliefs of the participants were identified to be an important impact factor of influence on attitudes toward spiritual care. However, their religious affiliation and attendance were shown not to impact these attitudes. The results of this study do not imply that nurses should adopt religious beliefs to provide spiritual care to patients but rather suggest that religious education for nurses may help improve the attitudes of nurses toward spiritual care.

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Author Contributions

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Data analysis and interpretation: YCH, YCC
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