

Nurses' spirituality and resilience during the month of Ramadan

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Abstract

Objective: To examine the relationship between spirituality and resilience among nurses during Ramadan.

Method: The cross-sectional, descriptive study was conducted at a state hospital in Turkey in May and June 2019, which coincided with the fasting month of Ramadan. The sample comprised nurses of either gender. Data was collected using a socio-demographic instrument, the Spirituality and Spiritual Care Rating Scale and the Resilience in Midlife Scale. Data was analysed using SPSS 24.

Results: Of the 207 nurses, 145(70%) were female and 62(30) were male. Most of the nurses were aged 25-29 years 88(42.5%). Also, 86(41.5%) were married and 167(80.7%) had university education. Age affected religiosity ($p=0.038$), and there was a positive correlation of resilience with the spiritual care subscale and the spirituality total score ($p<0.05$). Besides, education status affected resilience ($p=0.042$).

Conclusions: In order to increase spirituality among nurses, information should be provided during their education and training programmes about the importance of spirituality.

Key Words: Spirituality, Resilience, Religion, Nurses.

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Introduction

Nurses who have spirituality as part of their emotional repertoire have a deeper healing communication with patients and holistic caring in saving compared to those who do not. The term, spirituality, as used herein, represents an interconnected model based on spiritual and patient-centred care. Spiritual care supports people's spirituality by ensuring special intervention(s) regarding 'doing' or 'accompanying' sick individuals.¹ Spirituality can be affected by many variables. Spiritual care can involve spending time with family and friends, reading, spending time in nature, physical activity and following religious practices. There may be some overlap between spirituality/religion and resilience.^{1,2}

A positive response in the face of trouble, disaster, trauma, danger or major sources of strain is defined as resilience.³ Resilience affects emotional intelligence skills, autonomy, extroversion, conscientiousness, self-esteem, optimism, and individual values, such as having moral and spiritual factors as a person.⁴ The presence of spirituality and religion ensures that people have a source of comfort, hope, as well as resilience in the face of adversity. Nurses provide care in all circumstances,⁵ thus, they must be strong and resilient.

In Islam, Ramadan is a sacred month of fasting During which Muslims across the world stay away avoid from smoking, eating, drinking and sexuality from dawn to dusk. Ramadan is also known as a month of giving to people who are in need, acts of generosity and sharing in the shape of charity. Ramadan is a spiritual month for Muslims, symbolizing compassion, reflection and willpower. Although everything seems to change during Ramadan, many individuals still follow their normal work and study routines⁶ as people's resilience and spirituality increase to allow that.

Spirituality and resilience are intertwined variables that influence each other.⁷⁻¹⁰ Spirituality is an important factor in nurses' level of resilience.¹¹ There is a strong relationship between wellbeing and resilience, in particular.^{12,13} Spirituality is often not affected by burnout,⁷ but is positively associated with resilience and is related to an improved positive affect and satisfaction with life.⁸ Spiritual assistance is a favourable predictor of resilience, and resilience is fuelled by spirituality through a variety of processes.⁹

Many studies have associated spirituality with resilience.⁸ Spirituality reduces stress and enhances mental health in challenging times.^{1,2} Findings suggest that spirituality and resilience have a favourable and significant association.¹⁴⁻¹⁵ Life pleasure is negatively associated with mental vulnerability and positively associated with expectation and resilience.¹⁶ In addition, spirituality encompasses the belief in God.¹ The use of religious coping strategies are more common in religious societies,

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and have an impact on the quality of life among patients.¹⁵ Sacred values, religion, praying, ethics, self-knowledge, endurance and expectation, erudition, willingness and belief in the afterlife are factors that influence nurses' actions.¹⁷ Religiousness and spirituality are essential source in managing stress and preserving resilience.⁵ There is an association between burnout and resilience, indicating that employees who show spirituality and are more religious have grander resilience and consequently are less often affected by burnout.⁷ An optimistic viewpoint of nurses' psychological resilience would guide their work environment and patient care in this direction.¹⁸

The current study was planned to examine the relationship between spirituality and resilience among nurses during Ramadan.

Subjects and Methods

The descriptive, cross-sectional study was conducted at a state hospital in Turkey in May and June 2019 which coincided with Ramadan. After approval from the Ethics Committee of Gaziantep University Medical Faculty (2018/133), the sample size was determined using G*Power v3.1.9.7¹⁹. Power was expressed as $1-\beta$, with β being type II error, and is typically 80%. The effect size was 0.200 and power 85% at alpha (α) value 0.05. The sample comprised nurses of either gender who volunteered to participate and could be reached during the study period. Upon completion, the study was conducted with 207 nurses, who accounted for 75% of the nursing population. It was used convenience sampling method. Those who refused to volunteer or were not available were excluded.

After taking informed written consent, demographic and occupational data was collected using a questionnaire designed in the light of literature.^{18,20}

Perceptions of spirituality and spiritual care concepts were noted using the Spirituality and Spiritual Care Rating Scale (SSCRS)²¹. Cronbach's alpha (α) coefficient was 0.64. Validity and reliability tests of the Turkish scale have reported Cronbach's α coefficient to be 0.76²². The scale has 17 items, including sub-dimensions of spirituality and spiritual care (items 6-9, 11, 12 and 14), spirituality (items 4, 5, 13 and 16) and individual care (items 1, 2, 10 and 15). The scoring of the items ranges from 1 = strongly disagree to 5 = strongly agree. The first 13 items are scored straight, while the last 4 items are scored in reverse. As the total average score increases, the level of perception of spirituality and spiritual care concepts increases positively. The highest score for the spirituality and spiritual care subdimension was 35, and the highest scores for the spirituality and individual care

subdimensions were 20. The highest score that can be obtained from the scale is 85. The study Cronbach's alpha value in the current study was 0.81.

Also used for data collection was the Resilience in Midlife (RIM) scale that measures the resilience of individuals in middle age, a period of life when they must adapt to major changes and struggles in their lives.²³ The 25 items of the original scale are grouped into 5 factors: self-efficacy, family and social networks, determination, internal locus of control, and coping and compliance. Scores range 0-100. Items 6, 10, 12, 13, 17, 19, 20 and 23 are reverse-scored. The sum scores of all items represents the total resilience score. The scale is scored on a 5-point Likert scale ranging from 0 to 4, with higher scores indicating higher degree of resilience. Cronbach's α coefficient was 0.87, item-total correlation ranged 0.16-0.61, and split-half reliability was 0.88. The criterion-related validity findings were also noted.²³ Cronbach's alpha value in the current study was 0.77.

Data was analysed using SPSS 24. Normal distribution of data was checked using Kolmogorov-Smirnov test. Frequencies, percentages, mean values and standard deviations were used to express data, as appropriate. Also, t-tests, variance analysis, correlation analysis, multiple regression analysis and Cronbach's alpha internal consistency tests were employed. $P < 0.05$ was considered statistically significant.

Results

Of the 207 nurses, 145(70%) were female and 62(30) were male. Most of the nurses were aged 25-29 years 88(42.5%). Also, 86(41.5%) were married and 167(80.7%) had university education (Table 1). It was determined that 179(86.5%) nurses did not have spiritual care knowledge and could not provide spiritual care.

Table-1: Demographics and work environment.

Characteristics of nurses (N= 207)	Frequency (N)	Percentage (%)
Age groups		
25 year below	74	35.7
25-29 years	88	42.5
30 year and above	45	21.7
Gender		
Female	145	70
Male	62	30
Marital status		
Married	86	41.5
Single	121	58.5
Education		
High school/ Pre-licensing	40	19.3
University	167	80.7

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Having a child		
Yes (1 and 2 child)	55	26.6
No	152	73.4
Work year		
5 and ↓	152	73.4
5 ↑	55	26.6
Clinic		
Internal medicine	59	28.5
Surgical	34	16.4
Intensive care/Others	114	55.1
Factors affecting the providing of spiritual care		
Inappropriate environment	39	18.8
Insufficient facilities	42	20.3
Lack of information	29	14
Lack of time	97	46.9
Interventions for spiritual care		
Talking with patients	39	18.8
Listening to patients	31	15
Provide psychological support	33	15.9
Unable to provide spiritual care	28	13.5
Other interventions (prayer, worship etc.)	76	36.7

Table-2: Spirituality and Resilience scales (N = 207).

Scale (Number of Questions)	Mean±Standard deviation	Min-Max
Scale of Spirituality (17)	54.88 ± 5.78	38-73
Subscale of spirituality and spiritual care (7)	25.26 ± 3.63	12-34
Subscale of religiosity (4)	11.05 ± 2.49	4-20
Subscale of personal care (4)	13.72 ± 1.88	7-18
Resilience in Midlife Scale (25)	65.53 ± 10.95	24-93

Table-3: Relationship of Spirituality with Resilience.

Spirituality	Subscale of spirituality and spiritual care	Subscale of religiosity	Subscale of personal care	Scale of Spirituality Total Score
Resilience in r	,340**	,000	,132	,207**
Midlife P	<.001	,999	,059	,003
Scale Total n	207	207	207	207
Score				

**. Correlation is significant at the 0.01 level (2-tailed).

Mean spirituality and resilience scores of the subjects were noted (Table 2). Age group affected religiosity subscale ($F=3.324$; $p=0.038$), and interventions for spiritual care affected personal care subscale ($F=3.058$; $p=0.018$) and total spirituality ($F=2.889$; $p=0.023$). Younger nurses and those unable to provide spiritual care had low spirituality, while providing spiritual care by talking to patients had high personal care subscale score, and university graduates had higher resilience

scores ($t=-2.193$; $p=0.029$).

There was a positive correlation of resilience with the spiritual care subscale and the spirituality total score ($p<0.05$). Besides, education status affected resilience ($p=0.042$) (Table 3).

Discussion

The socio-demographic and occupational characteristics of the subjects in the current study were in line with earlier studies comprising Muslim nurses.^{24,25} In a study conducted in Turkey, talking with patients, listening to the patients, providing psychological support, making them comfortable, and therapeutic touch were spiritual care interventions, while excessive workload and time restriction, excessive number of patients per nurse and fatigue were barriers to implementation of spiritual care.²⁵ The findings are parallel to those of the present study. This can be explained by the fact that nurses do not receive the desired level of information and education on spiritual care, and their working conditions are not suitable for providing spiritual care.

The current study found positive correlations of resilience with spiritual care subscale and spirituality total score. Similar scores have been observed in nurses from different cultures and religions.^{24,25} A study reported that spiritual care had a likely helpful impact on spiritual wellbeing and quality of life of individuals with terminal diseases, suggesting that while supplying spiritual care, nurses and health workers should take into account individual's spiritual demands, preferences and cultural history.²⁶ A study demonstrated a positive relation between spirituality and general healthcare in nurses.¹⁰ Thus, regardless of religion or culture, spirituality and spiritual care are valuable both for nurses and their patients.

A study reported that relationship of life satisfaction with hope and resilience was positive, and it was negative with mental vulnerability.¹⁶ In a cross-sectional study, spirituality and resilience in individuals with anxiety were significantly associated with symptom severity, religious/spirituality services, self-esteem and resilience scores.²⁷ Another study showed that humour, spirituality and resilience after disasters were independently based on resilience.⁹ A study concluded that there was a considerable relation between resilience and spirituality.²⁸ Rushton et. al. found that nurses' higher levels of resilience prevented them from emotional weariness.²⁰ Another study found that spirituality could function as a crucial resilience strategy in older individuals.²⁹ Other studies also showed a positive relation between wellbeing and resilience.^{12,13} Similar

findings were presented by the current study.

Resilience is important for nurses working under difficult conditions. A study found that resilience and spirituality after stroke were crucial factors.³⁰ A study reported that individuals who were more religious and spiritual had more resilience and were less often affected by burnout.⁷ A study observed that it is necessary to improve resilience to improve professional life quality of nurses and to reduce burnout.³¹ Sacred values, religion, praying, ethics, self-knowledge, endurance and expectation, erudition, willingness and belief in the afterlife are factors that influence nurses.¹⁷ The findings of another study supported the theory that spirituality and religiousness are essential resources in managing stress and preserving resilience.⁵

Religion had an impact on the sense of spirituality in the current study because it was conducted among Muslim nurses during the holy month of Ramadan. The most important limitation of the current study is that the sample only included nurses from one hospital. Thus, the findings may not be generalisable.

Conclusion

The nurses did not have sufficient knowledge and skills regarding spiritual care. Younger nurses and those who could not provide spiritual care had low spirituality. University graduate nurses had higher resilience. Spirituality affected resilience in nurses, and the relationship between spirituality and resilience was not affected by sociodemographic characteristics except education status.

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