



Assessment of the relation between religiosity, anxiety, depression and psychological resilience in nursing staff

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Abstract

The nursing profession is considered to be an emotionally demanding profession often lead to various psychological difficulties and extend level stress. Religiosity and religion in general, have been associated with positive outcomes in an

individual's life such as higher self-esteem, better quality of life and psychological wellbeing. The purpose of this study was to examine the relation between nurses' religiosity, psychological resilience, and psychological wellbeing. In this cross-sectional study, 378 nurses participated. Data were collected by using Centrality of Religiosity Scale, The Patient Health Questionnaire Two-Item Depression Scale, The Generalized Anxiety Disorder Questionnaire, Connor-Davidson Resilience Scale 25. Percentages, means, and standard deviations were calculated. In addition the parametric t-test and ANOVA were used. Also, logistic regression analyses were used to determine which factors affect the depression and anxiety of nurses. Results indicated differences with a probability of less than or equal to 0.05 were accepted as significant. For statistical analysis, we used the statistical program SPSS 25. According to our results although religious practices can be a protective factor for both depression and anxiety, religious beliefs and experiences can increase the levels of depression and anxiety as well.

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Introduction

The nursing profession is considered to be an emotionally demanding profession often lead to various psychological difficulties and extend level stress. In general, nurses are supposed to be more prone to anxiety and job burnout and often are led to experiencing psychiatric disorders. Researchers attribute this phenomenon to the responsibility that nurses have for patients' health and wellbeing (Fradelos 2014; Papathanasiou, 2017). In research conducted in Hong Kong found that primary care nurses have low levels of anxiety and feel healthy. There is a strong difference between these nurses and their colleagues working in hospitals. The researcher attributes the result to the fact that these nurses do not come in contact with the stress of death in their work (Lee, Hwang, Kim, & Daly, 2004). In Greece the most important factors of the onset and maintenance of mental disorders were those related to the nature of nursing profession such as daily contact with human pain and end-stage patients, as well as factors related insufficient nursing potential, lack of training and continuing training (Antonioni, Looper, & Davidson, 2016; Fradelos, 2014).

Religiosity and religion in general, have been associated with positive outcomes in an individual's life such as higher self-esteem, better quality of life and psychological wellbeing. In a study among Iranian nurses, in which religious coping and quality of working life were examined, it was found that positive religious coping was associated with high levels of quality of working life (Bagheri-

Nesami *et al.*, 2017). In another study conducted among nursing students in Bosnia and Herzegovina was found that higher religiosity can act as a potential resilience factor in the specific population (Dilber *et al.*, 2016). A study conducted in Uganda indicated that religion influences nurses work-lives as well as the coping mechanisms of Ugandan nurses. In addition, the previous study revealed that various religious values seem to affect job performance and various religious activities help them to cope with work-related stress (Bakibinga, Vinje & Mittelmark, 2013). On the other hand, studies indicate that negative perceptions about God and religion may lead to poor psychological wellbeing and distress (Scandrett & Mitchell 2009). While in a study conducted among breast cancer patients was found that negative religious coping predicts worse psychological adjustment (Hebert, Zdaniuk, Schulz & Scheier, 2009).

The purpose of this study was to examine the relation between nurses' religiosity, psychological resilience, and psychological wellbeing. We expected that high levels of religiosity will be associated with resilience and less depression and anxiety.

Materials and Methods

Study population

The sample of the study consisted of 378 nurses (84 men and 294 women). Data were collected from two public hospitals in Greece. Criteria for inclusion in the study were: 1) ability to write and read the Greek language fluently and 2) working in hospital. The exclusion criterion was nurses without a history of mental illness. Data collection was performed via an interview using a questionnaire developed by the researchers so as to fully serve the purposes of the study. The data collected for each nurse included: socio-demographic characteristics (*e.g.* gender, age, educational level), and other nurses' characteristics. Completion of the questionnaires lasted approximately 10 min and took place during the nursing shift. In the present study, there was no control group.

Ethical considerations

Nurses who met the entry criteria were informed by the researcher for the purposes of the study and participated only after they had given their written consent. All of the nurses participated in the study on a voluntary basis and had their anonymity preserved. All participants were informed of their rights to refuse or to discontinue their participation, according to the ethical standards of the Helsinki Declaration of 1983. The study was approved by the Medical Research Ethics Committee of each hospital.

Assessment of religiosity

The religiosity of nurses was examined by the evaluation of the Centrality of Religiosity Scale (CRS) which was proposed by Huber in 2003 and assesses the importance or salience of religious meanings in personality. It includes five aspects of religiosity intellectual domain, ideology, private and public practice and finally the domain of religious experience. The scale consists of two subscales: the subscale of religious practices and the subscale of religious beliefs and experiences. All items are answered on a five-point Likert scale, ranging from 1 to 5. For the items which measure frequencies the five answers can be: never, rarely, occasionally, often, and very often, ranging from 1 to 5. The CRS scale has been translated and tested for its validity and reliability in the Greek population (Fradelos *et al.*, 2018).

Assessment of anxiety and depression

The anxiety and depression of nurses were evaluated by the short questionnaire. In the questionnaire two sections were included: 1) The Patient Health Questionnaire Two-Item Depression Scale (PHQ-2) which has been shown to be a reliable and valid ultra-brief tool for assessing diagnosis of depression, severity, and outcome (Kroenke *et al.*, 2003; Lowe *et al.*, 2005). The frequency of each symptom over the previous two weeks is assessed with response options including "not at all", "several days", "more than half the days", and "nearly every day." These responses are scored 0, 1, 2, or 3, respectively, resulting in a total score that can range from 0 to 6, with higher scores representing more severe depressive symptoms. PHQ-2 scores of 3 or greater indicate clinically significant depression. 2) The Generalized Anxiety Disorder Questionnaire (GAD-2) is a short version of the tool that is composed of the first two questions of the GAD-7 (Spitzer *et al.*, 2006). Normative values are available (Löwe *et al.*, 2010). The tool is a validated screening severity measure for generalized anxiety disorder as well as a good screening measure for panic, social anxiety, and posttraumatic stress disorders. The scale has been translated and tested for its validity and reliability in the Greek population (Konstantakopoulos *et al.*, 2013).

Assessment of resilience

The psychological resilience was measured with Connor-Davidson Resilience Scale 25 (CD-RISC-25) (Connor and Davidson 2003, Windle *et al.*, 2011), a self-evaluation instrument with 25 items that are ranked on a Likert scale from 0 to 4 points. The full range of the scale is 0-100 points, where higher scores indicate higher resilience. The instrument has been proven valid for Greek population by previous studies (Tsagarapoulou *et al.*, 2018).

Statistical analysis

Percentages, means, and standard deviations were calculated in order to provide a broader view of the data. Reliability of the instruments was tested with Cronbach's Alpha coefficient was used and found to be for CRS $\alpha=0.946$, RISC25 $\alpha=0.935$, GAD-2 $\alpha=0.798$. All data exhibited normal distributions and thus the parametric t-test and ANOVA were used. Pearson correlation coefficient was used to identify the relationship between the studied variables. Also, logistic regression analyses were used to determine which factors affect the depression and anxiety of nurses. Results indicated differences with a probability of less than or equal to 0.05 were accepted as significant. For statistical analysis, we used the statistical program SPSS 25.

Results

From the total of the sample, 77.8 % were female. The age ranged from 23 to 61 years old with a mean of 44.01 ± 7.84 . The working experience ranged from 1 to 37 years, with a mean of 17.17 ± 9.05 . Finally, regarding their religious preference, most of them were Christians Orthodox (97.1%) (Table 1).

Additionally, in order to assess depressive symptoms in nurses based on their psychometric values, nurses completed the PHQ-2. Mean depression scores were 2.39 and $SD=1.5$ on the PHQ-2. A percentage of 22% of respondents indicated a depressed mood. Moreover, the anxiety severity measured with the GAD-2, where the mean was 2.33 and $SD=1.65$ while 26 % of nurses suffered from high anxiety. Also, the resilience of nurses was measured with CD-



RISC25 with Mean=75.59 and SD=14.37.

Furthermore, statistical significance was found between the resilience scale CD-RISC-25 and both of two subscales of religiosity scale CRS; Religious Practices ($r=.133, p=.005$) and Religious Beliefs and Experiences ($r=.121, p=.014$). Also, nurses' Depression (PHQ-2) was correlated with Religious Beliefs and Experiences ($r=.113, p=.028$) while the Anxiety was correlated statistically significant negative with the the Resilience of nurses ($r=-.131, p=.011$).

Also, statistically significant differences were found between gender and religiosity. Women are more religious both in practices ($t(376)=.245, p=.00001$) and in religious beliefs and experiences ($t(376)=.024, p=.00001$). To describe these interactions in detail, we carried out the Independent Samples Test. Specifically, women use more religious practice ($M=3.08, SD=0.992$) than men ($M=2.29, SD=1.054$), and more religious beliefs and experiences ($M=3.0179, SD=0.94367$) than men ($M=2.4557, SD=1.01653$). Likewise, there is a statistically significant difference between marital status and religious beliefs and experiences ($F(4,373), p=0.004$). To describe these interactions in detail, we carried out one-way ANOVA for each scale. Specifically, married nurses use more religious beliefs and experiences ($M=2.946, SD=0.95233$) than single nurses ($M=2.6758, SD=1.02992$).

Regression analysis indicates that religious practice and religious beliefs and experiences can predict e nurses' depression as it is shown in Table 2. Especially, the coefficient $R^2=0.037$, that is, 37% of the dispersion of the performance of depression nurses can be interpreted by the influence of independent variables. The review of regression factors has shown that religious practice contributes negatively to anticipating the performance of depression ($\beta=-0.451, t=-2847, p=0.005$). While beliefs and experiences contribute positively to anticipating the performance of nurses' depression ($\beta=0.580, t=3.502, p=0.001$).

On the other hand, the result of regression shows that religious practice and religious beliefs and experiences can prognosticate nurses' anxiety as it is shown in Table 3. Especially, the coefficient $R^2=0.031$, that is, 31% of the dispersion of the performance of nurses' anxiety can be interpreted by the influence of independent variables. The review of regression factors has shown that religious practice contributes negatively to anticipating the performance of anxiety ($\beta=-.421, t=-2449, p=0.015$). While beliefs and experiences contribute positively to anticipating the performance of nurses' anxiety ($\beta=0.526, t=2.870, p=0.004$).

Finally, regression analysis shows that resilience doesn't affect either religious practices or religious beliefs and experiences.

Discussion

The aim of this study was to examine if nurses' religious beliefs and practices can enhance nurses' resilience and if can be a protective factor for depression and anxiety. These richly descriptive data of our study indicating that, although religious practices can be a protective factor for both depression and anxiety, religious beliefs and experiences can increase the levels of depression and anxiety as well.

According to our results, women nurses reported higher scores of religiosity both in religious practices and religious beliefs and experiences. These findings are consistent with the previously published literature and reinforce findings arguing that women are more religious than men (Carapina, 2015). This has been a predominant idea within the social scientific and psychological

research of religion (Beit-Hallahmi & Argyle, 1975; Paloutzian, 1996). Those gender differences in levels of religious beliefs and involvement as well as in the total religiosity been attributed to the fact that women can have of greater opportunity for attendance to religious activities and practices or some suggest that differences are associated with differences in personality and socialization (Beit-Hallahmi & Argyle, 1997). The result should be considered through the lens of the Orthodox confessional belonging of the vast majority of respondents, who are the bearers of the Christian Orthodox culture. Contemporary researchers in ethnic processes (Danylova, 2016; Danylova, 2017) determine the specific

Table 1. Descriptive statistics of sample characteristics (n=378).

Characteristics		N	%
Sex	Male	84	22.2
	Female	294	77.8
Marital Status	Single	93	24.6
	Married	250	66.1
	Divorced	29	7.7
	Widowed	6	1.6
Educational Status	Primary school	3	0.8
	Junior High school	10	2.6
	High school	145	38.4
	University degree	167	44.2
	Postgraduate degree	53	14
Profession	Nurse	306	81
	Nurse assistant	71	18.8
Religion	Christian orthodox	367	97.1
	Christian catholic	2	0.5
	Muslim	2	0.5
	Other	7	1.9
Years in the profession	Mean (SD)	17.17 (9.05)	
	Min – Max	1-37	
Age	Mean (SD)	44.01 (7.84)	

SD, standard deviation.

Table 2. Effect of religious practices, religious beliefs, and experiences in nurses' depression. Adjusted for age, sex, marital status and educational status.

Model	B	SE	Beta	t	Sig
(Constant)	0.932	0.697		1,337	0.182
Religious practices	-0.451	0.158	-0.317	-2,847	0.005
Religious beliefs and experiences	0.580	0.166	0.380	3,502	0.001

Dependent Variable: depression.

Table 3. Effect of religious practices, religious beliefs, and experiences in nurses' anxiety. Adjusted for age, sex, marital status and educational status.

Model	B	SE	Beta	t	Sig
(Constant)	1.246	0.772		1.614	0.107
Religious practices	-0.429	0.175	-0.273	-2.449	0.015
Religious beliefs and experiences	0.526	0.183	0.313	2.870	0.004

Dependent Variable: anxiety.

behavioral activity of the representatives of different cultures. Thus, it is possible to speak about the existence of the certain stable Orthodox cultural constructs, patterns of the respondents' value-semantic sphere, as well as a certain determination effect of these constructs, patterns of behavioral activity of the nurses. The results of statistical analysis allow concluding that religiosity determines the daily and professional activity of nurses in modern conditions.

According to our results, 22% of respondents reported depressed mood, 26% suffered from troubling levels of anxiety. These results are consistent with other studies that are reporting similar rates of depression and anxiety (Tsaras *et al.*, 2018; Schmidt, Dantas, & Marziale, 2011; Papathanasiou *et al.*, 2017). The nursing profession is considered being an emotionally demanding and very stressful occupation. The frequent or constant exposure to stress resulting in high prevalence of depression and anxiety for the specific group of health professionals. In addition, contemporary social environment, social conditions, activities related to social roles, family status, fulfillment of duties according to these roles and status may be seen as essential correlates that affect manifestations of nurses' depression and anxiety.

In our study, nurses reported in resilience scale Mean score 75.59 (14.37) reflecting moderate levels of resilience. In a study conducted in Australia in 2007 (Gillespie, Chaboyer, Wallis, & Grimbeek, 2007) among Operating theatre, surgical nurses were reported similar score. The reported value of resilience of our study is higher than of other studies. Within the context of a study which conducted by Baek, Lee, Joo, Lee, & Choi (2010) resilience was studied among a sample of young (average age = 27.4) Korean population of 576 students, nurses, and firefighters. The mean score of resilience was found to be 61.2. Moreover, despite the fact that resilience was found to be significantly correlated to religiosity, this relationship field to be proved within the linear regression analyses. This finding is consisted and reinforcing results from other studies which have been conducted in diverse populations and conclude that religion doesn't enhance psychological resilience (Mizuno *et al.*, 2017)

In general, nurses' religiosity is an essential resource which increases their adaptive potential, allows gaining a "sense of support", defines the purpose and meaning of any effort. The frequency of manifestations of religiosity in daily life and the degree of personal religiosity promote positive effect on their personal resilience. Therefore, the obtained statistical results indicate the linear conditionality/dependence of the level of resilience on the frequency of manifestations of religiosity in daily activity (Kasen, Wickramaratne, Gameroff, & Weissman, 2011). According to regression analysis, it was found that religious practices contribute greatly to the reduction of depression and anxiety. At the level of daily activity, "religiosity" of personality manifests in the nature of integration into the order of church-liturgical life, in the manner of performing religious practices. It is widely accepted that religion and attendance to religious rituals and performing religious practices offer a sense of coherence and it is a social support resource. Our finding is in partial accordance with other studies indicating that religiosity can improve the mental health of nurses (Cheung, Lee & Yip, 2017). That's why one of our main findings was that religious beliefs may increase levels of depression and anxiety. Also, a positive linear relationship was found between the level of depression and actualization of religious beliefs. For some, God can be associated with the concepts of sin and punishment. In a recent study conducted by Tong and Teo (2018) was reported that religious concepts and thoughts of God may increase negative emotions and thus, can be associated with the prevalence of depression and anxiety. In addition, in the large scale international cohort study of

Leurent *et al.* (2013) in which 8318 individuals participated, it was found that participants with strong religious belief had twice the risk for the onset of depression than participants with weak religious beliefs, setting in doubt the generally accepted notion that religious and spiritual life views enhance psychological well-being.

Strengths and limitations of the study

One of the main strengths of our research is the large sample size and the cross-sectional study design which allows us to have a clear view of the effect of religiosity in psychological variables among nurses. Our study has limitations, as well. It aimed to explore the effect of religiosity in anxiety, depression, and resilience of nurses, precisely in the Orthodox-cultural context (since the vast majority of the respondents identified themselves as Orthodox Christians). However, the results of the study may be extrapolated to the other forms of religious activity (relevant features should be taken into account).

Conclusions

This study attempted to enlighten the relationship between religiosity and psychological wellbeing of nurses. Our findings were mixed and don't allow us to drown some conclusion if the relationship is positive or not. For sure, religion can provide some comfort and a sense of coherence on nurses mostly through the social support that religious communities can offer. At the same time, the results of our study point out the need for more detailed research on the manifestations of religiosity in the consciousness of the contemporary personality in order to determine the specificity of its' impact on anxiety, depression, and resilience.

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