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Association between spirituality, religious coping, and sociodemographic variables in health residents of Recife

Associação entre espiritualidade, coping *religioso e variáveis sociodemográficas em residentes de saúde do Recife*

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ABSTRACT

Introduction: Spirituality, by providing positive coping or religious/spiritual coping, mobilizes resilience, a positive worldview, and a support network, thereby promoting physical and mental health.

Objective: To identify spiritual religious coping by analyzing the association between sociodemographic/educational variables and the level of spiritual guidance among health residents in Recife.

Method: This was a cross-sectional, exploratory, and quantitative analytical study. Spirituality was assessed using the Spirituality Self Rating Scale (SSRS), and religious coping was measured by the Brief Religious/Spiritual Coping Scale (RSC-Brief). The collected data were analyzed using Stata 12.1 software, with crude and adjusted prevalence ratios (PR) estimated, and 95% confidence intervals (CI). The study was approved by the Ethics Committee of IMIP under CAAE N. 42807221.2.0000.5201.

Result: Of the 107 participants, the majority were aged between 21 and 25 years (45.8%), female (79.4%), enrolled in multidisciplinary residency programs (50.5%), and attending the first year of their course (89.7%). Positive religious coping was identified as medium, high, or very high in 69.2% of participants, while low or no negative religious coping was found in 93.4%, and medium/high spiritual guidance in 57%. Residents with Lato Sensu postgraduate qualifications showed a 40% higher prevalence ratio for having a medium/high level of spiritual guidance compared to those with only undergraduate education, and this ratio was 46% higher in the nursing area when compared to the other fields.

Conclusion: Spirituality and religious coping were more prevalent among nursing professionals and those with higher academic qualifications.

Keywords: Mental health, Spirituality, Stress, Psychological, Internship and residency.

RESUMO

Introdução: *A espiritualidade, ao viabilizar o coping religioso/espiritual positivo ou enfrentamento religioso/espiritual, promove o fortalecimento da resiliência, a construção de uma visão positiva de mundo e a mobilização da rede de apoio social, desempenhando um papel relevante na promoção da saúde física e mental.*

Objetivo: *Este estudo teve como objetivo identificar o coping religioso/espiritual por meio da análise da associação entre variáveis sociodemográficas/educacionais e o nível de orientação espiritual em residentes de saúde do Recife.*

Método: *Trata-se de um estudo transversal, exploratório e quantitativo de caráter analítico. A espiritualidade foi avaliada por meio da Spirituality Self Rating Scale (SSRS) e o coping religioso/espiritual, pela Escala de Coping Religioso/Espiritual Abreviada (CRE-Breve). Os dados coletados foram analisados no software Stata 12.1 com razões de prevalência (RP) brutas e ajustadas estimadas, com intervalos de confiança de 95%. O trabalho foi aprovado pelo Comitê de Ética em Pesquisa (CEP) do Instituto de Medicina Integral Prof. Fernando Figueira (IMIP) com CAAE nº 42807221.2.0000.5201.*

Resultado: *Entre os 107 participantes, predominaram as seguintes características: faixa etária de 21 a 25 anos (45,8%), sexo feminino (79,4%), participação em programas de residência multiprofissional (50,5%) e matrícula no primeiro ano da residência (89,7%). Identificaram-se coping religioso/espiritual positivo médio, alto e altíssimo em 69,2%, coping religioso/espiritual negativo baixo ou nenhum em 93,4% e nível de orientação espiritual média/alta em 57%. Os residentes com pós-graduação lato sensu evidenciaram RP de 40% a mais para terem nível de orientação espiritual média/alta do que os que cursaram apenas a graduação, e na enfermagem essa razão foi 46% maior do que nas outras áreas.*

Conclusão: *Os maiores níveis de orientação espiritual e coping religioso/espiritual positivo mostraram-se mais prevalentes nos profissionais de enfermagem, assim como naqueles com maior formação acadêmica.*

Palavras-chave: *Saúde Mental; Espiritualidade; Estresse Psicológico; Internato e Residência.*

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INTRODUCTION

Historically, perceptions of health and pathology were intrinsically linked to religious and spiritual dimensions. Despite a certain distancing over time, currently, considering the growing evidence of the impact of spirituality on the clinical management and well-being of patients and health professionals, there is a tendency towards reintegration[1].

In ancient times, the Egyptians and Greeks encouraged the care of the body and soul. Theories such as the need for balance between organic humors (yellow bile, black bile, phlegm, and blood) and the prescription of rituals for healing entities were common[2]. In the Middle Ages, monasteries and convents were used not only for prayers and rituals, but also for health care. Moreover, according to the beliefs of the time, cures would only be achieved through divine will[3].

In the modern age, spirituality has come to be considered as a superstition. The Age of Enlightenment started to value rationality, making religion, spirituality, and health practices incompatible. In contemporary times, the relationship between spirituality and health has regained strength[4]. The Renaissance, the scientific movement, the emergence of research and scientific evidence on the subject promoted a more holistic view of people and health treatments related to spirituality[5].

In this context, spirituality can be defined as a personal quest to understand issues related to life, its meaning, and relations with the sacred or transcendent[6]. It can manifest itself from a self-connection, relationship with other people, with the Divine power or with nature, promoting purpose, meaning, or reason for being[7].

Spiritual practices are associated with higher levels of emotional well-being, hope, quality of life, and overall health, as well as reduced symptoms of depression and anxiety[8]. Furthermore, incorporating religion and spirituality into care and self-care, while valuing individual subjectivity, serves as a protective factor in fostering healthy behaviors and thought patterns[9].

A qualitative study that assessed the elderly's self-perception about the influence of spirituality in their lives corroborates these assertions. It was observed that the elderly who performed spiritual and religious practices felt more comforted, closer to something greater that encouraged them to cultivate a healthy interpersonal and self-care relationship. Additionally, it demonstrated that prayers, reading holy books and consuming religious content in digital media favored the reduction of stress and anxiety, and stimulated a healthier lifestyle[10].

Residency programs are considered the gold standard in *lato sensu* graduate programs for the training of health professionals[11]. Resident professionals have theoretical-practical training supported by more experienced professionals, on average, for 60 hours a week, covering a period ranging from two to five years of the program[12].

A 2023 census identified that of the 1,614 assessed resident physicians in Brazil, most were female, white, and had no previous specialty[13]. Furthermore, the Brazilian census indicated that the female population seeks more academic training compared to the male population, with most of them practicing some religion, with a predominance of Catholicism[14].

Participation in residency programs in the health area can be considered an adverse situation. The changes caused by these programs to the residents' lifestyle can trigger symptoms of stress, anxiety, and depression[15].

Some factors, such as intense academic pressures and the search for a balance between social commitments and life responsibilities, are examples of causes of stress[16]. Moreover, emotional exhaustion associated with the work environment is an important factor in the genesis of disorders such as anxiety, depression, and low professional achievement[17].

In this context, spirituality presents itself as a dimension of the integral being for stress management, due to the coping strategies it promotes[18]. Religious/spiritual coping can be defined as a set of cognitive and behavioral strategies related to the use of faith, religion, spirituality, or personal beliefs to deal with stressful situations[19].

Studies have shown that the higher the student's knowledge, level of spirituality and religious/spiritual coping, the better they cope with stress in clinical decision-making and resolution of unexplained events[20,21].

The present study aimed to identify religious/spiritual coping by analyzing the association between sociodemographic and educational variables with the level of spiritual guidance in residents attending the residency programs of a Health Secretariat in the state of Pernambuco, Brazil.

METHOD

This is a cross-sectional, exploratory, and quantitative analytical study, conducted within the scope of the Health Secretariat (SESAU, *Secretaria de Saúde*) of a city in the state of Pernambuco, Brazil.

The sample calculation was based on a population including the 76 resident professionals participating in the transversal module of spirituality and integrality in 2021 and the 67 different residents participating in 2022, totaling 143 residents. Using a confidence level of 95% and a margin of error of 5%, the calculated sample consisted of 105 subjects. The final sample included 107 subjects. Data collection was conducted from April 2021 to December 2022.

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The inclusion criteria comprised being over 18 years of age, being regularly enrolled in a SESAU residency program and attending the spirituality and integrality module. The exclusion criterion included absence due to parental leave or some clinical condition during the study period.

SESAU offers the transversal module of spirituality and integrality to nine residency programs in Health: Nursing in pre-hospital care, Obstetric Nursing, Family and Community Medicine, Psychiatry Physician, Dentistry in Collective Health and Multiprofessional Residencies: Health Surveillance, Psychosocial Care Network, Collective Health, and Family Health[22].

The content of the module is offered in 32 hours, divided into 8 meetings lasting 4 hours each. The following subjects are addressed: Concepts of health and spirituality, psychoneuroimmunology, humanization in health, finitude and spirituality, academic interest, research, and clinical practices related to the approach of spirituality in health practices. Teaching methods that favor meaningful learning and active exchanges among participants are used, such as discussion of scientific articles, use of digital tools such as Mentimeter, practical workshops and team-based learning.

The study data were obtained through a link on the Google Forms platform with the study questionnaire to obtain sociodemographic data and information on complementary training, as well as data related to spirituality and religious/spiritual coping through the following scales: Spirituality Self Rating Scale (SSRS) and the Brief Religious/Spiritual Coping Scale (Brief RCOPE).

The SSRS is a self-assessment scale that measures the level of spiritual guidance. It consists of six items that contain the numbers 1 to 5, in which 1 corresponds to totally agree, 2 to agree, 3 to partially agree, 4 to disagree and 5 to totally disagree. For the analysis, it is necessary to recode the numbers of the answers as follows: 5 is replaced by 1; 2 is replaced by 4; 3 is maintained as 3; 2 is replaced by 4 and 1 is replaced by 5. After the recoding, the scores are added. The total score ranging from 6 to 30 represents the level of spiritual guidance, the higher, the better. To compare the scores between groups, one should work with the means obtained in each one and apply an appropriate statistical test to verify whether there are differences between them[23].

The Brief RCOPE is the shortened form of the Religious/Spiritual Coping Scale, serving as an instrument to assess the use of religiosity and spirituality when coping with adversity. The Brief RCOPE Scale is a self-report instrument that contains 49 items distributed in two dimensions: positive religious/spiritual coping (PRC) with 34 items and negative religious/spiritual coping (NRC) with 15 items. Each item is answered on a five-point Likert scale ranging from 1 (not at all), 2 (a little), 3 (somewhat), 4 (a lot) and 5 (very much)[24].

The higher the score, the greater the use of the respective religious/spiritual coping dimension. The scale asks you to keep in mind a specific stressful situation experienced in the past three years. The classification of the results can be analyzed based on the mean values as none or negligible (1.00 to 1.50); low (1.51 to 2.50); medium (2.51 to 3.50); high (3.51 to 4.50); very high (4.51 to 5.00)

The data were entered into Excel using a double-entry method and validated with Epi Info 7.2.4. An ad hoc database was created for this study to include the variables of interest. Data analysis was conducted using Stata 12.1 software, and categorical variables were presented as absolute and relative frequencies.

The Wald test was applied in multivariate analyses to identify factors associated with religious/spiritual coping and spirituality, estimating crude and adjusted prevalence ratios (PR) with 95% confidence intervals and corresponding significance levels. Variables with a p-value < 0.20 in the univariate analysis were included in the final stage of multivariate model construction, with statistical significance defined as $p < 0.05$.

The present study was approved by the Ethics Committee for Human Research of Instituto de Medicina Integral Prof. Fernando Figueira (IMIP), under CAAE N. 42807221.2.0000.5201 and Opinion n. 5.097.535.

RESULTS

The present study included 107 resident health professionals who attended the transversal module of spirituality and integrality. Most were aged between 21 and 25 years (45.8%), were female (79.4%), lived in the city of Recife (91.6%), were single (82.2%), had no religion (40.2%), were attending a multiprofessional residency program (50.5%) and were in the first year of the course (89.7%) (Table 1).

For the statistical analysis, the results of the Brief RCOPE and SSRS scales were grouped as follows. Positive religious/spiritual coping was divided into two groups: group 1 (low and none) and group 2 (medium, high, and very high). Similarly, negative religious/spiritual coping was classified into group 1 (low and none) and group 2 (medium). The level of spiritual guidance was grouped into group 1 (low) and group 2 (medium and high).

In this context, it was identified that 69.2% of the resident professionals had medium, high or very high positive religious/spiritual coping, 93.4% had low or no negative religious/spiritual coping, and 57.0% had a medium or high level of spiritual guidance. (Table 2).

To estimate the prevalence ratios using Poisson regression analysis, the SSRS (outcome) was classified as a medium/high score (≥ 22) as "yes" and low (< 22) as "no". In

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the univariate analysis, the variables that met the criteria to participate in the multivariate analysis (p < 20%) were gender, specialty, degree, and religion (Table 3).

In the multivariate analysis, residents in the nursing specialty showed a prevalence ratio of 46% more for having a medium and high level of spiritual guidance than low when compared to the category of multiprofessional residencies.

Those with a *Lato Sensu* degree showed a prevalence ratio of 40% more for having a medium and high level of spiritual guidance than low, when compared to residents who only had a graduation degree.

Those who professed the Protestant religion had a prevalence ratio of 34% and 55% more for medium and high levels than for low levels, when compared to those who professed the Catholic religion and those without religion, respectively (Table 4).

Table 1. Sociodemographic and academic profile of resident professionals in the Health Residency Programs of the Health Secretariat of Recife in 2021 and 2022. Recife-PE. Brazil. 2023.

Variable	N	%
Gender		
Male	22	20.6
Female	85	79.4
Age (years)		
21 to 25	49	45.8
26 to 30	45	42.1
31 to 42	13	12.1
Residency Specialty		
Nursing	19	17.8
Medicine	16	15
Dentistry	18	16.8
Multiprofessional	54	50.5
Degree		
Graduation	65	60.7
Lato sensu	33	30.8
Stricto Sensu	9	8.4
Religion		
Catholic	39	36.4
Protestant	21	19.6
Spiritist	4	3.7
No religion	43	40.2
Marital status		
Single	88	82.2
Common-law marriage	19	17.8
Year attended in the course		
First	96	89.7
Second	11	10.3
Place of residence		
Recife	98	91.6
Recife Metropolitan Region	9	8.4
Total	*107*	-

Source: Prepared by the authors.

Table 2. Frequency distribution of the total, positive and negative results of the Brief Religious/Spiritual Coping Scale (Brief RCOPE) and the Spirituality Self Rating Scale (SSRS), in residents of the Health Residency Programs of the Recife Health Secretariat in 2021 and 2022. Recife-PE. Brazil. 2023.

Scales	N	%
Total Spiritual Religious/Spiritual Coping (Total RCOPE)		
None	13	12.1
Low	34	31.8
Medium	54	50.5
High	6	5.6
Positive Spiritual Religious/Spiritual Coping (PRC)		
None	11	10.3
Low	22	20.6
Medium	45	42.1
High	28	26.2
Very High	1	0.9
Negative Spiritual Religious/Spiritual Coping (NRC)		
None	47	43.9
Low	53	49.5
Medium	7	6.5
Spirituality (SSRS)		
High (>22)	54	50.5
Medium (= 22)	7	6.5
Low (< 22)	46	43
Total	*107*	-

Source: Prepared by the authors.

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Table 3. Estimates of the prevalence ratios of associations between sociodemographic, professional, and educational variables with medium/high spirituality by adjusting univariate Poisson regression models. Residents of the Health Residency Programs of the Recife Health Secretariat in 2021 and 2022. Recife-PE. Brazil. 2023.

Variables	Sample N	High/medium spirituality N (%)	$_{Gross}$PR (95% CI)[a]	P-value[b]
Age (years)				0.210
21 to 25	49	32 (65.3)	1.0	
26 to 30	45	21 (46.7)	0.71 (0.49 – 1,04)	
31 to 41	13	8 (61.5)	0.94 (0.58 - 1.52)	
Gender				0.139
Male	22	9 (40.9)	0.67 (0.39 - 1.14)	
Female	85	52 (61.2)	1.0	
Year attended at the course				0.616
First	96	54 (56.3)	0.88 (0.55 - 1.43)	
Second	11	7 (63.6)	1.0	
Degree				0.161
Graduation	65	34 (52.3)	0.75 (0.54 - 1.04)	
Lato Sensu	33	23 (69.7)	1.0	
Stricto Sensu	9	4 (44.4)	0.64 (0.30 - 1.37)	
Religion				0.001
Catholic	39	25 (64.1)	0.75 (0.56 - 1.00)	
Protestant	21	18 (85.7)	1.0	
Spiritist/other	8	4 (50.0)	0.58 (0.28 - 1.20)	
No religion	39	14 (35.9)	0.42 (0.27 - 0.66)	
Specialty				0.004
Nursing	19	16 (84.2)	1.0	
Medicine	16	9 (56.3)	0.67 (0.41 - 1.08)	
Dentistry	18	12 (66.7)	0.79 (0.54 - 1.16)	
Multiprofessional	54	24 (44.4)	0.53 (0.37 - 0.75)	
Common-law marriage				0.220
Yes	19	13 (68.4)	1.0	
No	88	48 (54.5)	0.80 (0.56 - 1.14)	
Total	*107*	-	-	-

[a] Prevalence Ratio; [b] Wald test.
Source: Prepared by the authors.

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Table 4. Multivariate Poisson model with initial and final adjusted prevalence ratios of sociodemographic, professional, and educational variables with spirituality in residents of the health residency programs of the Recife Health Secretariat in 2021 and 2022. Recife-PE. Brazil. 2023.

Variables	$PR_{Initial\ adjusted}$ [a]	p-Value[b]	$PR_{Final\ adjusted}$ [a]	p-Value[b]
Gender		0.743		
Male	0.91(0.54-1.56)			
Female	1.0			
Specialties		0.090		0.042
Nursing	1.0		1.0	
Medicine	0.72(0.42-1.22)		0.69 (0.42 - 1.14)	
Dentistry	0.74(0.50-1.09)		0.72 (0.50 - 1.05)	
Multiprofessional	0.55(0.35-0.88)		0.54 (0.35 - 0.83)	
Degree		0.019		0.008
Graduation	0.61(0.42-0.88)		0.60 (0.43 - 0.84)	
Lato Sensu	1.0		1.0	
Stricto Sensu	0.63(0.32-1.24)		0.63 (0.32 - 1.24)	
Religion		< 0.001		< 0.001
Catholic	0.66(0.49-0.89)		0.66 (0.49 - 0.88)	
Protestant	1.0		1.0	
Spiritist/other	0.59(0.33-1.05)		0.58 (0.33 - 1.04)	
No religion	0.45(0.29-0.71)		0.45 (0.29 - 0.70)	
Total	107		-	-

[a] Prevalence Ratio; [b] Wald test.
Source: Prepared by the authors.

DISCUSSION

The sociodemographic profile of the residents in this study aligns with previous findings, showing a predominance of women (56.5% to 79.2%) and a majority of white residents (70.1%)[13,25]. This trend may reflect recent social and political advancements in gender equality, which have facilitated greater entry of women into training programs and the labor market. However, the high prevalence of white residents highlights the need for enhanced policies promoting access and racial equity in postgraduate education[13].

The study identified a predominance of non-religious residents, followed by Catholics. This result contrasts with census data, which show that more than 190 million Brazilians declare themselves to be religious, of which approximately 64% profess the Catholic religion[14]. Additionally, studies involving graduate and post-graduate students in residency programs revealed that most participants declared themselves religious, corresponding to 51.2% and 74.1% of the samples, respectively[26,27]. These variations can be attributed both to regional customs and culture and to the trend of secularization in academic environments[27].

The study indicates a predominance of residents with a graduation degree as the highest level of education. A census conducted by the Brazilian Medical Association in 2023 identified that 72.8% of the residents had no previous specialization[13]. In addition, other studies have shown that 89.65% of residents in health programs and 72.8% of resident physicians had only a bachelor's degree[13,27]. These data suggest that most enter residency programs soon after graduation, perhaps aiming to accelerate entry into the job market or to acquire generalist clinical experience before the specialization.

Regarding spirituality, there was a predominance of medium to very high positive religious/spiritual coping and low or no negative religious/spiritual coping, with spiritual guidance at medium and high levels. Another study showed that health professionals and residents had high spiritual guidance and used religiosity related to temple attendance and prayers to maintain emotional and organic balance[22].

It is important to highlight that positive religious/spiritual coping acts as a protective factor and promotes health, while negative religious/spiritual coping can impair the way a person deals with stress[28]. Additionally, spirituality guides individual choices, influencing care, the perception of health and disease, and the interaction between patients and health professionals[29,30].

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In this context, the results of this study indicate that many residents probably use spiritual and religious practices to adapt positively to the demands of their work. It has been described that these practices promote emotional balance and greater empathy in residents in relation to patients and their spiritual issues[29,30].

A study that evaluated spirituality and its influence on the treatment of patients in a Psychosocial Care Center (CAPS, *Centro de Atenção Psicossocial*) in the state of Amazonas, Brazil, showed that professionals who professed some religion, when they encountered spiritual values, perceived greater tranquility to deal with these issues with their patients and families. Thus, these values favored the understanding of the appropriate moment to approach the patients' spirituality[31].

It is important to note that the World Psychiatric Association recommends that spiritual care be included in psychiatric practice, considering the religious beliefs and practices of patients as part of the anamnesis. Continuing professional training and development in mental health should include the study of the relationships between religion, spirituality, and mental disorders. Psychiatrists should collaborate with faith communities, respect spirituality in the workplace, and raise awareness of the potential benefits and harms of religious and spiritual views[32].

The study also identified that resident professionals with *Lato Sensu* training have a 40% higher prevalence ratio of having medium and high spiritual guidance in relation to low when compared to those with only a graduation degree. This result is significant, as the literature demonstrates the importance of spirituality in the life and academic training of individuals, although it does not confirm the direct relationship that higher academic levels necessarily lead to greater spirituality[33,34].

In this context, the national curricular guidelines for health-related courses, including medicine, emphasize that graduates should develop a critical and reflective professional profile, capable of addressing patients' needs in a comprehensive, humanistic, and ethical manner[35-37]. Consequently, as spirituality is an integral component of the individual, particularly regarding mental health, quality of life, and pain, graduates should be encouraged to engage with and incorporate values related to this subject[38].

In this study, nursing professionals were 46% more likely to have a medium or high level of spiritual guidance compared to those with degrees in medicine and dentistry. Another study identified that 87.8% of nursing undergraduates have spiritual thoughts and 83.4% live according to their religious faith. These data suggest that the spiritual dimension is valued in the nurses' academic and professional life since the beginning of their training[39].

Aspects that are intrinsic to nursing practice, such as holistic care, compassion and empathy, facilitate the approach with spiritual care[40,41]. The American Nursing Association highlights the importance of teaching and practicing spirituality in nursing curricula, stating that spiritual well-being is as crucial as the physical and emotional well-being in the recovery and maintenance of health[42-44]. Thus, for nursing professionals, spiritual care is essential to fully meet the patient's needs, promoting a comprehensive healing environment[45].

The results of this study regarding coping and the level of spiritual guidance suggest that the participating residents utilize religion and spirituality in a healthy manner. Among the practices, they may engage in prayer, attend religious services, or read materials related to their beliefs[6].

The cross-sectional design and sample size of this study did not allow the establishment of causal relationships between the sociodemographic variables, academic background, and spirituality, and this aspect should be considered a limitation to be investigated in future studies. Furthermore, although the study reached the proposed sample, it would have been interesting to have the census sample. However, it was not possible to include all individuals due to the refusal of some residents to participate in the study, despite fully participating in the transversal module.

CONCLUSIONS

The results of this study reflect trends observed in previous investigations, indicating a female predominance and entry into the residency program after obtaining only a graduation degree without other *Stricto* or *Lato Sensu* degrees.

Most of the resident professionals showed medium or high religious/spiritual coping, as well as the level of spiritual guidance in the medium or high categories. These data may suggest that the fact of not having a formal religion is not, in the analyzed sample, a necessary factor for good coping related to the individual's spirituality.

This study contributes to the understanding of the demographic, religious and academic characteristics of resident professionals, offering subsidies for the development of education and health policies that are more aligned with the current profile of these professionals.

Moreover, the absence of modules on spirituality and health in the residency programs is noteworthy, which gives the study an innovative character. The findings reinforce the need to include this topic in the curricula, encouraging its application in other training programs.

AUTHORS' CONTRIBUTIONS

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Caminha and Leopoldo Nelson Fernandes Barbosa contributed to the study concept and development, methodological design, supervision, data collection and treatment, analysis/interpretation, literature survey, writing and critical review of the manuscript. Brunna Haimenis, Lays Santana Freitas and João Victor de Albuquerque Muniz de Arruda Falcão contributed to the study concept and development, methodological design, data collection and treatment, analysis/interpretation, literature survey and writing of the manuscript.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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