Workplace Spirituality, Resilience, and Mental Health during a time of crisis among Professional Nurses in KwaZulu-Natal, South Africa: Developing a Guideline for Psychosocial Support through Intervention Mapping.

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27 **November 2025**

DECLARATION

I, Nompumelelo Penny Mahlaba declare that the work in the thesis titled, **"Workplace Spirituality, Resilience, and Mental Health during a time of crisis among Professional Nurses in KwaZulu-Natal, South Africa: Developing a Guideline for Psychosocial Support through Intervention Mapping."** has not been previously submitted for a degree nor has it been submitted as part of the requirements for a degree to any other university or institution other that the University of KwaZulu-Natal.

I hereby declare that this work is my own; I have acknowledged all references, citations, and borrowed ideas. Therefore, I have appropriately acknowledged any assistance I have received in my research and in the preparation of the thesis.

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Full Name: Nompumelelo Penny Mahlaba (222130715).

As the supervisor, I approve this thesis for submission.

Supervisor

Signed: Doctor CZ Madlabana-Luthuli Date:27-11-2025

DEDICATION

This thesis is dedicated to the memory of my late beloved parents, **Josias Tsose Mahlaba** and **Thokozile Elizabeth Mahlaba**. Although they are no longer here to witness this monumental milestone, their unwavering belief in me remains my greatest source of strength. I still recall the day I completed my matric, standing before your bedroom door, reminding you of the promise you had made – that when I passed my matric, you would send me to university. That promise has remained with me and has become my motivation to succeed. When the time came, and financial hardship threatened that dream, you did not let it fade away. I will never forget the sacrifice you made, turning to a loan shark just to make sure I could register. Today, as I complete this ultimate academic milestone, I know that wherever you are, you are watching over me with pride.

To **Lusanda** and **Laila**, may this achievement serve as a reminder that nothing is impossible when you are determined and when God is on your side. Even the sky is not the limit. Dream boldly and pursue your dreams with faith and perseverance.

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> *I have strength for all things in Christ Who empowers me. I am ready for anything and equal to anything through Him Who infuses inner strength into me. I am self-sufficient in Christ's sufficiency.*

Philippians 4: 13

First and foremost, I would like to express my gratitude to God for providing me with the strength to complete this PhD thesis. I am thankful for the divine favour that has accompanied me throughout this journey.

I extend my sincere appreciation to my research supervisor, Dr Cynthia Zandile Madlabana, for her unwavering support, guidance, and mentorship during this process.

Like an eagle that soars above storms, I embarked on my PhD journey amidst personal challenges, relying on resilience, focus, and a vision that extended beyond the present. The eagle's sharp sight, strength, and solitary determination reflect the path I traversed, often against the wind yet steadfast in purpose. I am profoundly grateful to my family and partner for their unwavering support, which has enabled me to spread my wings and rise above the turbulence.

I would also like to convey my heartfelt thanks to the participants of this study. Your time, insights, and generous contributions were invaluable, and this research would not have been possible without your involvement. Your willingness to share your experiences played a crucial role in shaping the findings of this work. Lastly, to all my friends and colleagues who have supported me on this long journey, I truly appreciate every kind word and gesture.

ABSTRACT

Introduction

Workplace spirituality is an increasingly significant construct in organisational research, particularly in healthcare, where challenges such as absenteeism and low engagement are prevalent. The COVID-19 pandemic further amplified these pressures on nurses, highlighting the critical need for well-being initiatives. This study explores workplace spirituality as a pathway to resilience and mental health among professional nurses.

Objectives

This study aimed to: 1) map existing evidence on the benefits of workplace spirituality for registered nurses in sub-Saharan African healthcare facilities; 2) explore nurses' perceptions of workplace spirituality, resilience, and mental health during a crisis; 3) ascertain nurses' recommendations for primary healthcare management to improve frontline worker preparedness during crises; and 4) develop a health promotional intervention through intervention mapping.

Method

A scoping review was conducted to identify existing evidence on the benefits of workplace spirituality in healthcare facilities. For the primary study, a qualitative research design was employed. Semi-structured interviews were conducted with 18 professional nurses and 2 healthy facility managers, purposively sampled from three sub-districts of uMgungundlovu District, KwaZulu-Natal. Data were thematically analysed.

Results

Findings from the scoping review indicated that workplace spirituality within healthcare facilities in sub-Saharan Africa offers significant benefits for both nurses and the institutions in which they work. These benefits include enhanced psychological well-being, improved professional engagement, and the promotion of compassionate care. However, the review also highlighted a notable gap in the literature, particularly within primary healthcare settings, underscoring the need for further empirical research in this area. Complementary findings from the primary research demonstrated that workplace spirituality can play a pivotal role in fostering resilience and supporting the mental well-being of nurses. Despite this potential, the

study revealed a persistent lack of managerial support in creating and sustaining spiritually supportive environments. Strengthening leadership commitment and organisational strategies to integrate workplace spirituality is therefore recommended to optimise its benefits. The findings from the two methodologies informed a needs analysis for a health promotion intervention using the intervention mapping framework.

Practical or Managerial Implications

The study underscores the critical role of management in fostering a spiritually supportive work environment. Healthcare managers, particularly in sub-Saharan Africa, are encouraged to actively integrate workplace spirituality into organisational practices. This includes creating spaces for reflection, promoting inclusive policies, and providing resources such as counselling. Leadership training should incorporate emotional intelligence, compassionate leadership, and value-based management to align organisational culture with employees' spiritual needs, thereby reducing burnout, improving retention, and enhancing patient care.

Keywords: *Workplace spirituality, resilience, mental health, nurses, primary healthcare, human resources for health*

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ABBREVIATIONS AND ACRONYMS

BPN	Bruntiville Professional Nurses
COVID-19	Coronavirus Disease
EPN	Eastwood Professional Nurses
GRR	General Resistance Resources
HCF	Healthcare Facilities
HCW	Healthcare Workers
IPN	Imbalenhle Professional Nurses
JD-R	Job Demand Resource Theory
KZN	KwaZulu-Natal
MERS	Middle East Respiratory Syndrome
MMAT	Mixed Methods Appraisal Tool
NDoH	National Department of Health
NDP	National Development Plan
PCC	Population, Concept, and Context
PHC	Primary Healthcare
SOC	Sense Of Coherence
SARS-CoV	Severe acute respiratory syndrome coronavirus 2
UHC	Universal Healthcare
WHO	World Health Organisation

CHAPTER 1:

INTRODUCTION AND BACKGROUND OF STUDY

1.1 Introduction

This chapter establishes the foundation for the study by situating it within the broader context of health systems and healthcare workforce dynamics, both nationally and globally. It begins by providing an overview of the South African health system, emphasising the structural challenges and systemic pressures faced by professional nurses (PNs). This national perspective serves to contextualise the specific issues under investigation.

Subsequently, the chapter expands its scope to explore the global health system, focusing on the core functions essential for strengthening healthcare delivery worldwide. This comparative lens offers a deeper understanding of the interconnected nature of health systems and highlights best practices and critical gaps relevant to this study.

The chapter further articulates the core components of the research, including the problem statement, the study's contributions, its aims and objectives, and the central research questions. Ethical considerations related to the study are also discussed to ensure alignment with established research standards. The chapter concludes with an outline of the structure of the thesis, guiding the reader through the subsequent chapters.

1.2 Background of Study

The National Department of Health (NDoH) in South Africa is committed to developing a unified health system that ensures quality healthcare is delivered to all citizens in an efficient and compassionate environment (Heunis et al., 2019). The World Health Organisation (WHO, 2010) defines a 'health system' as encompassing all organisations, institutions, and resources dedicated to producing actions whose primary purpose is to improve health. To ensure that every citizen has access to health services, the NDoH has decentralised the management of health services, placing emphasis on the district health system to enhance access to services by making primary healthcare available to all. This approach is embedded in the NDoH's mission statement, which articulates: "To provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa and to

provide caring and effective services through a primary healthcare approach" (National Department of Health, 1997, p. 6). Primary healthcare is the strategic approach that drives this initiative. Rechel (2020) defines primary healthcare as a comprehensive approach that emphasises universal coverage, accessibility, extensive care, disease prevention, health promotion, intersectoral action, and community and individual involvement.

According to the *National Development Plan (NDP): Vision 2030* (National Planning Commission, 2013), addressing persistent health inequities necessitates a holistic approach that promotes health and well-being. Lifestyle and behavioural choices, such as diet, alcohol consumption, and sexual behaviour, significantly contribute to poor health outcomes. Encouraging health and well-being is essential for controlling and preventing lifestyle-related disorders, particularly the primary non-communicable diseases that affect impoverished populations, including diabetes, high blood pressure, and heart disease. In the context of rising poverty and inequality, these diseases are likely to become more prevalent over the next 20 to 30 years (National Planning Commission, 2013). Moreover, social determinants of health, including birth, upbringing, housing conditions, and occupation, further contribute to health disparities (Saunders et al., 2017).

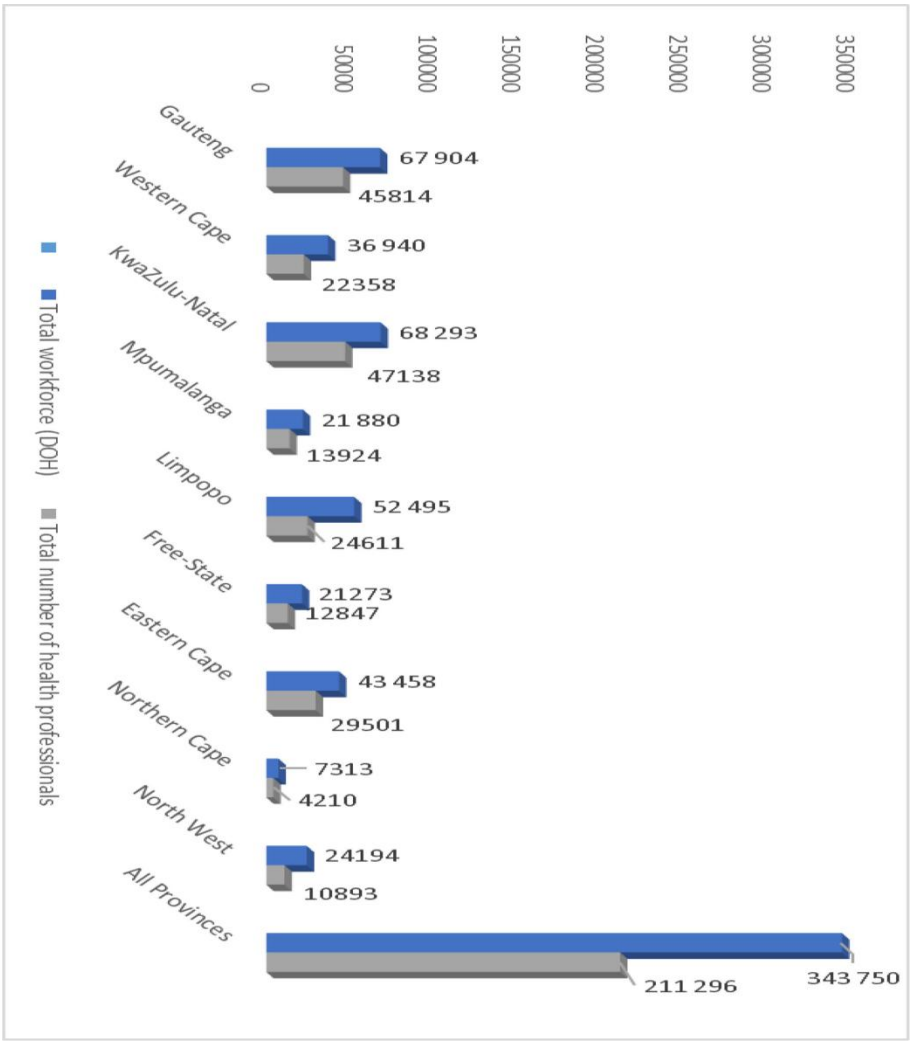
The National Development Plan (National Planning Commission, 2013, p. 330) outlines the principles that underpin South Africa's healthcare system: primary healthcare and district health systems. Primary healthcare emphasises universal access, equity, participation, and an integrated approach focused on prevention and the use of appropriate technology. Furthermore, it encourages improved access to and utilisation of first-contact care and prioritises patient-centred care over disease-focused approaches. Primary healthcare is a public health strategy derived from the social model of health, grounded in the philosophy that addressing basic needs is crucial to improving health outcomes (Keleher, 2001).

As a middle-income nation with a disproportionately large urban population, South Africa faces significant healthcare challenges. Despite possessing a robust network of over 3,500 primary healthcare clinics and community health centres, the country grapples with various health issues. Although 90% of the population can access free public primary healthcare within a 5-kilometre radius, access to quality care and adequate resources remains a challenge. This is compounded by disparities in health outcomes, particularly among historically disadvantaged communities. To address these challenges, a new network of community-based outreach teams comprising community health workers has been established to support improvements in health systems (WHO, 2017).

A recent study conducted by the World Health Organization (WHO) (2023) predicts a shortfall of 6.1 million health workers in Africa by 2030. These shortages jeopardise the likelihood that African nations will achieve Universal Health Coverage (UHC) by 2030 (WHO, 2023). The COVID-19 pandemic has exacerbated the challenges faced by the healthcare system, contributing to the long-standing deficit of Professional nurses in South Africa's public health sector. A study by Matseke (2023) analysed the distribution of Professional nurses across South Africa's nine provinces during the COVID-19 pandemic. As illustrated in Figure 1.1, the public health sector employed approximately 343,750 workers in March 2020. Of these, 61.5% (211,296) were healthcare professionals, including those in medical, dental, medical technology, and nursing roles.

Figure 1.1:

Number of Professional Nurses in South Africa's Public Health Sector by Province

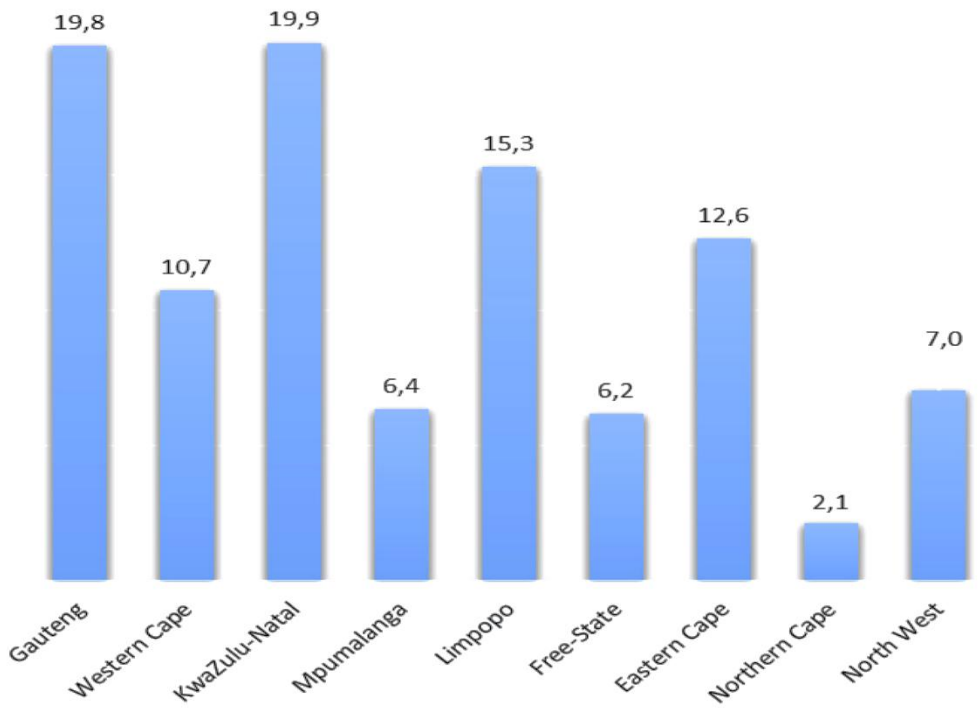


Note. Adapted from Taking Stock of the Healthcare Workplace in the Public Health Sector of South Africa during COVID-19: Implications for Future Pandemics. Africa Journal of Public Sector Development and Governance, 6(1)*,* 63.

Figure 1.2 below illustrates the provincial distribution of the public health sector healthcare workforce in South Africa as of March 2020. According to Matseke's analysis, KwaZulu-Natal had the highest concentration of Professional nurses, accounting for 19.9% of the total workforce, followed closely by Gauteng at 19.8%.

Figure 1.2:

Distribution of the Healthcare Workforce in the Public Health Sector in South Africa, March 2020



Note. Adapted from Taking stock of the Healthcare Workplace in the Public Health Sector of South Africa during COVID-19: Implications for Future Pandemics. Africa Journal of Public Sector Development and Governance, 6(1)*,* 65.

Figure 1.3 below provides a breakdown of the number of nursing professionals across South Africa's provinces. KwaZulu-Natal had the highest number of professional nurses employed (17,663), followed by Gauteng (15,378) and the Eastern Cape (12,479). The Northern Cape had the fewest professional nurses (1,689), followed by the Free State (2,422). In terms of staff nurses (those with less than four years of training) and student nurses,

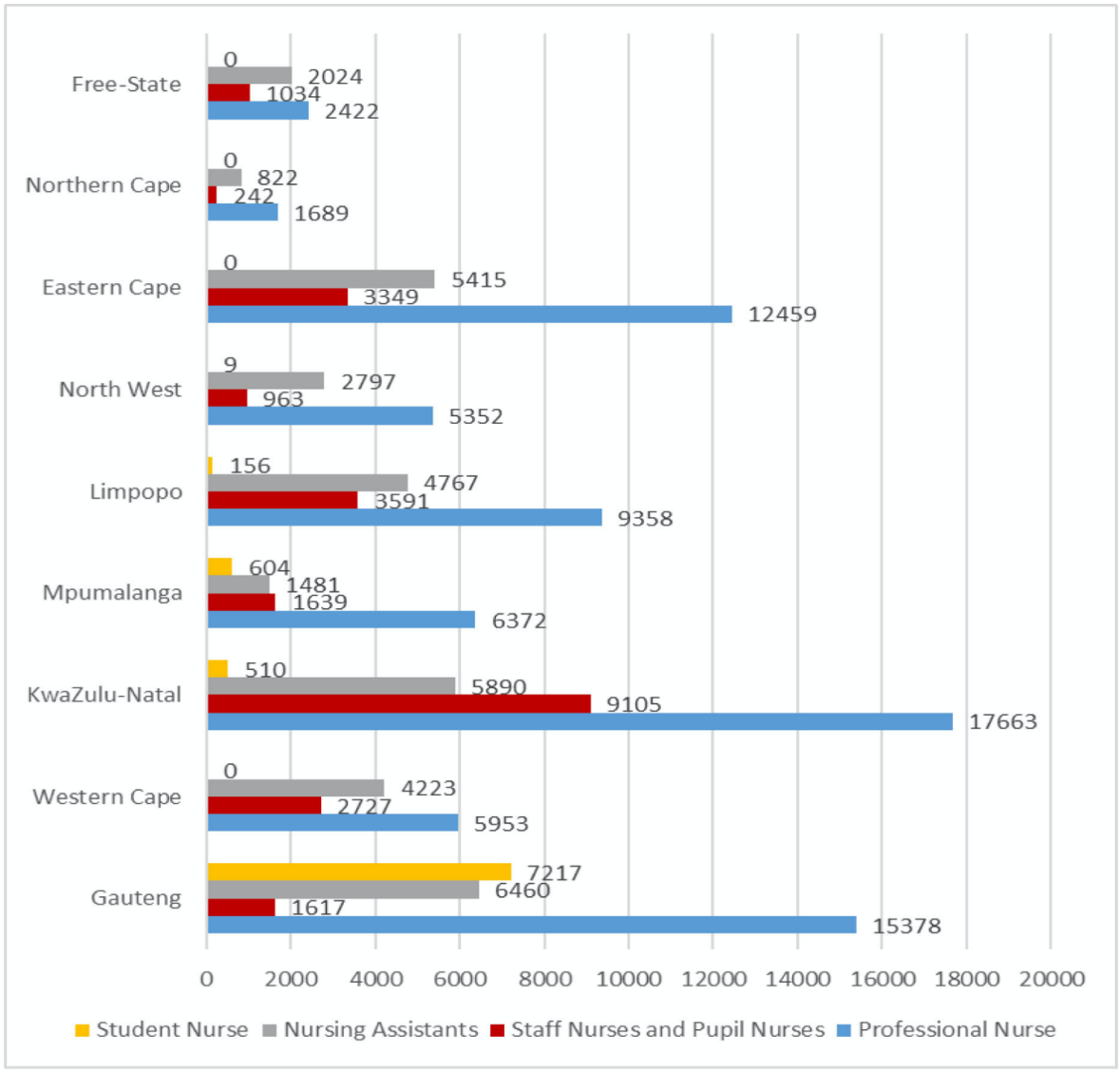
KwaZulu-Natal again had the largest number (9,105), followed by Limpopo (3,591) and the Eastern Cape (3,349). The Northern Cape had the fewest (242), followed by the North West (963) and the Free State (1,034).

Most nursing assistants were employed in Gauteng (6,460), followed by KwaZulu-Natal (5,890), Eastern Cape (5,415), Limpopo (4,767), and Western Cape (4,223). The Northern Cape had the fewest (822), followed by Mpumalanga (1,481), Free State (2,024), and North West (2,797).

In terms of student nurses, the majority (7,217) were employed by the Gauteng Health Department, while Mpumalanga reported the fewest (604). KwaZulu-Natal and Limpopo also had relatively low numbers of student nurses, with 510 and 156, respectively. The Western Cape, Eastern Cape, Northern Cape, and Free State did not report any student nurses employed in their health departments.

Figure 1.3:

Breakdown of the Number of Nursing Professionals Across South Africa's Provinces



Note. Adapted from Taking Stock of the Healthcare Workplace in the Public Health Sector of South Africa during COVID-19: Implications for Future Pandemics. Africa Journal of Public Sector Development and Governance, 6(1), 67.

The analysis reveals that the health system has made progress in increasing the number of professional nurses in the public healthcare sector. However, the current figures still fall short of the demands indicated by the WHO (2023). The shortage of nurses may negatively affect the well-being of professional nurses if left unaddressed. The Job Demand-Resources (JD-R) Theory posits that job demands should align with job resources to avoid employee burnout and foster engagement. One proposition of the JD-R theory is that job demands and resources trigger two processes: a health-impairment process and a motivational process. Job demands are considered the most important predictors of outcomes such as exhaustion and

psychosomatic health complaints (Bakker, Demerouti, & Schaufeli, 2003; Hakanen et al., 2006).

More recently, with climate change and its consequences, there is growing interest in natural disasters, man-made crises, and global health emergencies, such as the COVID-19 pandemic, which have also been shown to affect the resilience and mental health of professional nurses. Natural and human-induced disasters are increasing in both frequency and magnitude globally, posing significant challenges to communities and healthcare systems. Over the past decade, the frequency of disasters has reportedly increased by approximately 60%, resulting in considerable loss of life, injuries, and displacement (Lim & Skidmore, 2025). These events include both natural and man-made disasters. The World Health Organization defines natural disasters as sudden, catastrophic events arising from Earth's natural processes, including biological, geological, and meteorological hazards, that often result in extensive property damage and human casualties (WHO, 2022). In contrast, Canton (2021) describes man-made disasters as events that cause significant disruption and harm to society due to human intent, negligence, error, or the failure of human-made systems.

Global disaster data highlight the disproportionate impact of such events on low- and middle-income countries (LMICs). An analysis of the Emergency Events Database (EM-DAT) indicates that although lower-income countries account for approximately 44% of global disasters, they account for about 68% of disaster-related fatalities, compared with high-income countries, which experience 56% of disasters but only 32% of fatalities (CRED, 2022). Climate-related hazards account for the majority of recorded disasters worldwide, accounting for approximately 90% of the 7,345 disasters documented since 2000, with floods occurring five times more frequently than in the 1980s (CRED, 2022). Evidence from countries such as Nepal further illustrates the scale of the problem; between 1971 and 2016, more than 26,000 natural disasters were recorded, resulting in over 43,000 deaths and approximately 83,000 injuries (Shrestha, 2019). Recent global statistics also demonstrate a continuing upward trend in disaster occurrences. In 2021, 432 major disasters were reported worldwide, significantly higher than the annual average of 357 events recorded between 2001 and 2020, with floods representing the most frequent hazard (CRED, 2022). Similarly, during the first half of 2022, 187 natural disasters were documented across 79 countries, resulting in more than 6,000 deaths, affecting over 50 million people, and causing economic losses exceeding 40 billion US dollars, with LMICs experiencing the majority of fatalities (CRED, 2022).

Both natural and man-made disasters have far-reaching social, economic, and environmental consequences. These crises can severely damage critical infrastructure, such as electricity and communication systems, thereby disrupting healthcare services and limiting access to essential medical care. Such disruptions place considerable pressure on healthcare systems and professionals, particularly nurses, who are expected to deliver timely and appropriate care to affected populations under challenging conditions. Despite their essential role in disaster response, the impact of these crises on professional nurses is frequently overlooked (Salam et al., 2023).

During disasters, nurses often experience significant psychological and physical strain. Conditions such as anxiety, emotional distress, and physical exhaustion among professional nurses are common; however, these issues are rarely prioritised in disaster preparedness and response planning. These factors may negatively affect nurses' well-being and their ability to provide quality healthcare services. Furthermore, professional nurses may also be personally affected by disasters through damage to their homes, displacement, or personal loss, which may disrupt both their personal and professional lives (Salam et al., 2023).

To succeed in these challenging times, health organisations require flexibility, management capacity, and support from other institutions (Andreassen & Borch, 2020). Son et al. (2020) assert that organisational resilience is essential in times of crisis. Organisational resilience is the ability of an organisation to survive and thrive in a changing, uncertain environment (Hatton et al., 2012). As noted by Cristian (2018), organisational resilience is increasingly recognised as crucial due to the numerous unforeseen factors that impact daily life and the survival of organisations during crises. It is therefore critical to explore and understand professional nurse's workplace spirituality, resilience, and mental health, as they are at the forefront of delivering healthcare services during crises, such as natural disasters and infectious pandemics like COVID-19. Resilience involves coping, adapting, and thriving during times of crisis (Zanotti et al., 2020), making it an important asset in the face of health-related emergencies. A study by Kabunga et al. (2024) investigating crisis management among professional nurses found that PNs experience high levels of compassion fatigue and professional burnout. The systematic review further indicated that nearly three in four healthcare professionals in Sub-Saharan Africa experience compassion fatigue and or burnout, with prevalence rates increasing during the COVID-19 pandemic. This high prevalence underscores the urgent need to address and mitigate these conditions to safeguard the mental

health and emotional well-being of healthcare professionals who provide care under challenging circumstances, such as the pandemic. A further discussion on professional burnout follows.

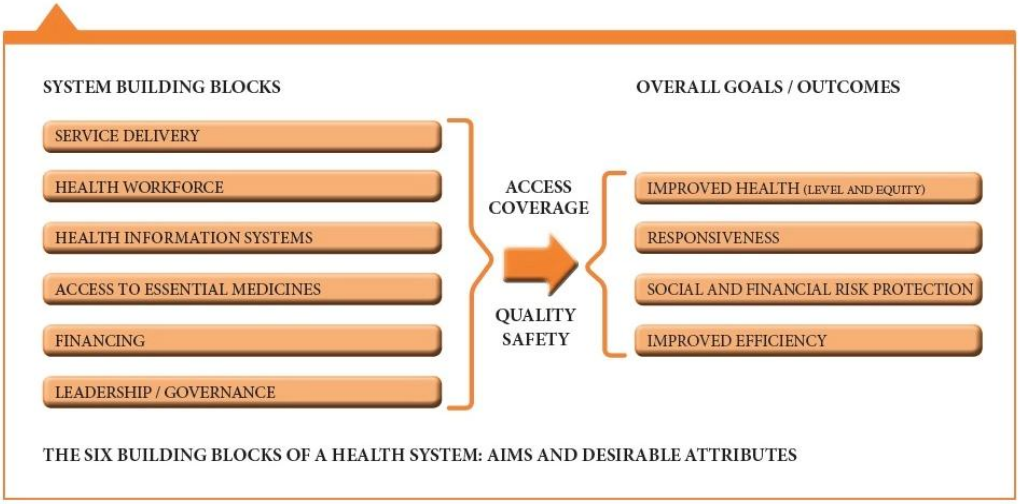
Professional burnout is regarded as a serious occupational hazard, significantly impacting job commitment, increasing medical errors, and reducing job performance among professional nurses (Duarte et al., 2020). The World Health Organization (WHO) identifies occupational burnout as a syndrome resulting from chronic workplace stress that has not been effectively managed. It is characterised by three core dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job or negative attitudes towards one's work; and reduced professional efficacy (WHO, 2019). Burnout is defined as "a state of physical, emotional, and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding" (Schaufeli & Greenglass, 2001). Despite the impact of COVID-19 on the world, several studies have highlighted the influence of various psychological factors, including depression, stress, and resilience, on burnout syndrome (Ahola et al., 2014). These studies were conducted during a specific period of the pandemic (Duarte et al., 2020). However, there is a paucity of research assessing workplace spirituality, resilience, and mental health status during times of crisis. According to Labrague and de Los Santos (2020), inadequate crisis management may increase turnover risk, thereby exacerbating the burden on nurses, who may be expected to work overtime. Therefore, conducting this proposed study to ascertain whether workplace spirituality can buffer the impact of crises on nurses' resilience and mental health presents a valuable opportunity. Poor mental health may result in nurses making medical errors and poor decisions due to burnout if not appropriately managed.

1.3 International Perspective on the Health System and Professional Nurses

The public health system serves as a critical pillar of the overall health system, aiming to enhance population health and well-being through sustainable approaches while strengthening the integration and coordination of healthcare services. Strengthening the health system refers to actions that will enhance a country's ability to successfully perform the functions described by the WHO's (2010) six health building blocks: health service delivery, healthcare workforce, health information systems, access to essential medical products, health system financing, and leadership and governance.

Figure 1.4:

The WHO Health Systems Framework



Note: Adapted from Monitoring the Building Blocks of Health Systems. WHO Documents Production Services.

Service delivery refers to the health system's ability to provide effective, safe, and quality personal and non-personal health interventions to those who require them while minimising resource waste. Information is crucial for a well-functioning health information system. A robust information system ensures the production, analysis, dissemination, and use of reliable and timely information on health determinants, health system performance, and health status.

Medical products are an essential component of a health system. A well-functioning system ensures equitable access to essential medical products, vaccines, and technologies that are high-quality, safe, effective, and cost-effective. These products must be utilised in a scientifically sound and cost-effective manner. Financing is another critical aspect of a health system. It involves raising sufficient funds to ensure that individuals can access essential services without facing financial hardship or impoverishment due to healthcare costs. Leadership and governance entail ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system design, and accountability.

The health workforce comprises the human resources engaged in actions whose primary intent is to enhance health (WHO, 2007). These human resources include support, managerial, and clinical personnel. A well-functioning health system requires properly trained health professionals to provide Universal Health Coverage (UHC). In the field of public health, UHC

is defined as the equitable provision of comprehensive, high-quality health services to all individuals and populations, ensuring that these services are accessible when and where they are needed, without causing financial hardship. UHC spans the full continuum of care, including health promotion, disease prevention, treatment, rehabilitation, and palliative care across the life course, and serves as a foundational element for achieving health equity and improving population health outcomes (World Health Organisation, 2025).

According to WHO (2007), an effective health workforce operates responsively, equitably, and efficiently to achieve the best possible health outcomes given available resources and circumstances. WHO (2016) argues that the health workforce plays a crucial role in building the resilience of health systems to respond to adversity caused by natural or man-made hazards, as well as environmental, technological, and biological risks. Such events can disrupt healthcare by causing staffing shortages, damage to medical facilities, interruptions in health programmes, and overburdened clinical services (WHO, 2016).

Despite efforts to address the shortage of health workers, a significant gap remains. Liu et al. (2017) postulated that 40 million health workers will be required worldwide, primarily in upper-middle and high-income nations. However, according to WHO (2016b), if universal health coverage is to be attained and maintained by 2030, job growth is anticipated to coincide with a possible shortage of 18 million health workers.

The public health system must excel in these six building blocks to be adequately prepared to respond when a country faces an epidemic or health-related crisis. Health systems that do not perform well are at a high risk of failing to contain epidemics when an outbreak is reported (Kamal-Yanni, 2015). For instance, three West African countries – Guinea, Sierra Leone, and Liberia – failed to contain an Ebola outbreak in 2014.

A health crisis is defined as any event with the potential to significantly impact human health (UI-Haq et al., 2019). These authors reported that over 1.5 billion people have been affected by crises in the last decade, with vulnerable groups being the most impacted. Public health has often remained silent and avoided its responsibilities during crisis events. Alexander (2018) noted a shift during the latter part of the 20th century, where societies began to actively explore the phases involved in the sudden onset of natural disasters, hoping these phases might serve as a roadmap to make the event and its response more comprehensible to those managing the crisis. These phases include prevention, preparedness, response, recovery, and rehabilitation. Ansell and Boin (2019) define crisis management as a set of preparatory and response activities aimed at containing a crisis and its consequences. Traditionally, local healthcare providers have invested only in the response phase of the disaster cycle; however,

in today's more complex crises, this approach is insufficient. In response to this challenge, the World Health Organisation (WHO) (2014) has developed a hospital preparedness plan, which provides a framework for hospital management when establishing mechanisms for developing and implementing a hospital emergency risk management programme. These programmes aim to ensure the effective management of risks associated with internal and external emergencies, including pandemics. Chapter 8 of the hospital preparedness plan (WHO, 2014) underscores the importance of actively managing psychological support for professional nurses to address anxiety among staff confronted with a crisis involving highly contagious infectious diseases. A study conducted by Kuan et al. (2019) reported that chronic infectious diseases, such as Middle East Respiratory Syndrome (MERS), commonly known as camel flu, tuberculosis, and severe acute respiratory syndrome coronavirus 2 (SARS-CoV), have had a detrimental effect on human health, with those infected subsequently experiencing various psychological issues (as cited in Abbas, 2021).

1.4 Problem Statement

Epidemics and public health crises pose substantial physical and psychological risks to professional nurses, primarily due to increased service demands and the overwhelming influx of patients seeking care (Donelli et al., 2022). Research indicates that between one and two out of every five Professional nurses (PNs) may report symptoms of anxiety, depression, and distress (Muller et al., 2020). It is evident that most HCWs do not report an increase in their levels of psychological distress (Greenberg et al., 2021), and the experience of stress, anxiety, and depression can be considered relatively normal emotional reactions during times of crisis (Walton et al., 2020).

Numerous international studies have reported alarming prevalence rates of mental health challenges among healthcare professionals, including anxiety (7.0%–97.3%), depression (10.6%–62.1%), stress (2.2%–93.8%), post-traumatic stress disorder (3.8%–56.6%), and insomnia (8.3%–88.4%) (Major & Hlubocky, 2021). This global concern is echoed at the local level, as evidenced by a study conducted in KwaZulu-Natal (KZN), South Africa, where 44.3% to 86.2% of professional nurses reported experiencing mild to extremely severe symptoms of depression, anxiety, and stress (Dawood et al., 2022).

Professional nurses, particularly in KwaZulu-Natal (KZN), are increasingly recognised as a vulnerable population due to the significant pressures they face within a resource-constrained

healthcare system (Naidoo et al, 2020). These professionals are often exposed to long working hours, high patient loads, and emotionally taxing environments, all of which contribute to elevated levels of stress, burnout, and other mental health challenges. Despite these risks, mental health services tailored to the needs of PNs are frequently neglected. This neglect often stems from the prioritisation of urgent communicable disease burdens, such as HIV and tuberculosis, which consume limited healthcare resources and leave little capacity for addressing the psychological well-being of the workforce. Consequently, support systems remain underdeveloped, which jeopardises the resilience of the very professionals mandated to deliver essential care.

Professional nurses represent a critical component of both the COVID-19 response and the delivery of routine healthcare services. Their motivation, emotional resilience, and capacity for empathy are fundamental to providing effective, safe, and compassionate patient care (Robertson et al., 2020). However, unaddressed psychological distress among HCWs can significantly diminish job satisfaction, reduce clinical performance, and compromise patient outcomes and safety (Bekker et al., 2020). This, in turn, may lead to adverse financial and systemic consequences within the healthcare sector (Ruotsalainen et al., 2014).

Regardless of the effect that the pandemic has had on professional nurses, some authors argue that it remains imperative for them to foster wholeness and remain connected through the practice of workplace spirituality (Chirayath, 2020). Workplace spirituality provides individuals with a holistic view of life, encompassing pursuing meaning and purpose in their work, the desire to connect with others and be part of the community, and aligning organisational goals with individual ethics and values (Sehra, 2015).

Similarly, studies on workplace spirituality have primarily focused on how it impacts employee engagement, performance, relationships, and ultimately the goals of an organisation. However, not much is known about the spiritual well-being of nurses who are mandated to ensure the quality of care provided to the public (Koren et al., 2009). According to Kuchina (2021), the Joint Commission in 2011 expected that healthcare organisations should encourage spirituality in the workplace; however, it has been reported that healthcare professionals remain doubtful about embracing this concept (Kuchina, 2021). In a study examining the relationship between spirituality, stress, and subjective well-being among professional nurses in Europe, Kuchinka (2021) conceptualised spirituality from a traditional, conservative perspective, in

which it is primarily associated with belief in God. The study further indicates that, within the American context, certain segments of the population have historically adopted a secular, anti-religious stance, contributing to resistance to the incorporation of spirituality into institutional environments such as schools and workplaces. Nevertheless, growing empirical evidence continues to demonstrate the positive role of spirituality in reducing stress and enhancing subjective well-being. Kuchinka (2021) suggests that the increasing interest in spirituality within healthcare is largely influenced by substantial evidence in the literature highlighting its benefits for both professional nurses and patients (Kumar, 2016; Waddill-Goad, 2019).

Although the concept of workplace spirituality lacks a universally accepted definition, it is commonly conceptualised through three core dimensions: inner life, meaningful and purposeful work, and a sense of community and connectedness (Houghton, Neck, & Krishnakumar, 2016). These dimensions highlight the importance of acknowledging employees' deeper values, personal fulfilment, and interpersonal relationships within the work environment. Research increasingly indicates that workplace spirituality plays a significant role in promoting both organisational and individual well-being.

Beyond organisational outcomes, workplace spirituality also contributes to employees' psychological health. A study by Maghadam and Rashidi (2020) revealed a positive relationship between workplace spirituality and psychological well-being among nurses. This relationship can be understood through a holistic perspective of health. In 1998, the World Health Organization defined health as a state of complete physical, mental, and social well-being, rather than merely the absence of illness or disability. Within this framework, spirituality represents an important dimension that supports and sustains overall well-being. Consequently, fostering spirituality in the workplace can be viewed as an important strategy for promoting mental health, as it helps employees experience greater meaning, emotional balance, and connectedness in their professional lives. While global literature suggests that spirituality buffers stress, there remains a critical doctoral gap in understanding how these constructs intersect within the unique socio-cultural and resource-constrained context of the South African primary healthcare system. Current models are often descriptive and 'off-the-shelf,' failing to provide a traceable mechanism that translates nurses' lived experiences into organizational protocols. This study matters because it moves beyond mere exploration; it addresses the lack of a systematically developed, evidence-based framework for healthcare managers to foster

resilience. By failing to bridge this gap, the healthcare system risks continued nurse burnout, high turnover, and a diminished capacity to respond to future public health crises.

This study aims to explore this further and fill the knowledge gap by examining workplace spirituality, resilience, and mental health among professional nurses during times of crisis, such as the COVID-19 pandemic and natural disasters (e.g., flooding) in the KwaZulu-Natal (KZN) province.

The following are the main objectives of the study:

1.5 Research Aim and Objectives of the Study

The aim of the study is to explore nurses' experiences and perceptions of workplace spirituality, resilience, and mental health during a time of crisis, such as a natural disaster or pandemic (COVID-19), in the context of KwaZulu-Natal, to propose an appropriate intervention or strategy for the prevention of mental health-related challenges during a health-related crisis. The study will be conducted in three phases. The researcher will first conduct a scoping review to map the available literature on workplace spirituality in sub-Saharan Africa. The second phase of the study will involve a qualitative study to explore nurses' experiences and perceptions of workplace spirituality, resilience, and mental health during a health-related crisis. To address the main aim, the specific objectives of this study are to:

Objective 1 – Scoping Review

- To map existing evidence on workplace spirituality among registered nurses in sub-Saharan African countries.

Objective 2 – Qualitative Research Study

- To explore nurses' perceptions of workplace spirituality, resilience, and mental health during a crisis.
- To ascertain nurses' recommended actions that primary healthcare management may consider towards improving frontline workers' preparedness during times of crisis.

Objective 3 – Intervention Mapping

- To systematically develop a theory and evidence-based intervention aimed at improving the mental health and resilience of professional nurses.

In line with the aforementioned objectives, this study sought to answer the following research questions:

1.6 Research Questions

- **Scoping review research questions**

The main research question:

- What is the existing evidence on the benefits of workplace spirituality among registered nurses in primary healthcare (PHC) settings in sub-Saharan Africa?

The sub-research questions are as follows:

- What are the common benefits of spirituality at work?
- What are the reported trends regarding the promotion of spirituality at work in healthcare facilities?

- **Qualitative research questions**

- What are nurses' perceptions of workplace spirituality, resilience, and mental health during a crisis?
- What are the experiences of nurses regarding workplace spirituality, resilience, and mental health during a crisis?
- What actions do nurses recommend that PHC management consider to improve frontline workers' preparedness during a health-related crisis?

- **Intervention Mapping research question**

- What are the systematic steps involved in developing a theory- and evidence-based intervention to enhance the mental health and resilience of professional nurses?

1.7 Contribution of the Study to the body of knowledge

This study makes a significant contribution to the limited body of knowledge by exploring the intersection of workplace spirituality, resilience, and mental health among healthcare professionals, an area that has not been previously studied within the context of primary healthcare, particularly in the uMgungundlovu district, especially during a time of crisis. The study employs a rigorous methodological approach that combines a scoping review, qualitative research through three focus groups, and Intervention Mapping. This integrated approach not only provides an in-depth understanding of the psychological challenges faced by professional

nurses but also informs the development of practical, evidence-based guidelines for psychological support interventions. By addressing a critical gap in both the literature and practice, this research offers valuable insights for healthcare systems seeking to support Professional nurse's mental well-being during times of crisis.

Overall, this thesis makes an original contribution to the field of implementation science by moving beyond a descriptive analysis of nurse distress toward a formative intervention design. Its primary contribution is the development of a traceable logic model of change that bridges the gap between qualitative empirical evidence and structured intervention development. By utilising the Intervention Mapping (IM) protocol, this study provides a methodological blueprint for operationalising workplace spirituality as a health-strengthening resource. This research is the first of its kind in the uMgungundlovu district to integrate a scoping review and primary qualitative data into a formal design framework, offering a scalable model for health system strengthening in Sub-Saharan Africa.

This study makes a meaningful contribution to the limited body of knowledge by examining the relationship between workplace spirituality, resilience, and mental health among professional nurses during times of crisis. By focusing on primary healthcare professionals in the uMgungundlovu district, the research provides context-specific insights into how spiritual dimensions of the workplace can support nurses' psychological well-being and adaptive capacity in high-stress environments. In doing so, the study expands the existing literature by highlighting workplace spirituality as a potentially important protective factor that strengthens resilience and promotes mental health among professional nurses operating under crisis conditions.

Methodologically, the study adopts a rigorous and integrative design that combines a scoping review, qualitative inquiry through three focus groups, and the application of Intervention Mapping. This comprehensive approach allows for both a deeper exploration of professional nurses lived experiences and the systematic development of practical, evidence-informed guidelines for psychological support interventions. As a result, the study not only advances theoretical understanding of the links between workplace spirituality, resilience, and mental health but also translates these insights into actionable strategies for healthcare settings.

Furthermore, the study offers important implications for human resource management and organisational leadership within healthcare institutions. By demonstrating the value of

workplace spirituality in supporting nurses' mental well-being, the research highlights the need for HR policies and leadership practices that foster supportive, meaningful, and connected work environments. Integrating spirituality-sensitive approaches into organisational culture, such as promoting purpose-driven work, encouraging supportive relationships, and creating spaces for reflection and emotional support, can strengthen employee resilience and psychological health. Consequently, the findings may inform the development of workplace policies, leadership strategies, and organisational cultures that recognise employees as holistic individuals and prioritise their mental health, particularly during periods of crisis.

Overall, this study contributes to both scholarship and practice by providing evidence that workplace spirituality can serve as a valuable resource for enhancing resilience and mental well-being among professional nurses, while also guiding healthcare leaders and human resource practitioners in designing policies and cultures that more effectively support the psychological needs of their workforce.

1.8 Ethical Considerations

Ethical approval for this study was granted by the Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal, South Africa. Additionally, a letter of support was obtained from the uMgungundlovu District Manager, along with formal approval from the Provincial Health Research Committee to conduct the study at three selected community health centres. The study adhered to established ethical principles, including voluntary participation, informed consent, anonymity, and confidentiality. A detailed account of the ethical procedures followed is provided in Chapter Five.

1.9 Outline of the Chapters

Chapter 1: Introduction and Background. The first chapter of this study introduces the research by providing an overview of the research problem and the rationale for the study. The researcher also contextualises the setting of the study. The research objectives will be highlighted, along with what the researcher aims to achieve through the study.

Chapter 2: Narrative Literature Review and Theoretical Framework. This chapter presents a narrative literature review of the relevant literature on workplace spirituality, resilience, and mental health among professional nurses.

Chapter 3: Scoping Review Methodology (Registered Protocol). This chapter outlines the rationale for selecting a scoping review approach, the research questions that drive the review, and the inclusion and exclusion criteria for study selection.

Chapter 4: Scoping Review Findings and Discussion. This chapter provides evidence on the benefits of workplace spirituality among nurses working in healthcare facilities in sub-Saharan Africa.

Chapter 5: Primary Research Study Methodology. In this chapter, the researcher will detail the study design, population, selection procedure, data collection, and data analysis. This chapter outlines the methodology used to conduct the qualitative study.

Chapter 6: Qualitative Research Findings and Discussion. This chapter presents the findings from the exploration of nurses' perceptions and experiences of workplace spirituality, resilience, and mental health during times of crisis.

Chapter 7: Intervention Mapping. This chapter focuses on the design of the health promotional intervention and its conceptual model. It also provides the significance of this framework.

Chapter 8: Integrative Chapter, Recommendations and Conclusion. This chapter provides a synthesis and integrative discussion of all findings. It includes associated recommendations for intervention and future research. The chapter concludes with a discussion of the study's limitations.

CHAPTER 2:

NARRATIVE LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter provides a comprehensive exploration of the constructs of workplace spirituality, resilience, and mental health, establishing a theoretical foundation for understanding their interrelationship within the workplace context. The chapter begins by examining the concept of spirituality through diverse cultural lenses, including Eastern, Western, and African perspectives, to offer a broad and inclusive understanding of its meaning and relevance. Following this, a literature review is presented, which critically discusses key themes and empirical findings related to workplace spirituality, resilience, and mental health, with particular attention to their impact on healthcare professionals. The latter part of the chapter focuses on the theoretical framework underpinning these constructs, tracing their historical development, conceptual evolution, and theoretical integration. By offering a structured, in-depth analysis, this chapter aims to enhance understanding of how workplace spirituality, resilience, and mental health interact and contribute to the overall well-being and performance of individuals in professional settings.

2.2 Spirituality

The term "spirituality" is derived from the Latin word *spiritus*, which means something that gives life to physical organisms (Tecchio et al., 2016). It is considered to be a complex and multidimensional concept (Withers et al., 2017). However, it is still viewed as an important concept (Lucchetti & Lucchetti, 2014). The multi-dimensionality of spirituality makes it prone to association with religion, complicating its conceptualisation and distinctly separating it from religion (Van Niekerk, 2018). Peng-Keller (2019) contends that there is an ongoing debate about whether a universal definition of spirituality is possible. It has been reported that in the past, individuals who dedicated their lives to religious services were defined as spiritual (Koenig, 2008). While this notion persists in some Eastern cultures, Western perspectives often differentiate spirituality from religion.

Spirituality can be viewed from three different perspectives: intrinsic, religious, and existential (Krishnakumar & Neck, 2002). The intrinsic perspective emphasises that spirituality is rooted in the inner interconnectedness of individuals with others and the universe (Gupta and Mikkilineni, 2018). This viewpoint is reflected in definitions that describe spirituality as "our

inner consciousness“ (Guillory 2000, p. 33), “the basic feeling of being connected with one’s complete self, others, and the entire universe”, and “oneness with all other beings“ (Krishnan, 2008, p. 13).

The second perspective perceives spirituality through the prism of religion. Hindus define spirituality as carrying out one’s duties with the fullest devotion, as exemplified in the *Bhagavad Gita*, one of their religious writings (Tablan, 2017). Similarly, Buddhism emphasises “hard work and devotion that enrich life and work“ as central to spiritual understanding (Jacobson, 1983, as cited in Gupta & Mikkilineni, 2018). Christians also share this perspective, often referring to their work as a “calling” (Gupta & Mikkilineni, 2018). The existentialist perspective views spirituality as an individual’s search for personal meaning in life. This viewpoint is reflected in definitions of spirituality such as “a personal search for meaning and purpose in life“ (Tanyi, 2002; de Brito Sena, 2021) and “a personal quest for understanding answers to ultimate questions about life, about the meaning, and about the relationship to the sacred or transcendent” (Koenig et al., 2001, p. 18).

Below is an overview of how spirituality is perceived and defined from the Eastern perspective.

2.2.1 Eastern Perspective of Spirituality

Eastern spirituality is often deeply intertwined with religion and philosophical traditions such as Hinduism, Buddhism, Taoism, and others, as reported in several studies conducted in the Middle East (Rassool, 2000; Ahmad & Khan, 2014; Heydari et al., 2016). A similar observation has been noted by Ahmad and Khan (2016), who opine that spirituality and religion overlap with one another and extend throughout all aspects of a person’s life. Weathers (2018) highlighted the significance of Islamic beliefs and values in shaping the conceptualisation of spirituality, further emphasising the close connection between religion and spirituality in Eastern contexts. Key practices emphasised in Eastern spirituality include harmony, enlightenment through meditation, mindfulness, self-awareness, and connection to the divine. These practices are considered essential for cultivating inner peace (Miller & Ewest, 2024; Akmal, 2024).

Markani et al. (2013) conducted a study in the Middle East that also revealed the interconnectedness of spirituality and religion in the context of the workplace. Nurses in their study described searching for God as the most significant theme in relation to their spiritual experiences. Gielen et al. (2016) conducted a systematic review of spirituality in Indian palliative care and reported similar findings, emphasising the importance of religion in all

dimensions of spirituality. Spirituality is perceived as a journey of self-discovery, self-realisation, and transcendence of the ego to attain a deeper understanding of the interconnectedness of all beings and the universe (Miller et al., 2024). It often involves practices that focus on inner transformation, personal growth, and the pursuit of wisdom and compassion.

Eastern spirituality also places a strong emphasis on the interconnectedness of all living beings, the impermanence of life, and the cyclical nature of existence. Practices such as yoga, meditation, chanting, and mindfulness are commonly used to cultivate spiritual awareness and inner peace. However, Buddhism and Vedic traditions seem to define spirituality differently. Buddhism views spirituality as a means to alleviate suffering and achieve happiness through compassion, mindfulness, and letting go of the self (Shrestha et al., 2023; Kernochan, McCormick & White, 2007). According to Buddhist beliefs, happiness arises from mental balance and insight into the nature of reality (Ulluwishewa et al., 2020). Buddhists believe that virtues like compassion and mindfulness, along with the practice of letting go of the self, are essential for achieving happiness and relieving suffering (Kjonstad, 2020). The interconnectedness of all beings and mindfulness are also important for achieving enlightenment (Segall & Segall, 2020).

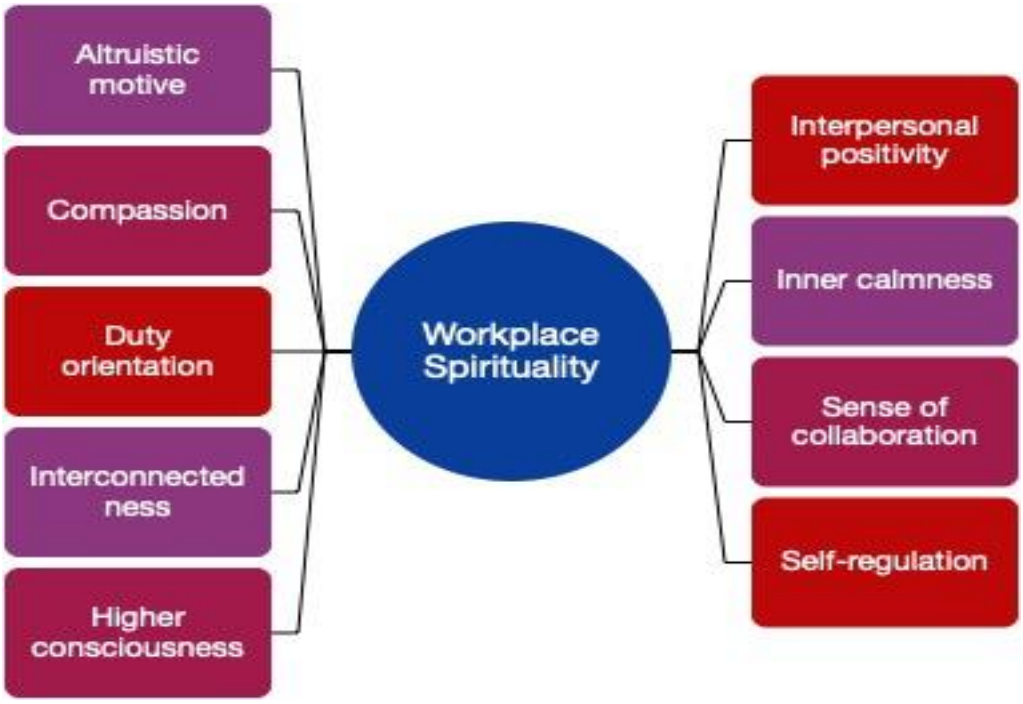
Vedic spirituality, on the other hand, emphasises the importance of oneness in creation, highlighting a single reality with multiple manifestations when defining spirituality (Nandram, Bindlish, Purohit, Joshi & Hingorani, 2019). Concepts such as *svadharma* (individual duty) and *lokasangraha* (welfare of society) are integral to Vedic spirituality. Like the Buddhist perspective, Vedic spirituality focuses on interconnectedness, duty, and the journey towards the higher self by overcoming impurities such as desires, anger, and ego. These perspectives offer unique insights into the understanding of spirituality from Vedic and Buddhist traditions. Akmal (2024) observed that a common understanding of the interconnectedness of all aspects of existence exists across various belief systems, demonstrating a holistic perspective on reality. For example, Hinduism's concept of Brahman emphasises the interrelated nature of all things, while Buddhism's concept of dependent origination highlights the mutual dependence of all phenomena. Taoism's concept of the Tao showcases a deep awareness of interconnectedness.

A study by Shrestha et al. (2023) in an Eastern context, primarily dominated by Vedic and Buddhist influences, identified nine themes related to workplace spirituality. These themes include:

- **Altruistic Motive:** Motives or desires to give selflessly for the well-being of others and the welfare of humanity.
- **Interpersonal Positivity:** Behaviour or inclination characterised by optimistic thinking and emotions of friendliness toward others, a genuine effort to be straightforward and honest, and abstaining from actions that harm others.
- **Compassion: P**ossessing empathy, awareness, and a desire to alleviate the pain of others.
- **Inner Calmness:** A condition characterised by an intense sense of calm, equilibrium, and absence of hurt, attachment, sadness, or delight, accompanied by bliss.
- **Duty Orientation:** A willingness to carry out tasks and commit oneself to work with a greater sense of responsibility, complete dedication without expecting anything in return for labour.
- **Sense of Collaboration:** Actions and attitudes centred on working cooperatively to achieve a shared purpose and cultivating mutual trust and respect among team members to accomplish the aims of the team or organisation.
- **Self-regulation:** Self-awareness and the capacity to regulate one's thoughts and conduct.
- **Interconnectedness:** A person's inner self-relationship with all others, including nature and its creations, or their sense of unity with these elements, which helps them recognise that they are all part of the same existence.
- **Higher Consciousness:** A higher state of consciousness in which an individual is not only aware of the present moment but also possesses a profound understanding and acceptance of the nature of existential reality, the self's relationship to such reality, and the generative aspect of the self in producing elevated experiences in life.

Figure 2.1:

Nine Themes Related to Workplace Spirituality as Indicated by Shrestha et al. (2023).



Note. Adapted from Conceptualization of Workplace Spirituality in an Eastern Context. Journal of Business and Management Research, 5(1-2), 35-59.

Based on the above themes, Shrestha et al. (2023) define spirituality as a pattern of experience that employees encounter. When all employees possess altruistic motivation, interpersonal positivity, compassion, and inner serenity, they perceive their work as their primary responsibility. Employees collaborate with their colleagues, demonstrate self-restraint and concern not only for their coworkers but for all of humanity, and ultimately, they experience a profound sense of higher consciousness.

Having discussed the definition of spirituality from an Eastern perspective, the next section will explore the African perspective on spirituality.

2.2.2 African Perspective of Spirituality

Marumo and Chakale (2018) highlight the diverse perspectives of spirituality within the African context. The authors argue that spirituality is shaped by culture and encompasses deeper human values, attitudes, beliefs, and practices rooted in various African worldviews. African spirituality fosters the development of a heightened degree of consciousness and

awareness of one's life and surroundings, leading to a connection with one's higher self (Marumo & Chakale, 2018). The concept of spirituality is deeply intertwined with the interconnectedness of individuals with their community, ancestors, nature, and a higher being (Marumo & Chakale, 2018). Olupona (2020) defines spirituality as a belief in a higher spirit or energy, which may encompass concepts such as God, gods, or undefined universal entities. He further characterises African spirituality, in the context of African religion, as a belief system that informs every facet of human life. He posits that African spirituality extends beyond religious beliefs and practices to encompass a greater consciousness of self and the interconnectedness of the human race with economic, societal, and environmental systems. Olupona (2020) further argues that spirituality involves internal strength, emotional management, and a positive mindset that influences one's behaviour towards others and the environment.

Adofo (2016) asserts that our existence is not contingent on what is observable but rather on two aspects: the physical and the spiritual. He perceives spirituality as the afterlife, which is further divided into different realms or dwellings for spirits, departed ancestors, and the ultimate source of creation from which all things in existence originated (Adofo, 2016). The author contends that these two worlds are interconnected, and events in one realm can impact the other. According to Marumo and Chakale (2018), Africans hold the belief that everything is interrelated and interacts universally. Below are some key points on how spirituality is defined from an African perspective:

Collective Spirituality**:** African spirituality emphasises a collective spirituality wherein individuals are interconnected with others, nature, and a higher power. This entails a strong focus on communal well-being (Ohajunwa & Mji, 2018; Amanze, 2011; Mji, 2012).

Connection to the Unseen Spirit**:** African spirituality acknowledges the presence of an unseen spirit, which can be accessed through prayer, rituals, and spiritual intermediaries. This connection to the unseen spirit provides strength, guidance, and support in times of need (Singh & Bhagwan, 2020).

Ancestral Worship**:** An important aspect of African spirituality is the reverence for ancestors as spiritual beings who influence and guide individuals. Ancestors are seen as intermediaries between the living and the divine, playing a significant role in spiritual practices and healing methodologies (Singh & Bhagwan, 2020).

Cyclical Existence**:** African spirituality is based on the idea of cyclical existence, where spirituality is not confined to written texts but is passed down through oral traditions, stories,

and songs. It honours the interconnectedness of all aspects of life, including the physical and spiritual realms (Marumo & Chakale, 2018).

Ubuntu Philosophy**:** The spirit of ubuntu, central to African spirituality, emphasises the interconnectedness of humanity. It reflects the idea that individuals exist through and with others, highlighting the importance of community, kinship networks, and extended family in providing spiritual support (Ohajunwa & Mji, 2018; Mji, 2012). Mshayisa and Bhagwan (2024) highlight ubuntu as a concept that underpins African spirituality and shapes the empathy Africans have for one another, especially during difficult times. Mshayisa et al. (2024) contend that Africans are characterised by ubuntu, which informs their empathy for each other, particularly during challenging times. Eze (2017) emphasises that ubuntu is based on the notion of "Umuntu ngumuntu ngabantu" (I am because you are).

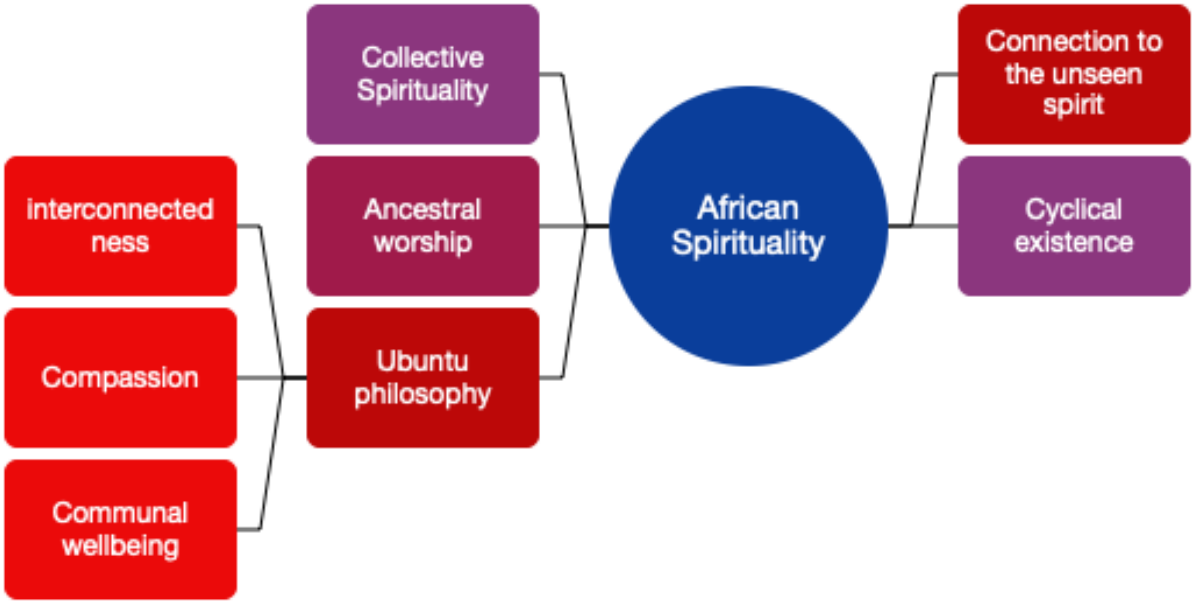
Kobe (2021) believes that ubuntu is deeply intertwined with spirituality, particularly in the context of African philosophy and culture. In her study of ubuntu as a spirituality of liberation for black theology and liberation, Kobe (2021) explores ubuntu as a philosophy that transcends mere humanism and encompasses the dimension of spirituality. Ubuntu is described as an African attribute that prioritises the common good, people, community, and respect. In many African communities, it serves as the cornerstone of ethics for strong interpersonal relationships (Magezi, 2020).

Dladla (2017) opines that ubuntu promotes a sense of communal harmony and collective well-being, which are central to many spiritual traditions and emphasise interconnectedness, compassion, and communal well-being (Kobe, 2021). It is noteworthy to observe the similarities emerging from the Eastern and African perspectives on spirituality. Van Niekerk (2018) suggests that religion and spirituality are intimately related but not identical. He indicates that spiritualists criticise religion for its antiquated, patriarchal, and dogmatic teachings that impose rules from above. He further suggests that religions are hierarchical, vesting authority in clergy and other religious leaders, and are generally institutional, making them less appealing and more narrow, rigid, and prescriptive.

Spirituality, on the other hand, has been lauded for its understanding of the sacred, the human, and nature as a unit, which includes politics, the environment, and the sociocultural milieu. It has also been praised for its holistic perspective and comprehensive worldview (Hedlund-de Witt, 2011). The following themes emerged from the literature reviewed in this study on African spirituality.

Figure 2.2:

Themes Emerging from the Literature Review on African Spirituality



Note. This figure illustrates themes and sub-themes identified in the literature on African spirituality.

The perception of spirituality and religion as similar or interrelated is not universally accepted in Western literature. However, Gielen et al. (2016) argue that although the understanding of spirituality in the Middle East is deeply rooted in religion, many characteristics and dimensions identified are akin to those reported in Western literature. For instance, spirituality is often associated with connection, peace, transcendence, and the pursuit of meaning and purpose (Hatamipour et al., 2015; Weathers et al. 2016).

2.2.3 Spirituality from a Western Perspective

Withers et al. (2017) define spirituality as a broad concept encompassing values, meaning, and purpose. It involves introspection regarding human traits such as honesty, love, caring, wisdom, imagination, and compassion. Additionally, they propose that spirituality may involve the existence of a higher authority, guiding spirit, or transcendence. This definition emphasises the personal and transformative nature of spirituality, highlighting its role in enhancing humanity, promoting the healing of the body-mind-spirit, and fostering personal growth in advanced practice nursing. Conversely, Ariani (2021) defines spirituality as a personal search for the meaning of life, a connection with others, and a sense of purpose beyond oneself. He further indicates that spirituality involves exploring beliefs, values, experiences, and practices

that provide individuals with a sense of inner peace, harmony, and fulfilment. He posits that spirituality is often associated with concepts such as desires, thought patterns, and the meaning of life, experienced both within and outside a religious context.

While religiosity and spirituality are related concepts, they possess distinct characteristics. Ariani (2021) delineates religiosity and spirituality as follows:

Table 2.1:

The Different Characteristics of Religiosity and Spirituality

Religiosity	Spirituality
• Religiosity is often seen as a formal, institutional, and visible expression of adherence to specific religious beliefs and practices.	• Spirituality is more individualistic and focuses on the personal search for meaning, connection with others, and a sense of purpose beyond oneself.
• It is typically operationalised with behaviours and rituals associated with organised religions.	• It involves exploring one's inner beliefs, values, experiences, and practices that provide a sense of inner peace, harmony, and fulfilment.
• Religiosity may involve participation in religious ceremonies, adherence to religious doctrines, and involvement in religious communities.	• Spirituality is not necessarily tied to organised religion and can encompass a broader range of beliefs and practices.
• Religiosity is often associated with organised religions and their established traditions and practices.	• Spirituality is often viewed as a holistic dimension that includes personal growth, relationships, and the search for deeper meaning in life.

Note. The different characteristics of religiosity and spirituality.

The literature reviewed demonstrates the complex nature of spirituality, particularly when considering perspectives from various contexts. It is noteworthy to observe similarities across different cultures. For instance, Hindus, Muslims, Buddhists, and Africans perceive spirituality as interconnected with culture and religion, whereas Westerners often distinguish spirituality from religion. Nevertheless, shared values exist among these cultures. Having defined spirituality, the next section will focus on defining workplace spirituality.

2.3 Workplace Spirituality

This study explores the meaning and implications of spirituality within the workplace context. While spirituality at work is considered a highly personal and philosophical construct, nearly all academic definitions acknowledge that spirituality involves a sense of wholeness, connectedness at work, and deeper values (Gibbons, 2000). O'Brien et al. (2019), Niu, et al. (2022), and Shrestha (2023) concur that spirituality at work is subjective and personal, influenced by individual contexts and cultural backgrounds. It is also important to note that for some, workplace spirituality has a religious connotation, while for others, it does not (Neck & Milliman, 1994; Zinnbauer et al., 2015). In recent decades, there has been a surge of interest in workplace spirituality among academics and practitioners across various fields (Shrestha et al., 2023). This heightened interest is partly due to the belief that spirituality can address complex organisational issues such as improving productivity and employee well-being (Benefiel et al., 2014; Karakas, 2010; Chaudhary & Lata, 2021; Shrestha & Jena, 2021). Despite the reported positive benefits, confusion, contradictions, and controversies persist regarding the conceptualisation of workplace spirituality.

Gupta et al. (2014) observed that most literature on workplace spirituality is theoretical, with limited empirical research. Regardless of this limitation, the increasing number of scholarly articles on spirituality in the workplace cannot be overlooked (Daniel, 2015; Krishnakumar & Neck, 2002; Pardasani et al., 2014). De Klerk (2005) concurs that the growing interest in spirituality in organisations is undeniable. Konz and Ryan (1999); Tigedi et al. (2024) also argue that spirituality, in general, and in the workplace, in particular, has become a crucial topic in recent years. Several researchers have highlighted the significance of workplace spirituality. Saks (2011) and Zsolnai (2011) opine that the recent surge in workplace spirituality research is primarily attributable to a shift in management theory from a mechanistic to a non-mechanistic approach. Riasudeen and Singh (2021) share similar views, emphasising a growing desire for meaningful and purposeful work rather than viewing work solely as a means of material gain. Bolton (2007) indicated that the human relations school of thought later recognised that the scientific management ideas of the early 20th century made people function like machines and had no place for human qualities.

The human relations school of thought has had a significant historical impact, inspiring contemporary theorists to study topics like spirituality, which has received little attention in traditional literature (Rego & Cunha, 2008; Bhatia & Arora, 2017; Milliman & Gatling, 2017; Zou & Dahling, 2017). Mukherjee, Bhattacharjee, and Singha (2016) observe that while the traditional management paradigm neglected workplace spirituality, it is now becoming

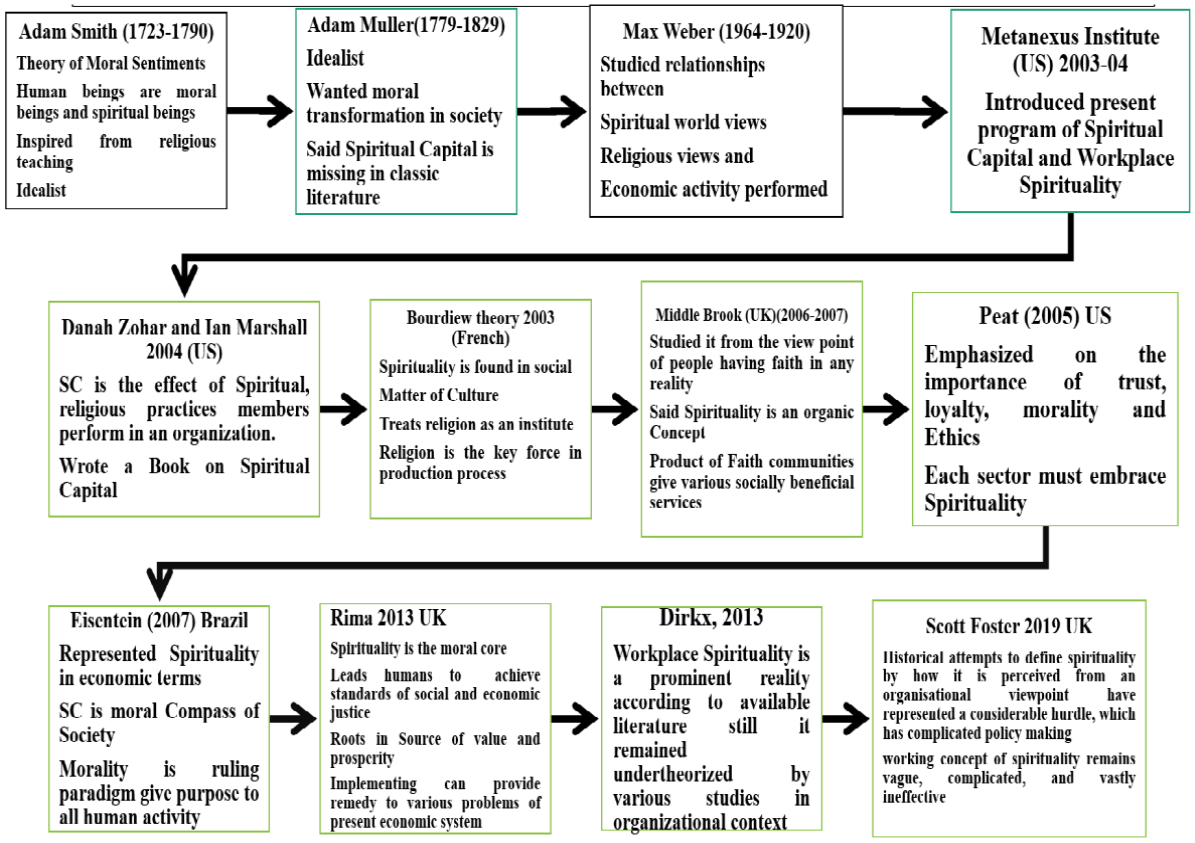
increasingly prevalent as individuals seek to understand their purpose beyond their work lives. The traditional model emphasised achieving organisational goals without considering employees as human beings with needs that must be fulfilled through work. Moreover, when the organisation is the focus, employees' personal lives have little impact on how effectively tasks are executed. Presently, businesses face challenges such as financial losses, strained relationships with certain clients, agitated staff members, and employee departures. These issues can lead to feelings of loneliness and demoralisation among employees, making workplace spirituality a mechanism for overcoming these challenges (Mukherjee et al., 2016).

Workplace spirituality has become a buzzword among researchers (Saxena & Saxena, 2011; Alas & Mousa, 2016; Joshi & Jain, 2016; Shin & Kong, 2016; Shahzadi & Hassan, 2020; Lokshmi & Das, 2021). It has also gained acceptance at top-tier conferences and from respected institutions, with the Academy of Management establishing a special interest group on the topic and allocating a separate track to spirituality and religion at its annual meeting (De Klerk, 2005).

The persistent interest in workplace spirituality has resulted in various conceptualisations and meanings of the construct (Cendemic et al., 1999). This is evident in the work of Yousaf and Dogar (2022) on the historical realities of workplace spirituality. Below is an overview of how the concept of workplace spirituality has evolved over the past few years.

Figure 2.3:

The History Map of Workplace Spirituality



Source: Adapted from Historical Actualities of Workplace Spirituality. Indian Journal of Economics and Business, 21(2), 497-510.

The concept of workplace spirituality has been influenced by several key factors throughout history, which are discussed below:

2.3.1 Philosophical and Sociological Perspectives

Influential thinkers such as Adam Smith, Adam Müller, and Max Weber have explored the relationship between individuals, society, morality, values, and religion/spirituality in the context of economic activities (Yousaf & Dogar, 2022).

Their ideas have shaped our understanding of how spirituality can impact individual behaviour and social order within organisations. Adam Smith also emphasised the importance of moral transformation in society and organisations through the encouragement of religion and spirituality, laying the foundation for considering spiritual elements in the workplace (Berger & Hefner, 2003; Noghiu, 2020). Another influential factor is the contemporary studies conducted by authors such as Zohar and Marshall (2004), which highlight the role of spiritual capital in corporate culture and leadership vision. This focus on leadership and culture has

influenced the integration of spirituality in organisational practices (Zohar & Marshall, 2004). Contemporary studies support this perspective, indicating that spiritual leadership and workplace spirituality contribute to the development of value-based organisational cultures that promote ethical behaviour, employee well-being, and organisational commitment. For instance, recent research demonstrates that spiritual leadership fosters organisational cultures grounded in shared values, inclusivity, and employee connectedness (Hlatywyao & Van der Walt, 2024). Jurkiewicz and Giacalone (2004) view workplace spirituality as a framework of values experienced by employees when an organisation fosters a sense of transcendence, connectedness, and completeness.

2.3.2 Globalisation and Trust

Scholars such as Peat (2005) have introduced the concepts of spiritual capital and globalisation, emphasising the importance of trust and loyalty in the workplace. The increasing interconnectedness of organisations globally has led to the recognition of the significance of spiritual values in fostering trust and collaboration (Verter, 2003).

2.3.3 Research and Development

Ongoing research and critical analysis of workplace spirituality, as seen in studies by Pandey (2017), have contributed to a deeper understanding of the individual-level constructs of spirituality and the importance of implementing spiritual values in organisations (Houghton et al., 2016; Pandey, 2017). These studies have provided insights into how spirituality can enhance employee well-being and organisational success.

In summary, the concept of workplace spirituality has been influenced by philosophical, historical, cultural, and leadership perspectives, as well as ongoing research and development in the field. These factors have collectively shaped the understanding and implementation of spirituality in the workplace throughout history (Yousaf & Dogar, 2022). Most researchers agree on the complexity and multidimensionality of the construct of workplace spirituality. Some authors attribute this to perceptions of workplace spirituality across different cultural perspectives and contexts (Gupta et al., 2014; Hisam, 2021; Shrestha et al., 2023). Foster and Foster (2019) also attribute the lack of a universal definition of the phenomenon to the subjective nature of spirituality.

Pandey (2017) conducted a literature review on workplace spirituality and synthesised themes reported by various scholars in the field. These themes represent the progressive development

and conceptualisation of the construct of workplace spirituality within organisational research. The following table presents these themes.

Table 2.2:

Themes of Workplace Spirituality as Summarised by Pandey (2017)

Author/s	Year	Themes Identified.
Ashmos and Duchon	2000	Inner life of an employee. Sense of belonging to the community. Meaningful work.
Sheep	2004	Self-workplace integration. Meaning in work. Transcendence of self. Development of one's inner self at work.
Kinjeeski and Skrypnek	2004	Physical Affective. Cognitive. Interpersonal. Spiritual. Mystical.
Pandey and Gupta	2008	Harmony of self. Harmony with the social and natural environment. Harmony with the transcendence.
Pawar	2009	Employees' experience of self-transcendence. Transformational leader-experience of transcendence. Organisational citizenship behaviour. Organisational support and organisational justice as precursors for workplace spirituality.

In summary, the concept of workplace spirituality is multifaceted and influenced by various factors, including philosophical perspectives, historical developments, cultural contexts, and

leadership styles. While the literature offers diverse perspectives on workplace spirituality, common themes include the acknowledgement and nurturing of one's inner life, the discovery of meaning and purpose at work, the feeling of connection to others and the broader world, and the experience of transcendence (Pandey, 2017). It is concluded that these themes are commonly found in Buddhism, Christianity, Hinduism, and Islam, which collectively represent 71% of the world population, as all these themes contribute to positive relationships with intrinsic work values such as expanding one's horizons, contributing to society, and having meaningful work (Parboteeah et al., 2009).

Pradhan, Jenar, and Soto (2017), in their study conducted in India, concluded that workplace spirituality can be experienced at four levels, which they categorised as follows: meaningful work, spiritual orientation, compassion, and value alignment. Examining these four categories, one can deduce that meaningful work is an individual perception that the work provides meaning and purpose in one's life. The second category, "spiritual orientation", can be viewed as the transcendent aspect of workplace spirituality, where an individual feels that their work is a calling. Krishnakumar and Neck (2002) conducted a study on the "what", "why", and "how" of spirituality in the workplace. They concluded that there are three primary viewpoints and perspectives on workplace spirituality, which are discussed below:

2.4 Intrinsic-origin Perspective

According to Krishnakumar and Neck (2002), this perspective views spirituality as residing within an individual and as unrelated to religion, which is more formal and ceremonial. This notion is supported by other scholars who view spirituality as an inner search for meaning or fulfilment that anyone can engage in regardless of religious affiliation (Guillory, 2000). Mahoney and Graci (1999) propose that spirituality includes a sense of giving and service, a sense of connection (community), meaning, and morality. This perspective aligns with the communal/interpersonal perspective highlighted by Israa and Suneel (2018), which emphasises the importance of belongingness, interconnectedness, and community as indicators of workplace spirituality.

2.5 Religious Perspective

The religious perspectives define spirituality through a religious lens. The spirituality-related religious beliefs are those unique to a particular religion. Mahlaba (2015) conducted a study with government employees in Kwa-Zulu Natal on employee perceptions of workplace spirituality. The study reported that spirituality in the workplace is still viewed through a

religious lens. Gupta (2016) concurred that, among all forms of spirituality, arguably the most controversial is religion-based spirituality.

2.6 Existentialist Perspective

One may argue that the existential perspective on spirituality has the strongest connection to ideas such as the pursuit of purpose in one's profession (Neck & Milliman, 1994). One of the most frequently cited reasons for workers quitting their employment is the search for a more spiritually fulfilling life (Burack, 1999). Parma et al. (2022) support this perspective and associate the existential viewpoint with self-actualisation, which imparts greater significance and direction to work tasks. Hakimi and Jamal (2020) argue that providing employees with a deeper understanding of what makes work creative, meaningful, and purposeful is crucial to improving performance and fostering greater creativity and productivity in the workplace. The existential and philosophical approach holds that workplace spirituality will provide managers and employees with a deep sense of purpose (Han, 2017).

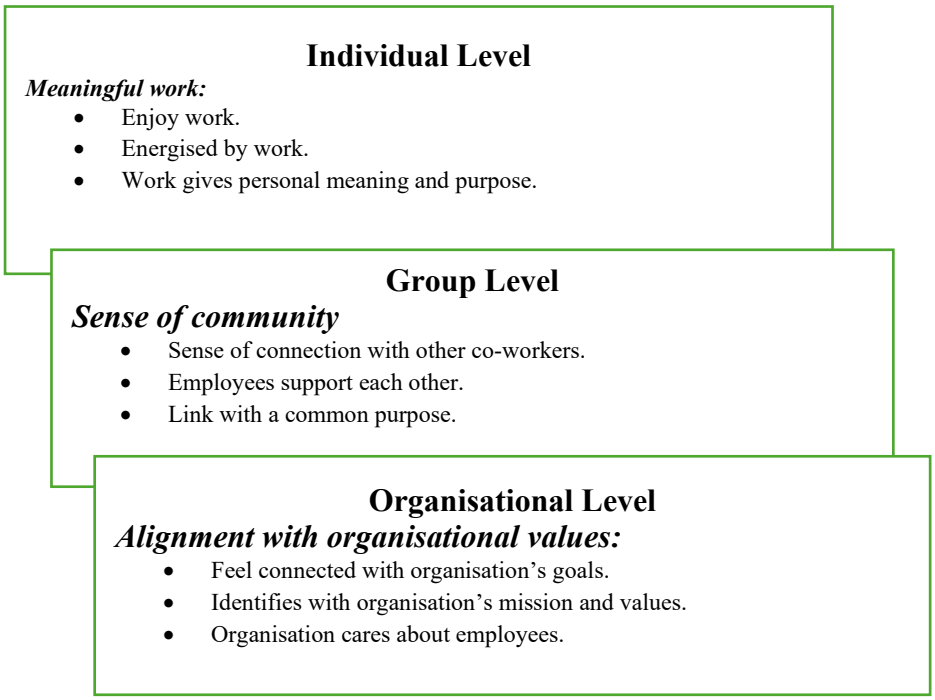
2.7 Human Resources Perspective

This includes, but is not limited to, the positive effect of spirituality on one's commitment, well-being, and morale. From an HR standpoint, workplace spirituality is seen as enhancing employee morale, which in turn leads to greater dedication and well-being, ultimately resulting in stress reduction, workaholism, and decreased burnout among staff members.

Milliman and Czaplewski (2003), along with Leung and Pong (2021), suggest that workplace spirituality can be conceived at three different levels: individual, community, and organisation. These dimensions were selected due to their alignment with previous research, their ability to capture the complexity and diversity of workplace spirituality, and their practicality for focused research. By understanding workplace spirituality at these levels, we can gain valuable insights into how it manifests and influences organisational dynamics. Below are the three levels of workplace spirituality as explained by Milliman and Czaplewski (2003) and Leung and Pong (2021).

Figure 2.4:

Three Different Levels of Workplace Spirituality



Source: Adapted from Workplace Spirituality and Employee Work Attitudes: An Exploratory Empirical Assessment. Journal of Organizational Change Management, 16(4), 426-447.

2.8 Dimensions of Workplace Spirituality

2.8.1 Meaningful Work

A profound sense of meaning and purpose in one's work is a fundamental component of spirituality in the workplace. This aspect of workplace spirituality illustrates how employees personally engage with their daily tasks. The concept is predicated on the belief that every individual possesses inner motives and truths, alongside a desire to partake in activities that enrich both their own lives and the lives of others (Ashmos & Duchon, 2000). Hewley (1993) concurs with Ashmos and Duchon, asserting that workplace spirituality encompasses the recognition of the inherent inner drive and truth within each individual. This drive compels individuals to seek work that provides a deeper sense of meaning and purpose for themselves and for others. Engagement, characterised by zeal, commitment, and a desire to learn, is distinct from the meaning derived from work (Schaufeli, 2014). Widodo et al. (2021) further differentiate meaningful work from job design or job enrichment, indicating that these concepts are not synonymous.

Meaningful work is perceived as a pathway that brings harmony to often hectic work routines, fostering a sense of comfort among employees and enhancing organisational performance, rather than merely serving as a mechanism for balancing work and life (Widodo & Suryosukmono, 2021). The term "meaningful work" describes an individual's profound emotions regarding the relationship between their work and the ultimate purpose of life (Esievo et al., 2019). Bailey and Madden (2016) perceive meaningful work as an authentic connection between work and life experienced by an individual. Steger (2016) proposes a three-tiered framework for understanding meaningful work: first, an employee believes that their work has significance; second, an employee's job contributes to a deeper sense of meaning or purpose in life; and finally, the highest level is when the job is perceived as benefiting humanity or others.

2.8.2 Sense of Community or Interconnectedness

The sense of community or interconnectedness refers to the perception that individuals belong to a group or community where everyone is valued and shares common goals (McMillan & Chavis, 1986). Winaina, Iravo and Waititu (2014) emphasise that strong relationships with others are essential for fostering a sense of community. This aspect of workplace spirituality centres on the relationships between peers and staff members, occurring at the collective level of human behaviour. The foundation of community at work is the belief in interconnectedness, linking individuals' inner selves with those of others (Maynard, 1992; Miller, 1992; Fernandes Bella, 2018). This level of spirituality encompasses the mental, emotional, and spiritual ties among team members and groups within an organisation. Fundamental characteristics of community include a deeper sense of interconnectedness, support, freedom of expression, and genuine concern (Neal & Bannett, 2000; Majeed et al., 2018). The concept "Sense of Community" aligns with the philosophy of Ubuntu, as defined by Lefa (2015), which promotes human engagement that facilitates critical thinking, non-domination, and the development of human relationships. Ubuntu encourages solidarity and community, translating literally as "humanness" or "humanity to others". Mahlaba's (2015) study with government employees in KwaZulu-Natal found that employees recognised workplace spirituality when organisations fostered teamwork and the spirit of *Ubuntu*.

2.8.3 Alignment with Organisational Values

This dimension of workplace spirituality reflects the connection between individuals' personal values and the goals and objectives of their organisation. It involves employees'

interaction with the broader organisational purpose (Mitroff & Denton, 1999; Indradevi, 2020). Organisational values are the guiding principles or moral standards that are deeply ingrained in the ethos and culture of an organisation (Hisam & Sanyal, 2021). These fundamental principles represent what the organisation stands for and are considered enduring. When an employee aligns with the organisation's values, it indicates their desire to work for a company that prioritises ethics and integrity, aiming for a significant societal impact (Ashmos & Duchon, 2000). Hisam and Sanyal (2021) suggest that employees who identify with their employer's values and share them personally experience a greater sense of loyalty to the organisation. When an employee's personal values align with those of the organisation, they tend to work more happily and feel motivated to contribute to the company's success. This alignment serves as an intrinsic motivator, enhancing employees' motivation to complete tasks effectively.

2.8.4 Transcendence

Self-transcendence extends beyond self-interest in pursuit of a greater benefit. According to Venter (2016), self-transcendence occupies the pinnacle of Maslow's hierarchy, above self-actualisation. Venter contends that individuals who achieve self-actualisation experience peak moments characterised by feelings of love, understanding, happiness, and gratitude, motivating them to actively deepen these experiences. Maslow ranked self-transcendence as the foremost need, as it encompasses a desire to connect with a higher power or divine force and attain a state of consciousness beyond human capabilities. Self-transcendence is seen as a foundational element in the formation of strong communities, fostering mutual trust and close personal relationships among colleagues (Kinjerski & Skyrpnek, 2004). Oliver et al. (2018) assert that "self-transcendence" increasingly refers to concepts that extend beyond personal interests, such as pursuing a higher purpose, connecting with divine forces, or serving others to identify with something beyond the ego.

Self-transcendence embodies a moral perspective that encompasses ethical behaviour and the preservation of others' well-being (Schwartz et al., 2012). Graham et al. (2011) also identify justice and the avoidance of harm to others as the two pillars of morality. This idea is grounded in Schwartz's (1992) self-transcendence model, which posits that social justice, equality, and mutual aid are the cornerstones upon which self-transcendence is built.

This study focuses on the four dimensions of workplace spirituality outlined above to explore the resilience and mental health of professional nurses during times of crisis.

A study conducted by Srivastava and Gupta (2022) on the association between workplace spirituality and the well-being of employees in the hospitality industry during COVID-19 found

that organisational practices valuing workplace spirituality can enhance employee resilience and aid in navigating crises. They posited that workplace spirituality fosters a culture of compassion, sincerity, and mindfulness, which is vital for employee well-being during challenging times. Their findings suggest that organisations should ensure that employees' work is meaningful, promote teamwork to cultivate a sense of community, and align employee values with organisational values to enhance employee identification (Srivastava & Gupta, 2022). This indicates that workplace spirituality can bolster the resilience and mental well-being of employees in this sector. Notably, the study used the two dimensions of workplace spirituality that are also employed in the current study, with self-transcendence being the only dimension not included.

Similar findings were reported in the study by Demir and Cabanoglu (2023), which investigated the effect of workplace spirituality on teachers' psychological resilience. In this context, workplace spirituality refers to the perception of a higher purpose or meaning in one's work environment, potentially leading to feelings of transcendence, inner peace, and meaningful interactions (Sabuncuoglu & Tuz, 2005). The results indicated a statistically significant positive impact of workplace spirituality on educators' psychological resilience, particularly when teachers experienced meaningful work. This suggests that meaningful work is a robust construct associated with enhanced psychological resilience (Demir & Cabanoglu, 2023).

Abbobaker's (2021) study on workplace spirituality and employee well-being during the COVID-19 pandemic explored the influence of fear. Employing the Job Demands-Resources theory as a framework, the study examined the relationship between job demands, job resources, and employee well-being. Workplace spirituality was investigated through the three dimensions of meaningful work, sense of community, and alignment with organisational values. The Job Demands-Resources Theory posits that the balance between job demands and job resources is crucial for determining employee well-being, work engagement, and job performance (Bakker & Demerouti, 2017). Data were collected using a self-administered questionnaire from employees in the hospitality sector in India, with workplace spirituality examined through the dimensions of meaningful work, sense of community, and alignment with organisational values.

Abbobaker and Zakkariya (2022) found that employees with higher spiritual values experienced fear in threatening situations, but also derived greater meaning and purpose from their work, formed stronger bonds with coworkers, and reported increased happiness and contentment when their individual values aligned with organisational values. This suggests that

employees with strong spiritual values exhibit greater resilience and can recover swiftly from challenges. Similar findings were reported by Yadav et al. (2022) regarding workplace spirituality and employee well-being, highlighting the critical role of workplace spirituality in enhancing employees' psychological well-being through meaningful work, community engagement, and alignment with organisational values.

Norouzi et al. (2017) conducted a study on the association between workplace spirituality and job stress, as well as occupational ethics among nurses in Zahedan, Iran. Their findings revealed a significant positive effect of workplace spirituality on nurses' occupational ethics. Nurses with high workplace spirituality demonstrated improved interactions with colleagues, derived satisfaction from their work, and fully utilised their individual potential in alignment with organisational goals and values. The reviewed literature clearly indicates that workplace spirituality offers numerous positive benefits for organisational factors, such as improved work engagement, productivity, and performance. It is also evident that both organisations and individual employees benefit from fostering workplace spirituality. Employee psychological well-being, resilience, and reduced stress levels are among the positive outcomes associated with workplace spirituality.

Having defined and indicated the dimensions of workplace spirituality and its benefits at both individual and organisational levels, the chapter will now explore resilience as the second construct of this study.

2.9 Conceptualising and Defining Resilience

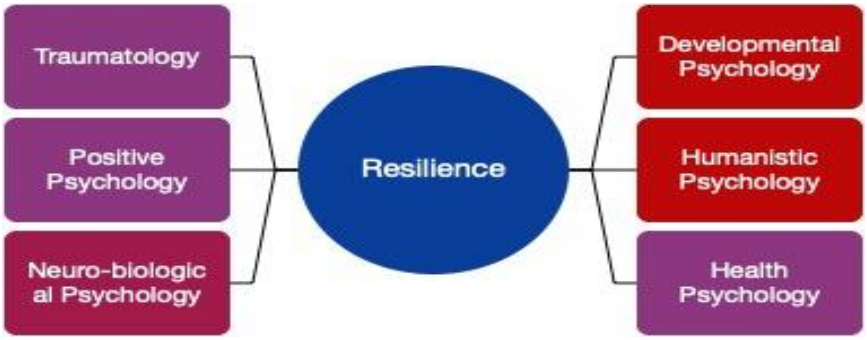
Various disciplines have shown interest in the construct of resilience, particularly in contexts requiring change, adaptation, flexibility, and sustainability (Sivilli & Pace, 2014; Scoloveno, 2016; Xu & Kajikawa, 2017). Traumatology, developmental psychology, positive psychology, humanistic psychology, health psychology, and neurobiological psychology are among the disciplines that inform research on resilience (Graber et al., 2016). Graber et al. (2016) differentiate between the focus of traumatology and developmental psychology; while traumatology is concerned with how adults respond to trauma, developmental psychology focuses on how children respond to difficult situations. Positive psychology emphasises human flourishing, positive emotions, and relationships, whereas humanistic psychology concentrates on meaning-making and growth.

Intersections between neurobiological psychology and health psychology are becoming increasingly prevalent. Both positive psychology and the philosophy underpinning resilience studies are philosophically grounded in humanistic psychology. Techniques and areas of

interest have been borrowed from developmental psychology and traumatology (Graber, 2016). The visual presentation below illustrates the various lenses through which resilience can be researched.

Figure 2.5:

Different Lenses on How Resilience Can be Researched



Note. This illustration depicts the various perspectives through which resilience is viewed.

While resilience has garnered significant attention, there remains no consensus on its definition (Ayed, Toner & Priebe, 2019; Christmas & Khanlou, 2019; Vella & Pai, 2019). Mastern (2018) opines that the multiple definitions, approaches, and theoretical orientations used to study resilience obscure knowledge acquisition, highlighting the need for clarification. This clarification would facilitate a coherent basis for practical applications and the development of health policies (Ayed et al., 2019). However, Fletcher and Sarkar (2013), as well as Luther, Crossman, and Small (2015), argue that despite the ongoing lack of consensus on how resilience is defined, adversity and positive adaptation are consistently recognised as core dimensions of resilience. Several researchers also agree that resilience begins with adversity (Ungar, 2003).

Resilience is widely understood as a dynamic process that emerges through the interaction of three core elements: the individual, exposure to adversity or risk, and positive adaptive outcomes**.** Contemporary resilience research emphasises that resilience cannot be understood without the presence of adversity, as it refers to the ability to adapt successfully despite significant challenges or stressors. In this regard, resilience involves the process through which individuals utilise internal and external resources to maintain or regain psychological well-being when confronted with difficult circumstances (Merluzzi et al., 2025; Last et al., 2024).

The individual dimension refers to the personal characteristics and psychological resources that enable individuals to respond effectively to challenging situations. These resources may include coping abilities, emotional regulation, self-efficacy, and social support, which function as protective factors that help individuals manage stress and recover from adversity. Research indicates that such individual assets play an important role in enabling positive adaptation following traumatic or stressful experiences (Ungar, 2023).

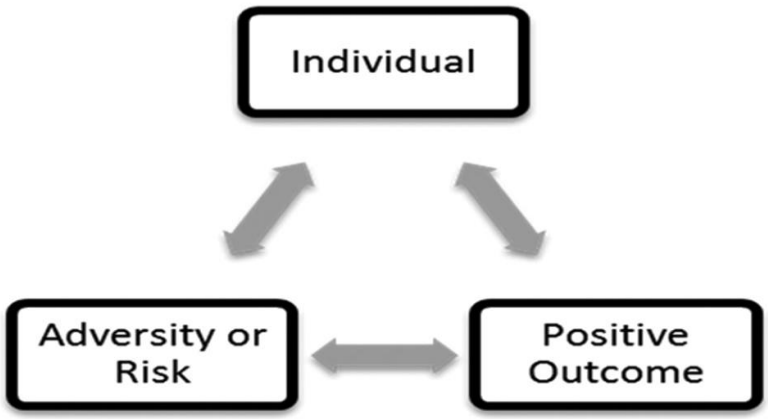
The second dimension, adversity or risk**,** refers to exposure to stressors, threats, or challenging life events that may negatively affect an individual's functioning or well-being. These adversities may include trauma, workplace stress, illness, or crisis situations. Importantly, resilience research highlights that adversity is a necessary condition for resilience, as resilience reflects the capacity to navigate and respond to difficult circumstances rather than simply functioning under normal conditions (Merluzzi et al., 2025).

The third dimension, positive outcomes**,** refers to the ability of individuals to adapt successfully despite exposure to adversity. Positive adaptation may involve maintaining mental health, sustaining functioning, or demonstrating recovery and growth following stressful experiences. Recent conceptualisations emphasise that resilience research consistently focuses on the interaction between adversity and positive adaptation outcomes, supported by protective resources that enable individuals to cope effectively (Denckla et al., 2020)).

Taken together, these three dimensions illustrate that resilience is not a fixed trait but a dynamic and multidimensional process. It emerges when individuals encounter adversity and draw on personal and contextual resources to achieve positive adaptation. The intersection of these elements provides a comprehensive framework for understanding how individuals maintain psychological well-being and functional stability in the face of challenging life circumstances.

Figure 2.6:

Three Core Dimensions of Resilience



The following section explores how the construct has evolved over time, tracing its development from the 1950s to the present day.

The evolution of resilience as a construct can be traced back to the 1950s and 1960s within the field of mental health (Wright et al., 2013), with a focus on traumatology in adult and developmental psychology among children and youth (Graber et al., 2015). Initially, resilience was viewed through a disease-oriented lens, concentrating on mental health and threats to development (Wright et al., 2013). Early research primarily focused on defining and understanding resilience (Metais et al., 2022). Observations revealed variations in adaptation responses attributed to internal psychological resources, such as personal abilities and strengths (Garcia-Dia et al., 2013; Wright et al., 2013). Graber et al. (2015) also opine that resilience was initially perceived as a personality trait that enabled positive outcomes under extreme adversity.

In the 1970s and 1980s, an ecological perspective on resilience was introduced to provide a more comprehensive understanding of the construct. This perspective highlighted the importance of external factors and viewed resilience as a process rather than a static trait (Metais et al., 2022). This shift led to a focus on understanding the underlying processes that influence adaptation (Masten & Best, 1990, p. 439). Under the ecological perspective, resilience is perceived as the capacity of a dynamic system or individual to adapt positively to disturbances that are seen as threatening to an individual's feasibility, functioning, or growth (Masten, 2014). During exposure to risk and an individual's engagement in an adaptive process, factors that cause harm and those that promote positive outcomes can be identified (Metais, 2022). These factors are grouped into three categories, which include both internal and external features: individual personal attributes, family aspects such as security and caring

relationships, and broader external influences from the social environment, including schools, peer relationships, and community connections (Anaut, 2015; Masten, 2014).

The third era, spanning the 1990s to the 2000s, saw advancements in the theoretical understanding of resilience, enabling researchers to develop and test interventions to facilitate well-being (Masten, 2007).

To fully embrace the complexity of this construct, the modern and fourth era integrated internal and external resources with knowledge from various disciplines (Liu, Zhang, Ji & Yang, 2018; Shrivastava et al., 2019). Christmas et al. (2019) and Vella and Pai (2019) view this modern era as integrative and holistic, considering previous findings since the inception of resilience research, alongside the technical advancements that enable better understanding of physiological and more realistic outcomes assessment with the growing influence of multidisciplinary knowledge (Masten, 2007). Three key questions emerged during the evolution of the resilience construct, sparking debates and critiques among theoretical approaches. These questions will be addressed below:

2.9.1 Is Resilience Based on Internal or External Factors?

Traditional approaches to resilience often perceived it as an innate feature of an individual, suggesting that a person is born with a psychological disposition that enables them to face adversity or renders them vulnerable (Anthony, 1974). Individuals were assessed for resilience based on the presence or absence of psychopathology following exposure to adversity (Anthony, 1974). While this approach has limitations, it has contributed to understanding the importance of internal cognitive and coping skills that individuals require to overcome adversity and achieve homeostasis (Metais, 2022). Prince-Embury (2014) identified intellectual ability, easy temperament, autonomy, self-reliance, communication skills, and effective coping skills as essential qualities for resilience. Ungar and Liebenberg (2013) acknowledge the value of this approach for emphasising the significance of personal assets in promoting resilience. However, they argue that environmental factors play a more significant role in the developmental gains of at-risk populations than individual factors.

2.9.2 Is Resilience a Static or Dynamic Construct?

There is growing consensus against the static, fixed, and stable notion of resilience (Infurna & Luthar, 2018; Liu et al., 2018). Steward and Yuen (2011) opine that resilience, as a state, includes concepts of maintenance, equilibrium (Bonanno, 2004; Wagnild & Young, 1990), hardiness (Wilks et al., 2011), psychosocial well-being (Bekhet & Avery, 2017; Fletcher &

Sarkar, 2013; Gillespie et al., 2007; Shaw et al., 2009), and equanimity (Wagnild, 2003). The ecological approach was the first response to this notion, emphasising the importance of viewing resilience as a developmental process or dynamic capacity, rather than as a static outcome or trait (Yates et al., 2015). Two processes have been identified by researchers in this regard: the first is the compensatory process. Sameroff (2000) stated that compensatory processes, also known as promoting factors, have neutralising or counteracting effects regardless of the level of adversity, while risk factors hinder positive adjustment. Examples of promoting factors include intellectual ability (Meng et al. 2018) and extraversion (Cuartero & Tur, 2021). The second is moderating processes, which are known as vulnerability factors. These factors exacerbate the already existing negative effects of adversity, whereas productive factors are moderators that mitigate the negative impact of adversity (Wright et al., 2013; Rutter, 2013; Prince-Embury, 2014; Wang et al., 2015).

2.9.3 Does Resilience Consist of Bouncing Back or Bouncing Forward?

Kumper (1999) opines that resilience originates from the Latin word *resilere* meaning to jump back. Yates et al. (2015) define resilience as an individual's capacity to achieve positive outcomes after exposure to adversity. The question that arises from this definition is whether positive outcomes translate to bouncing back to the initial homeostasis and well-being levels prior to exposure to adversity, or whether it means thriving toward increased levels of health, which translates to bouncing forward, resulting in growth stemming from exposure to adversity (Tedeschi et al., 2018). Positive psychology, as one lens used to study resilience, emphasises the importance of promoting well-being, giving more weight to the thriving and bouncing forward orientation of the resilience process (Schwarz, 2018). However, other researchers contend that bouncing back is a key component of resilience, with many supporting the notion that resilience is about adapting positively to adversity and returning to the initial state of well-being (Aburn, Gott, & Hoare, 2016; Dowrick et al., 2008; Edward et al., 2009).

The orientation that should be given to the resilience process and its outcomes remains a challenge that needs to be resolved. Other researchers concur with the perspective that resilience should be viewed as a process of moving forward rather than returning to the initial state of well-being. According to Southwick et al. (2012), this notion makes sense when considering existence as a developmental continuum, where every experience reveals a new strength that an individual never thought they possessed. This notion is echoed by Cyrulnik and Duval (2006), who view resilience from a neo-developmental perspective as an outcome of the resilience process (Anaut, 2015).

2.9.4 Towards Transactions: Resilience in a Systematic-Oriented Perspective

Systems understandings are increasingly being considered in psychological research to help define the theoretical framework of resilience (Masten, 2018; Wright et al., 2013). The growing prominence of the trajectory method in clinical psychology and the positive paradigm shift from deficit-based and individual-level treatments to strength-based and environment-enhancing approaches are paralleled in developmental research (Christmas & Khanlou, 2019). Yates et al. (2015) postulated that the transactions emanating from different hierarchical levels, such as micro, meso, and macro, influence an individual's development. He further indicates that transactions should occur between the levels themselves, with either a stronger or lighter influence. In practical terms, the macro system stands for national policies and cultural backdrops, the meso system for larger communities and institutions, and the micro system for the internal traits of the individual and their peer/family relationships (Bronfenbrenner & Morris, 2006).

2.9.5 Resilience as a Constructivist and Dynamic Person-Situational Defined Process

The ecological perspective suggests that an individual's competence to adapt positively to environmental adversity lies within them. A recent integrative review explains that, within the ecological approach competence is related to an individual's ability to adapt to environmental demands (Metais et al., 2022). In contrast, the constructivist approach believes that competence arises from the interaction between the individual and the environment, not solely from the individual. According to this approach, competence can be confirmed when an individual returns to an equilibrium state after positively responding to environmental adversity (Metais et al., 2022). The constructivist understanding of resilience is currently being adopted by several authors, including Ungar and Liebenberg (2013). Their understanding refers to "a person's successful navigation towards the resources necessary to sustain well-being and their negotiation with those who control resources to provide them in ways that are culturally meaningful" (Ungar & Liebenberg, 2013, p. 247). Pangallo et al. (2015) highlight another important aspect: the person-situation-defined pattern in the conception of resilience.

These dynamic viewpoints and situational subjectivity address the fact that resilience is not a universal phenomenon. People can be resilient in certain contexts and domains but not in others (Infurna & Luthar, 2018; Rutter, 2013; Wright et al., 2013). Additionally, depending on a person's differential susceptibility or subjective sensitivity, adversity and protective factors may not affect them in the same way (Masten, 2014).

Another perspective raised by Masten (2001) is that resilience is development-dependent and fluctuates across the lifespan; it should not be considered as ordinary or guaranteed. Craciun (2013) suggests that even when someone exhibits resilience in one situation, change can introduce new vulnerabilities or strengths, highlighting the importance of timing. Fisher et al. (2019) mention the significance of temporal issues, arguing that the time variable is sometimes neglected despite the importance of considering the frequency, duration, and cycle of resilience. They also advocate that resilience at one point in time does not guarantee resilience when new adversity presents itself (Masten, 2014; Rutter, 2015). The acknowledgment of acute and chronic adversity emphasises the need to consider the co-occurrence of either both kinds of adversity or multiple adversities (Hughes et al., 2017). Masten and Barnes (2018) introduce the concept of culture, emphasising that diverse responses to adversity and the factors that promote resilience are culturally dependent. A person's manner of feeling, thinking, behaving, sharing, knowing, expressing, and relating can be characterised as their culture. Languages, concepts, morals, symbols, traditions, and religions are all involved. Naji (2020) opines that cultures are better felt than described and better experienced than articulated.

Noltemeyer and Bush (2013); Panter-Brick (2015) assert that resilience is not solely about adapting well to adversity but also involves cultural norms, moral values, and social aspirations, which have different meanings for different individuals (Liebenberg & Joubert, 2019). Triandis (1972) indicated that culture should be incorporated into the definition of resilience, and Kalmanowitz and Ho (2017) agree that cultural beliefs and values influence individuals' interpretations of adversity and their reactions to traumatic events. Furthermore, Ungar (2003) postulates that researchers should challenge the individualistic interpretation of coping by incorporating the concept of culture, thereby shifting from presumptions about functional adaptation.

Resilience can be characterised as a person-situational process from a transactional and constructivist perspective. It is the capacity of an individual to demonstrate and obtain assistance from available resources when faced with adversity. This interaction triggers adaptive mechanisms, enabling the individual to confront and overcome challenges. Resilience is a complex and dynamic concept. Southwick (2014) emphasises that resilience can have different meanings for different people in various contexts, making it multifaceted. He also highlights the importance of clarifying whether resilience is understood as a quality, a process, or a result. Resilience involves numerous interrelated biological, psychological, social, and cultural factors.

From a psychological perspective, resilience is the ability to bounce back successfully from significant setbacks, severe trials, or unexpected disasters. It may involve healing and recovery, along with some emotional development and moving closer to pre-established objectives even in the face of enduring difficulties (American Psychological Association, 2014). Resilience is perceived as returning to the original state of function after being significantly stretched and pressed by adversity. Sandberg and Grant (2017) opine that resilience is the strength and speed with which individuals respond to crises. Naji (2020) addresses the common misconception of how individuals deal with setbacks, struggles, and suffering, highlighting three cognitive positions that can hinder and delay the recovery process: Personalisation, permanence, and pervasiveness.

Naji (2020) argues that personalisation is the tendency to attribute the causes of adverse events to oneself. Permanence is the belief that the situation will never pass and will remain as it is, while pervasiveness is when one thinks the situation will worsen and eventually affect all spheres of one's life. Naji (2020) further indicates that these three perceptions will delay the recovery process instead of aiding one to bounce back more quickly. Sandberg and Grant (2017) concur that individuals facing difficulties tend to project them indefinitely. Naji (2020) emphasises the importance of reflecting on past experiences of overcoming difficulties, reminding oneself that challenges can be surmounted.

Abi-Hashem (2001) and Meichenbaum (1994) suggest that resilience is a learned skill that gradually builds up and can be stored as an energy reserve for use during crises. Naji (2020) believes that the degree of resilience stored within an organism is fluid and flexible, varying according to needs, challenges, trials, and the availability of internal and external resources, such as the circumstances surrounding the event, meaningful support, connectivity, and predisposition.

From a developmental psychology perspective, resilience is seen as a typical adaptation that occurs despite unusual conditions. It is the driving force behind all stages and moments of the life journey, enabling healthy coping, endurance, management, regrouping, mobilization, survival, reliance, regulation, and ultimately blossoming and flourishing.

When considering resilience from a spiritual perspective, Abi-Hashem (2019) emphasises the significant benefits of individual or collective spiritual practices, religious traditions, and socio-normative rituals on the mind, psyche, mood, behaviour, soul, body, and relational connectedness. These practices support the maintenance of a more expansive mental viewpoint, sufficient motivation, a transcendental understanding of reality, a closer bond with people and the natural world, and overall wellness. Spirituality and religious faith are perceived as valuable

resources for coping with crises and fostering growth, striving, and flourishing amidst adversity. A community is more than just a collection of people; it is a close-knit group that assists one another through mental, emotional, and social continuity, as well as generational support and vital networking (Kulig et al., 2013). Community resilience is perceived as the glue that holds the collective pieces together with a deep organic connectivity that endures over time (Güngör & Elburz, 2024). Lerch (2017) defines resilience as the ability of a system (individual, family, institution) to positively respond to short-term crises and return to its original state.

Ungar (2003) focused on the role of the community in promoting mental health and emotional restoration. In his research, he advocated for a shift away from the micro entity prevalent in Western societies towards a macro ecological perspective that emphasises appreciating the larger identity. According to Ungar (2003), this leads to a true existential meaning, where the notion of "I" is replaced by "we". Wang et al. (2014); Kulig et al. (2013); and Ungar (2003) opine that a step toward a better contextualised understanding of all people, regardless of age or background, requires moving beyond the isolated cell, one brain, and single neuron to a rich contextual capability, stored in the psychosocial-tribal and intercultural existence of community. Therefore, strong cultural ecologies, along with people's psycho-emotional lives, considerably contribute to healthy coping, sustainability, creativity, and flexibility, and ultimately, a great deal of resilience (Ungar, 2003).

For this study, the researcher adopts a multidimensional approach to resilience, encompassing multiple interactions of internal individual systems and external social and ecological protective and promotive factors (Ungar & Theron, 2020). The operational definition of resilience for this study is: resilience is an individual's ability to successfully access the psychological, social, cultural, and physical resources necessary to maintain their well-being, as well as their ability, both individually and collectively, to negotiate for these resources to be made available and experienced in ways that are culturally meaningful.

2.10 Healthcare Sector related: Antecedents of Resilience

To understand the antecedents of resilience, it is essential to recognise the diverse perspectives on the construct. Researchers have defined resilience in various ways, including as an individual-based competence, external factors, and cultural influences. Curtin et al. (2022) identified the following as antecedents of resilience.

2.10.1 Moral Purpose and Duty

Resilience as a subject illustrates a common moral goal among professional nurses as they strive to provide care for their patients. Research revealed a sense of identification, accountability, and dedication to their work, as well as to the patients they care for.

2.10.2 Connection with Others

This refers to the importance of building relationships and support with peers, leaders, and colleagues. According to McDonald et al. (2016), nursing workers may utilise their support network, including partners, family, friends, and colleagues in the workplace, for emotional support and coping with stress. A sense of belonging and feeling connected to the nursing profession and the workplace fosters a sense of identity and support, which contributes to resilience (McDonald et al., 2016).

2.10.3 Collaboration with Leaders Providing Necessary Communication

Effective communication from organisational leaders to address concerns and support the well-being of professional nurses is crucial.

2.10.4 Culture of the Work Environment

Creating a supportive and positive work culture that promotes resilience among Professional nurses is essential.

2.10.5 Characteristics of the Individual

Personal traits and coping strategies of healthcare workers contribute to their resilience.

2.10.6 Potential for Growth

Opportunities for personal and professional growth during challenging times lead to increased resilience. Curtin et al. (2022) surmise that these antecedents play a crucial role in supporting the resilience of Professional nurses and can assist in promoting their well-being during a pandemic. Agostini et al. (2023) presented a classification framework for resilience in healthcare management.

2.10.7 Types of Crises

This distinguishes between chronic and acute crises. Chronic crises are those challenges that are dealt with on a day-to-day basis and which are less acute in terms of intensity but higher in frequency. Acute crises, on the other hand, are perceived as those events that are sudden, unexpected, and destructive in nature (e.g., infectious diseases, natural disasters).

2.10.8 Approach to Resilience

Proactive responses aim to reduce the occurrence and negative impact of adversity, while reactive responses focus on returning the system to its initial state after a crisis (Chowdhury & Quaddus, 2017).

2.10.9 Level of Analysis

This involves examining crises from a macroscopic perspective (system-wide capacity such as countries or communities) or a microscopic perspective (individual or organisational impact, e.g., hospitals, health units). The microscopic level can also refer to single teams or individual capacity to respond to adversity.

This study aims to explore the resilience of professional nurses during times of crisis, and based on this framework, it will focus on both acute and chronic crises. Regarding the approach to resilience, the study is more concerned with the proactive approach to resilience, as it will investigate workplace spirituality and resilience.

Van Gool et al. (2017) discuss a multidimensional organisational learning approach that draws influence from ecological science. They emphasise the importance of considering a system's reaction to a crisis as the outcome of the interplay of various elements operating at different levels, as indicated below:

- **M1: Micro** (individuals)
- **M2: Meso** – small (interpersonal/teams)
- **M3: Meso** – large (organisations)
- **M4: Macro** – small (groups of organisations, communities, networks)
- **M5: Macro** – large (country or groups of countries)

2.10.10 Country context

The fourth feature pertains to the national context of the resilience study. This perspective aids in determining if local or global health systems are under threat, as well as in identifying opportunities or obstacles unique to a given environment when implementing resilience strategies (Biddle et al., 2020).

2.10.11 Resources to Nurture Resilience

Identifying and categorising the resources that can nurture resilience in healthcare systems is another important component of the framework. This includes both physical resources (hardware) such as human resources and infrastructure, as well as intangible resources (software) like organisational systems and relationships (Barasa et al., 2017). These components provide a structured approach to understanding and enhancing resilience in healthcare management, offering a comprehensive framework for researchers and practitioners in the field.

A study conducted by Campos et al. (2020) on resilience among professional nurses in hospitals identified five factors that enhance resilience. These factors are: age, length of time in the profession, length of time in the institution, protective mechanisms, and organisational support. According to Campos et al. (2020), older workers demonstrated a higher level of resilience compared to younger workers. The study also revealed that professional nurses with extensive work experience exhibited greater reliance than those with less work experience, and that more years in the same institution were reported to positively impact resilience. Supportive mechanisms, such as social support, positive communication, and beliefs in their ability to cope with challenges, were reported as some of the mechanisms utilised by nurses to overcome adversity. Autonomy, optimism, sense of belonging, and self-care were among the supportive mechanisms identified in this study as correlating with the resilience of nurses working in hospital environments. Autonomy is perceived as having a voice in decision-making, while optimism and self-belief involve maintaining a positive outlook and believing in one's ability to cope with life's adversities. A sense of belonging is viewed as being connected to the nursing profession and the workplace group, which can provide a sense of identity and support that contributes to resilience. Self-care encompasses engaging in self-care practices, self-awareness, and self-motivation, all considered important components of resilience among nursing professionals. Lastly, organisational support, according to this study, was linked to organisations that promote workers' welfare and provide tools aimed at improving coping mechanisms to deal with work conditions and adversities.

Similar antecedents were identified in the study conducted by Morganstein and Flynn (2021) on enhancing psychological sustainment and promoting resilience in professional nurses during COVID-19 and beyond, including self-care, self-awareness, social connection, and optimism. Other factors reported include sense of purpose, adaptability, emotional regulation, and problem-solving skills. The authors suggest that if these factors are cultivated and incorporated into daily practice, professional nurses can enhance their resilience and better navigate the challenges they face. Sense of purpose is defined as having a clear sense of meaning in one's work, which can provide motivation and resilience in challenging circumstances. Adaptability is another reported factor, referring to the ability to adjust to changing circumstances and remain flexible in the face of adversity, which is believed to be crucial for resilience. Developing skills to manage emotions and cope with stress, referred to as emotional regulation, can enhance resilience and well-being. Problem-solving is also noted as a contributing factor to resilience, defined as the ability to effectively resolve issues and find solutions to challenges (Morganstein et al., 2021).

Identifying professional nurses at risk for adverse mental health outcomes is crucial during pandemics and other crises. Overall, the study underscores the importance of implementing targeted interventions and organisational practices to enhance psychological sustainment, promote resilience, and support the well-being of professional nurses facing prolonged stress and challenges during the COVID-19 pandemic and similar crisis situations.

Having explored resilience, the following section will delve into the conceptualisation of mental health, beginning with its historical context and progressing to its definition for the purposes of this study. Antecedents of mental health will be discussed, followed by an empirical analysis and conclusion.

2.11 History of Mental Health

The term “mental health“ emerged within the context of public health, clinical psychiatry, and other related fields (Bertolote, 2008). While the concept of mental health as a state has been recognised since the 20th century, references to mental health as a distinct field or discipline are not found before 1946 (Bertolote, 2008). A significant milestone in establishing mental health as a separate field and practice occurred in 1946 with the founding of the World Health Organization and the Mental Health Association at the International Health Conference in London. Prior to 1946, references to mental health were limited to mental hygiene in English literature. However, as early as 1849, the Berlin Society of Physicians and Surgeons proposed the healthy mental and physical development of citizens as the first objective of public health in a draft law (Rosen, 1993).

In 1948, the first International Congress on Mental Health took place in London, solidifying the global importance of mental health. This congress facilitated discussions on mental health policies and practices, contributing to the formalisation of mental health as a discipline. It was at this conference that mental health and mental hygiene were defined. Mental hygiene is understood as a dynamic state influenced by biological and social factors, enabling individuals to effectively assess potential conflicting instinctive drives and to form and maintain harmonious relationships within their social and physical environments (WHO, 1951).

To further understand the origins of mental health, it is crucial to explore mental hygiene and its movement, which can be attributed to the work of Beers in the USA. In 1908, Beers published the book “A Mind That Found Itself”, based on his personal experiences of being admitted to three mental hospitals (Beers, 1937). This led to the establishment of the Mental Hygiene Society of Connecticut.

The term mental hygiene gained popularity following the National Commission of 1909 (International Committee on Mental Hygiene, 1948). National associations dedicated to mental hygiene were subsequently founded in 1919 and the years that followed, reflecting the influence and activities of the original Commission. Six National Associations were established in France, seven in South Africa in 1920, eight in Italy, and nine in Hungary in 1924. These National Committees on Mental Hygiene paved the way for the establishment of the World Federation of Mental Health. The primary focus of mental hygiene initially centred on improving the care of people with mental disorders (Beers, 1937). The Committee then expanded its services to incorporate milder forms of mental disability, with a growing emphasis on preventive measures. The rationale behind this shift was the perception that preventive measures are most effective when implemented early in life. Mental disorders often have their origins in childhood and adolescence, and environmental factors and lifestyle can significantly impact mental health.

To achieve its goals, the National Committee prioritised early diagnosis and treatment, adequate hospitalisation, research, public understanding and support, individual and group education on mental hygiene principles, and collaboration with relevant agencies. While preventive measures distinguished the mental hygiene movement from psychiatric care, many practitioners in both fields followed a psychoanalytic approach. The mental hygiene movement envisioned a community as a collective, where each member's mental and emotional well-being was influenced by various factors. Prevention, rather than cure, was seen as the primary need. The Mental Hygiene Movement and psychiatry are interconnected, similar to the relationship between public health and medicine (Furtado, de Oliveira Camilo & de Luiz, 2018). Both represent coordinated efforts to address community health needs (Beers, 1938). While there may have been distinctions in the past, it is increasingly recognised that psychiatrists and mental hygienists share common goals and depend on each other to achieve them (Beers, 1938).

2.12 Global Effort for Improving Mental Health

The WHO has consistently maintained an administrative section dedicated to mental health, responsible for addressing the needs of its member states. Early WHO publications referred to this section as "Mental Health" in English and "Hygiène Mentale" in French. In the 1960s, it became apparent that "hygiene" was sometimes used as a translation for "health" in French WHO publications, and it was also discovered that mental hygiene was used interchangeably with mental health in the English versions of some documents.

The WHO played a pivotal role in shaping mental health policies through several key actions and initiatives. The first initiative was to conceptualise mental health. In 1948, the WHO (2001) defined mental health as a state of well-being that encompasses emotional, psychological, and social aspects, influencing how mental health was perceived and addressed globally. The second initiative was promoting mental health as a public health issue, emphasising the importance of mental health as an integral part of public health. By framing mental health within the broader context of health, the WHO (2001) helped elevate its status and encouraged countries to incorporate mental health considerations into their public health policies and programmes. The third initiative focused on supporting national mental health programmes: The WHO provided guidance and support to countries in developing national mental health policies and programmes, including promoting the integration of mental health services into primary healthcare. The fourth initiative was the advocacy of human rights, where the WHO has been a strong advocate for the rights of individuals with mental disorders. It has emphasised the need to eradicate abuse and improve standards of care for people with mental health issues. This aligns with the broader goals of the mental hygiene movement and, later, the mental health movement.

The first International Congress of Mental Health was organised in London by the British National Association for Mental Hygiene in 1948, culminating in several recommendations on mental health (Bertolete, 2008). Bertolete noted that the terms “mental hygiene” and “mental health” were used interchangeably during the conference, and that the International Committee on Mental Hygiene was later replaced by the World Federation for Mental Health (World Federation for Mental Health, 2017). Additionally, a shift from mental hygiene to mental health was evident in discussions and policies, reflecting a broader understanding of mental well-being. While mental hygiene focused on specific activities to maintain mental health, the term mental health encompasses a wider range of issues, including emotional, psychological, and social well-being, thus shaping the discourse around mental health as a holistic concept.

2.13 Conceptualisation and Definition of Mental Health

Mental well-being has always been incorporated in the definition of health by the WHO (2001). Health is defined as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 2001b, p.1). This definition highlights three concepts that are essential in improving health: mental health is a component of overall health, mental health is more than just the absence of mental illness, and mental health and behaviour are closely related. Herman et al. (2005) indicated that mental and physical health

are interconnected and cannot exist in isolation. Although cultural, societal, and individual differences can make it challenging to reach a universal definition of mental health, it is possible to understand its fundamental meaning without limiting its interpretation across cultures (WHO, 2001c). Similar to concepts like wealth and age, which have diverse manifestations but a shared core meaning, mental health can be understood without rigid cultural boundaries. Kovess-Masfety, Murray, and Gureje (2005) opine that, for the past 30 years, research has contributed to the conceptualisation of mental health. However, there have been limitations due to the reliance on English-language evidence primarily from developed countries. This suggests a need for more diverse and inclusive research to fully understand mental health across different contexts.

According to Kovess-Masfety et al. (2005), mental health has been defined as a positive emotion (affect), such as feelings of happiness; as a personality trait inclusive of the psychological resources of self-esteem and mastery; and as resilience, which is the capacity to cope with adversity. Johoda (1959) defined mental health as consisting of three domains: self-actualisation, which is the ability to fully realise one's potential; secondly, sense of mastery pertains to the capacity to control one's environment; and lastly, autonomy, which is the ability to identify, confront, and solve problems. Murphy (1978) argued that these ideas favoured individualism and were influenced by North American cultures, excluding many other cultural perspectives. Murphy also cautioned that excessive inspiration might negatively impact mental health. Keyes (2002) defines mental health from a salutogenic perspective as a positive state of human capacities and functioning in cognitive, affective, and behavioural domains. Mental health is seen as an individual's subjective evaluation of their life in terms of affective state, psychological, and social functioning. According to the World Health Organization (2004), mental health is a condition of well-being where individuals recognise their potential, manage everyday stressors, perform effectively, and contribute to their community. In this regard, mental health serves as a foundation for individual and community well-being and efficient functioning. This core concept of mental health is compatible with diverse cultural interpretations (WHO, 2004).

Mjosund (2021) opines that mental health cannot be discussed without considering health. Health is a state of complete physical, mental, and social well-being and not merely the absence of illness. Health is a complex concept with different meanings for different people (Green & Tones, 2010). Mjosund et al. (2015), and the WHO (2004) emphasise the interconnectedness of social, physical, emotional, spiritual, and mental health. Furthermore, Sartorius (1990)

argues that health and illness can co-exist, and are mutually exclusive only if health is defined narrowly as the absence of disease.

Research has identified two primary pathways by which an individual's functioning, mental, and physical health interact with social and environmental factors to influence health over time (WHO, 2001c). According to the WHO (2001c), the first pathway involves physiological systems, including immunological and neuroendocrine processes. The second pathway involves healthy lifestyle choices, such as responsible eating, regular exercise, adequate sleep, avoiding tobacco, practising safe sex, using seat belts in cars, and adhering to prescribed treatment plans. Stress, for example, has been linked to various issues, including the common cold (Cohen, Tyrrell & Smith, 1991), and is known to delay wound healing (Kielcot-Glaser et al., 1999). In an integrated and evidence-based model of health, mental health (including emotions and thought patterns) emerges as a key determinant of overall health. Anxious and depressed moods, for example, can initiate a cascade of adverse changes in endocrine and immune functioning and increase susceptibility to a range of physical illnesses (Seiller et al., 2020). The mental well-being of an individual has a significant impact on their health behaviours. Therefore, psychological stress or mental disease, for instance, influences health behaviour (WHO, 2001c, p. 9).

Lehtinen et al. (2005) highlight misconceptions about mental health among politicians, professionals, and the public. These misconceptions stem from the undervaluation of mental health and its frequent confusion with severe mental disorders, which carry social stigma and negative attitudes. Lehtinen et al. (2005) emphasise the importance of recognising the positive value of mental health, which contributes to an individual's well-being, quality of life, and creativity. They perceive mental health as inseparable from general health and well-being, reflecting a balance between the individual and the environment in a broad sense.

Lahtinen et al. (1999) proposed a structural model in which determinants are categorised into four groups, illustrating the reciprocal influence between mental health and its determinants. This model offers a framework for understanding the intricate factors that impact mental health.

Figure 2.7:

Structural Model of Mental Health Adapted from Lehtinen et al. (2005)

2.13.1 Mental Health as an Individual Capacity and Experience

Mental health is defined as an individual's evaluation of his or her abilities to cope with adversities, remain productive, and contribute positively to society (WHO, 2001). Earlier studies on mental health identified three individual aspects that contribute to mental well-being: locus of control, self-efficacy, and sense of coherence. Rotter (1966) introduced the concept of locus of control, which is divided into internal and external. He defines internal locus of control as an individual possessing the necessary resources to cope with adversity, whereas external locus of control attributes outcomes to external factors, resulting in feelings of powerlessness. Self-efficacy is defined as an individual's belief that they possess the capabilities to succeed in various situations, and individuals with strong self-efficacy have been shown to experience less psychological and physiological strain in stressful situations (Rotter, 1966). Sense of coherence refers to an individual's ability to find structure in stressful events, exert control over his or her environment, and derive meaning and value from challenging situations (Antonovsky, 1979).

2.13.2 Mental Health and Social Interaction

This aspect of mental health focuses on the quality of relationships that one establishes and maintains. Social relationships are perceived as a protective mechanism against the onset or recurrence of mental ill health and can facilitate recovery from mental disorders. Lehtinen et al. (2005) argue that some authors regard the availability of social support as directly contributing to increased mental health, whereas others perceive its role primarily as a buffer against stressful adversities or life events.

2.13.3 Mental Health's Contribution to Social Capital

Putnam (1993) posits that social capital is one way of perceiving the relationship between mental health and society. He refers to social capital as characteristics of social life, such as institutions, networks, and social trust, which shape the quality and quantity of social interactions and facilitate collective actions, coordination, and mutual benefits. These aspects of social capital are considered crucial determinants of an individual's mental health.

2.13.4 Cultural Values and Mental Health

Lehtinen et al. (2005) note that mental health is a foreign concept in many cultures, complicating discussions of cultural values in relation to mental health. Nevertheless, they argue that it is possible to identify cultural values that are specifically related to the fundamental components of mental health. For instance, cultural interpretations that view suffering as a necessary aspect of the human condition (such as Buddhist interpretations) may supplement or replace ideas about mental illness. Positive subjective experiences may be understood in terms of religion or as a sense of inner and interpersonal harmony (Wig, 1999). In contrast to the emphasis on interdependence and familial loyalty in Asia, Africa, and other regions, Euro-American cultures tend to place a greater emphasis on personal achievement and independence.

In multicultural societies, various external influences can either directly or indirectly impact an individual's mental health by causing stress or providing support. Socioeconomic factors, societal structures, and cultural beliefs shape opportunities for meaningful and fruitful actions. Cultural ideas about mental health, while diverse in emphasis and content, share common elements. In therapeutic situations, the clinical formulation of health as a state resulting from successful therapy often proves inadequate. The WHO's broader definition of health avoids specificity that could exclude members of certain cultural groups; instead, it seeks to respect the interests of a variety of cultures (Lehtinen et al., 2005).

Past psychiatric conceptions of mental health were less focused on cultural issues and more focused on providing a practical framework for therapeutic treatment. Havens (1984) was one of the few psychodynamically oriented clinical researchers and educators to specifically address the need to define mental health within the framework of psychiatric assessment. He contended that self-protectiveness and human connectivity should be included as essential components.

2.13.5 Spiritual Dimension of Mental Health

Many people would concur that experiencing spirituality is an essential part of the human experience (Smith & Silva, 2003). While it extends beyond personal and community comfort to encompass broader ambitions, spiritual well-being can be considered a component of mental health. Spirituality significantly impacts the quality of life for many individuals worldwide, as confirmed by a WHO study (2001) involving over 4,000 participants in 18 locations globally.

Beyond psychological well-being and social connections, qualities such as wonder, purpose in life, faith, and connection to a spiritual being significantly contribute to the overall evaluation of quality of life (Saxena et al., 2002). Although spirituality can exist outside of religion, most people's spirituality is rooted in a particular religion. In an article discussing how religion affects public health theory and practice, Chatters (2000) indicated that positive perceptions of human nature and the self-lead to attitudes and emotional states linked to improved physical and mental health outcomes. Religious precepts can also influence interpersonal behaviours and attitudes towards others, minimising the possibility of unpleasant and stressful interactions while emphasising positive and pro-social goals such as warmth, friendliness, love, compassion, harmony, tolerance, and forgiveness (p. 345).

For the purposes of this study, mental health is defined as a condition of well-being in which individuals recognise their own potential, manage everyday stressors effectively, perform efficiently, and contribute positively to their community (WHO, 2001c). Studies have indicated the impact of crises on the mental health of primary professional nurses, which should no longer be ignored (Robertson et al., 2020). Htay et al. (2021) argue that this definition comprises three components. The first is emotional well-being, defined as the ability to manage emotions, express feelings appropriately, and maintain a positive outlook on life. The second component is psychological well-being, which involves self-acceptance, personal growth, purpose in life, and autonomy. Lastly, social well-being pertains to the ability to form and maintain healthy relationships, engage in social activities, and contribute to the community.

2.14 Antecedents of Mental Health

Now that the construct of mental health has been conceptualised and defined, the next section will explore the antecedents of mental health. Onwubu et al. (2023) conducted a study on the experiences of primary healthcare nurses working in Durban, KwaZulu-Natal (KZN), regarding mental health challenges during COVID-19. They reported the following antecedents:

2.14.1 Biological Factors

Genetics and neurobiology play a significant role in nurses' mental health. They argue that a family history of mental health disorders can increase the risk for individuals to develop mental illness (Onwubu et al., 2023).

2.14.2 Psychological Factors

Mental health can be impacted by personality traits, coping strategies, and past stress or trauma. Individuals who have experienced trauma in the past, for example, might be more vulnerable to mental health **problems.** Makhado et al. (2024) also reported that the emotional strain experienced by professional nurses contributed to their mental health challenges. Ortiz-Calvo et al. (2022) noted that a history of prior mental health problems was a potential antecedent influencing current mental health outcomes. Jun et al. (2020) indicated that the emotional burden of caring for critically ill patients, witnessing suffering and death, and coping with the loss of colleagues can lead to significant psychological distress. Anxiety resulting from the fear of infecting family members and colleagues was reported as another factor negatively affecting nurses' mental well-being (Makhado et al., 2024). Pre-existing stressors in nurses' lives were also exacerbated by the impact of the pandemic, negatively impacting their mental well-being (Makhado et al., 2024). Hou et al. (2020) concur that previous experiences, such as SARS and trauma, can influence how nurses respond to adversities. They argue that those with prior exposure may experience heightened psychological pressure due to the accumulation of past traumas. In their study investigating the impact of COVID-19 on the mental health of Soweto residents, Kim et al. (2021) reported that adults who had experienced childhood trauma and other related adversities were at a higher risk of developing depressive symptoms precipitated by the risks imposed by their working conditions.

2.14.3 Social Factors

Onwubu et al. (2023) argue that relationships with family, friends, colleagues, and the community can impact one's mental health. They contend that social support significantly increases resilience against mental health challenges. Inadequate support systems, such as the breakdown of social support networks during the pandemic, coupled with the isolation imposed by social distancing measures, exacerbated feelings of loneliness and helplessness among healthcare professionals. A study conducted by Hou et al. (2020) on the impact of social support among professional nurses in China reported that higher levels of social support contribute to better mental health outcomes through increased resilience. These findings

underscore the importance of social support in maintaining the mental health of professional nurses especially during crises like the COVID-19 pandemic. They argue that creating supportive work environments, encouraging teamwork, and facilitating connections among colleagues will help mitigate stress and enhance resilience. This is also supported by Ortiz-Calvo et al. (2022), whose findings indicate that social support plays a significant protective role in the mental health of professional nurses with self-perceived social support from loved ones and colleagues being inversely associated with negative mental health outcomes. According to Ortiz-Calvo et al. (2022), social support can assist in mitigating the adverse effects of stress and trauma experienced by professional nurses, providing emotional support and practical resources that enhance resilience.

2.14.4 Environmental Factors

Living conditions, socioeconomic status, and exposure to violence or discrimination can influence the mental health status of professional nurses. The study conducted by Hou et al. (2020) on the factors influencing the mental health of medical workers during COVID-19 reported that the high-risk environment of direct contact with infected patients, coupled with long working hours, contributed to the deterioration of mental health among medical staff. Furthermore, their study emphasised that these factors led to negative emotional states and increased psychological burden. Long working hours, inadequate resources, and healthcare settings characterised by high patient loads were also reported by Htay et al. (2021) as factors that negatively affected nurses' mental health.

2.14.5 Cultural Factors

Cultural beliefs and practices can shape attitudes towards mental health and influence help-seeking behaviour. Different cultures define mental health and illness differently, as what is considered normal or appropriate in expressing emotions varies. Children are socialised regarding acceptable behaviour and how they should express themselves (Milner & Ancer, 2021). Mental health practitioners should be mindful of these cultural differences and sensitive to them when designing programmes for improving mental well-being (Milner & Ancer, 2021). South Africa, as a multicultural country, faces challenges in establishing a common understanding of mental health. Concepts like *ifufunyanana* and *ukuthwasa*, which are considered callings to serve ancestors in Zulu culture, may be misinterpreted as psychotic episodes by psychologists who do not understand the culture.

A study by Htay et al. (2021) on how professional nurses cope with mental health challenges during COVID-19 revealed significant psychological distress, with reported prevalence rates of insomnia (38.9%), stress (27.4% to 71.5%), anxiety (23.04% to 44.6%), and depression (8% to 50.4%). The study also highlighted the need for timely mental health support and coping strategies to mitigate the psychological impact of the pandemic. However, they noted a lack of information on effective coping mechanisms and emphasised the importance of multidisciplinary teamwork and peer support for reducing burnout and improving job satisfaction. Hou et al. (2020) reported the importance of social support, resilience training, and policy development aimed at protecting the mental health of workers by mitigating stress and the risk of mental health issues. This is supported by Giorgi et al. (2020), indicating that during the pandemic, many nurses expressed that they did not receive adequate resources, including mental health support. Feelings of loneliness and burnout were exacerbated by this lack of emotional support.

Shozi et al. (2021) conducted a study on mental health, culture, and resilience during COVID-19 in South Africa. In their study, they argued that the importance of spirituality and religion in promoting mental well-being cannot be ignored. Lazar (2011) concurs that spirituality plays a significant role in shaping people's thoughts and behaviour. Shozi (2021) believes that spirituality provides a framework of meaning for individuals in their daily lives as well as during major crises. This meaning is created through religious, cultural, and spiritual practices, which can promote resilience, thereby making people susceptible to psychological distress and mental health problems.

Having examined the key constructs of workplace spirituality, resilience, and mental health, along with their definitions, dimensions, and relevance in the context of healthcare and crisis, the focus now shifts to the theoretical frameworks that underpin these concepts. A strong theoretical foundation is essential for understanding how these constructs interact and influence one another within professional settings, particularly in high-stress environments such as healthcare. The following section introduces and discusses two theoretical frameworks that provide a lens through which the interrelationship among workplace spirituality, resilience, and mental health can be interpreted.

2.15. Links Between Workplace Spirituality, Resilience, and Mental Health

Recent empirical evidence increasingly highlights the interconnected relationship between workplace spirituality, resilience, and psychological well-being. Workplace spirituality is

conceptualised as the experience of meaning, purpose, and transcendence within the work environment, often characterised by feelings of inner peace, compassion, sincerity, and meaningful interpersonal interactions (Sabuncuoglu & Tuz, 2005). Within organisational contexts, these spiritual dimensions contribute to employees' sense of belonging and alignment between personal values and work roles, which are essential components of psychological well-being.

Empirical studies support the positive influence of workplace spirituality on resilience. For example, Srivastava and Gupta (2022), in a study conducted within the hospitality industry during the COVID-19 pandemic, found that organisational practices that value workplace spirituality enhance employee resilience and support coping during crises. The authors argue that workplace spirituality fosters a compassionate and mindful organisational culture, which strengthens employees' adaptive capacity and emotional stability in times of uncertainty. This suggests that workplace spirituality functions as a protective organisational resource that helps individuals manage stress and maintain psychological balance.

Similarly, Demir and Cabanoglu (2023) examined the effect of workplace spirituality on teachers' psychological resilience and found a statistically significant positive relationship between the two constructs. Their findings indicate that when employees perceive their work as meaningful and purpose-driven, their psychological resilience increases. Meaningful work, a core dimension of workplace spirituality, was identified as a particularly strong predictor of resilience, highlighting the importance of purpose and value alignment in promoting adaptive functioning.

Collectively, these findings demonstrate that workplace spirituality contributes to resilience by fostering meaning, connectedness, and inner stability, which in turn support mental health. Resilience serves as a mediating psychological resource that enables individuals to cope effectively with stressors, thereby reducing vulnerability to anxiety, depression, and burnout. Consequently, workplace spirituality can be understood as an upstream organisational factor that strengthens resilience and promotes mental well-being, particularly in high-stress professions such as healthcare. This conceptual linkage provides a strong foundation for examining the interrelationship between workplace spirituality, resilience, and mental health among professional nurses in crisis contexts.

2.16. Theoretical Frameworks

2.16.1. Humanistic Organisational Theory (HOT)

The current study utilises Humanistic Organisational Theory to provide a theoretical framework for understanding the role of workplace spirituality in enhancing resilience and mental health. The humanistic organisational theorist emphasises the importance of human dignity, human needs, and motivation (Maslow, 1968), contrasting with the mechanistic or technical view often adopted in managing employees (Follett, 1941; Barnard, Drucker, 1990). Humanistic organisational theory serves as an alternative to mechanistic management. Humanistic scholars in economics and business advocate for a holistic view of human beings, stressing the significance of human dignity, the primacy of people over material goods, and the necessity of considering new business paradigms (Mele, 2016). The following are the premises of humanistic management theory as postulated by Mele (2016), which collectively contribute to the development of humanistic management as an alternative perspective to traditional economic paradigms in management theories:

- **Person-Organisation Fit:** Aligning individuals with the organisation through factors such as job design, job rotation, job enlargement, and job enrichment to enhance employee satisfaction and productivity. This aligns with the workplace spirituality dimension of alignment with organisational values.
- **People-Centric Approach:** Placing people at the centre of management practices to recognise their importance, contributions, and value. This fosters a sense of belonging and meaningful work among employees.
- **Community of People:** Viewing the organisation as a community of individuals rather than merely a set of contracts, fostering involvement, commitment, and participation amongst employees.
- **Stakeholder Management:** Considering the interests of various stakeholders beyond shareholders in decision-making processes and organisational activities.
- **Values-Based Management:** Prioritising ethical leadership and management according to ethical principles, alongside economic considerations.
- **Positive Organisational Scholarship:** Promoting humanistic practices that lead to positive outcomes in organisations, focusing on strengths and virtues within the organisational context.

- **Comprehensive Decision-Making:** Encouraging a holistic approach to decision-making that considers both individual and relational-social aspects, as well as other essential anthropological features.
- **Transcendence:** Acknowledging the human capacity for transcendence and spiritual fulfilment, encouraging a deeper sense of purpose, meaning, and connection in work and organisational life (Mele, 2016).

These propositions provide a framework for understanding and implementing humanistic management principles that prioritise the well-being of individuals, ethical considerations, and societal impact in organisational practices. The following are some of the positive outcomes associated with adopting a humanistic approach within an organisation:

- **Respect for Human Dignity:** Emphasising human dignity in business practices can lead to a more respectful and inclusive workplace culture, where employees are valued for their unique contributions and treated with dignity and respect (Dierksmeier, 2011; Andreu & Rosanas, 2012).
- **Employee Well-being and Satisfaction:** Prioritising the well-being, satisfaction, and self-actualisation of employees can result in higher levels of employee engagement, motivation, and overall job satisfaction. This, in turn, translates to increased productivity and organisational success (Amaud & Wasieleski, 2014).
- **Focus on the Common Good:** Embracing the concept of the common good in business practices can promote fairness, justice, and benevolence. This leads to a more harmonious and socially responsible approach to conducting business.

2.16.2. Applicability of the Humanistic Organisational Theory to this study:

The theory is particularly applicable to this study because it supports the idea that organisations should foster environments that promote alignment between individual values and organisational goals (person–organisation fit), ethical leadership, community belonging, and values-based management. These principles correspond closely with the core dimensions of workplace spirituality, including meaningful work, sense of community, and alignment with organisational values. By promoting such humanistic conditions, organisations create supportive environments that may strengthen employees' psychological resilience. Furthermore, HOT recognises transcendence and the human need for purpose as essential aspects of organisational life. This is especially relevant in healthcare settings, where professional nurses often experience high emotional demands

and crisis-related stress. A humanistic organisational environment that acknowledges dignity, compassion, and shared values can enhance employees' sense of meaning, thereby contributing to resilience and improved mental health. In this way, workplace spirituality functions as a practical expression of humanistic management principles within the organisational context. Therefore, Humanistic Organisational Theory underpins this study by providing a theoretical explanation for how spiritually supportive organisational cultures can enhance resilience and promote the mental well-being of professional nurses, particularly in primary healthcare settings during times of crisis. The theory reinforces the study's argument that organisations must prioritise human-centred values to foster sustainable employee well-being and psychological health.

2.16.3. The Salutogenesis model of health:

The salutogenesis model of health is used as the theoretical framework underpinning the study on resilience and mental health. This model illustrates how various components interact to predict an individual's position along the ease – dis-ease continuum. Considering the different disciplines indicated by Grager (2016), the salutogenesis model of health is located within humanistic psychology, which also governs positive psychology. Antonovsky (1979), in the salutogenesis model of health, focuses on what makes people healthy rather than the pathogenesis, which focuses on the origin of disease. Antonovsky (1979) asserts that salutogenesis is a health model based on the assumption that life experience contributes to one's sense of coherence. According to Antonovsky (1979), a strong sense of coherence activates one's resources to cope with adversities and manage tension successfully.

Antonovsky (1979) emphasises two aspects when perceiving the world:

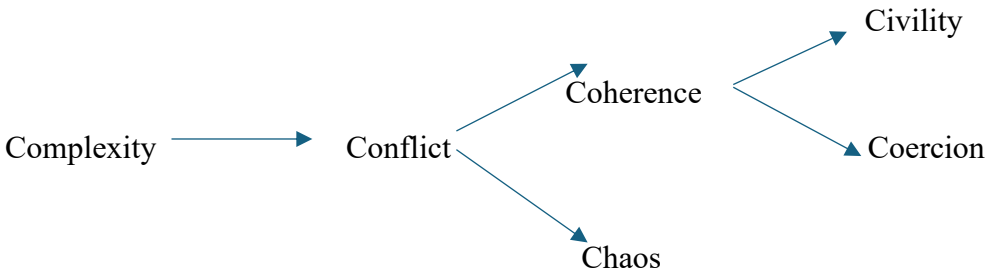
- **Human-Environment Interaction:** He views humans as interacting with their environment.
- **Chaos and Change as Norm:** He perceives chaos and change as the natural state of life.

Antonovsky sees daily life as constantly changing, heterostatic rather than homeostatic. He believes that individuals must access strategies and resources to manage chaos and cope with change effectively.

He then introduced the six C's: Complexity, Conflict, Chaos, Coherence, Coercion, and Civility to explain his perspective on the interaction between humans and the environment. These six Cs help us understand the dynamics of this interaction and the consequences of both positive adaptation and maladaptation.

Figure 2.8:

Six C's Adopted from Antonovsky (1979)



To further elucidate:

- **Complexity** refers to the degree of organisation within a system. Through interactions among subsystems and suprasystems, this level both creates challenges and opportunities for sustaining a dynamic steady state. He posits that complexity has the potential to lead to conflict.
- **Conflict** refers to individual tension, tension between individuals, tension between an individual and the suprasystems, and finally tension between or among such suprasystems (Antonovsky, 1993). While complexity can present flexibility in terms of choices and possibilities for one to adapt to change, it is important to manage the tension created by conflict to avoid stress.
- **Chaos** is a metaphor for war, representing senseless and unpredictable violence. In contrast,
- **Coherence** is the ability to adapt and manage life's chaos.
- **Civility** is the perspective we have toward others, involving respect and humanity.
- **Coercion** is the antithesis of civility and respect (Antonovsky, 1993).

The illustration indicates that adversity can create tension. Successfully managing this tension leads to coherence, resulting in positive health outcomes. Antonovsky (1993) perceives health as movement along a continuum of ease and dis-ease. He described the feeling of coherence as the capacity to comprehend the entire situation and effectively utilise the available resources to overcome adversity. This ability arises from individuals' capacities, which include

comprehensibility, meaningfulness, and manageability, combined with their ability to evaluate and understand circumstances and derive meaning to promote health.

The salutogenesis model emphasises an individual's ability to utilise general resistance resources (GRR), both internal and external, to manage persistent stressors. GRR is defined as the physical, biochemical, artefactual-material, cognitive, emotional, valuative-attitudinal, interpersonal-relational, and macro sociocultural characteristics of an individual, group, subculture, and society that are effective in avoiding and combating a wide variety of stressors. Antonovsky argues that GRR can also create stressors. He posits that general resistance resources are fundamental to developing a sense of coherence. According to Lindstrom and Eriksson (2005), GRR can be unique in that they can be genetic and institutional; they can also be psychosocial, cultural, spiritual, and preventive in orientation. Antonovsky (1979, p. 103) asserts that GRR exist at the individual, group, subculture, and societal levels.

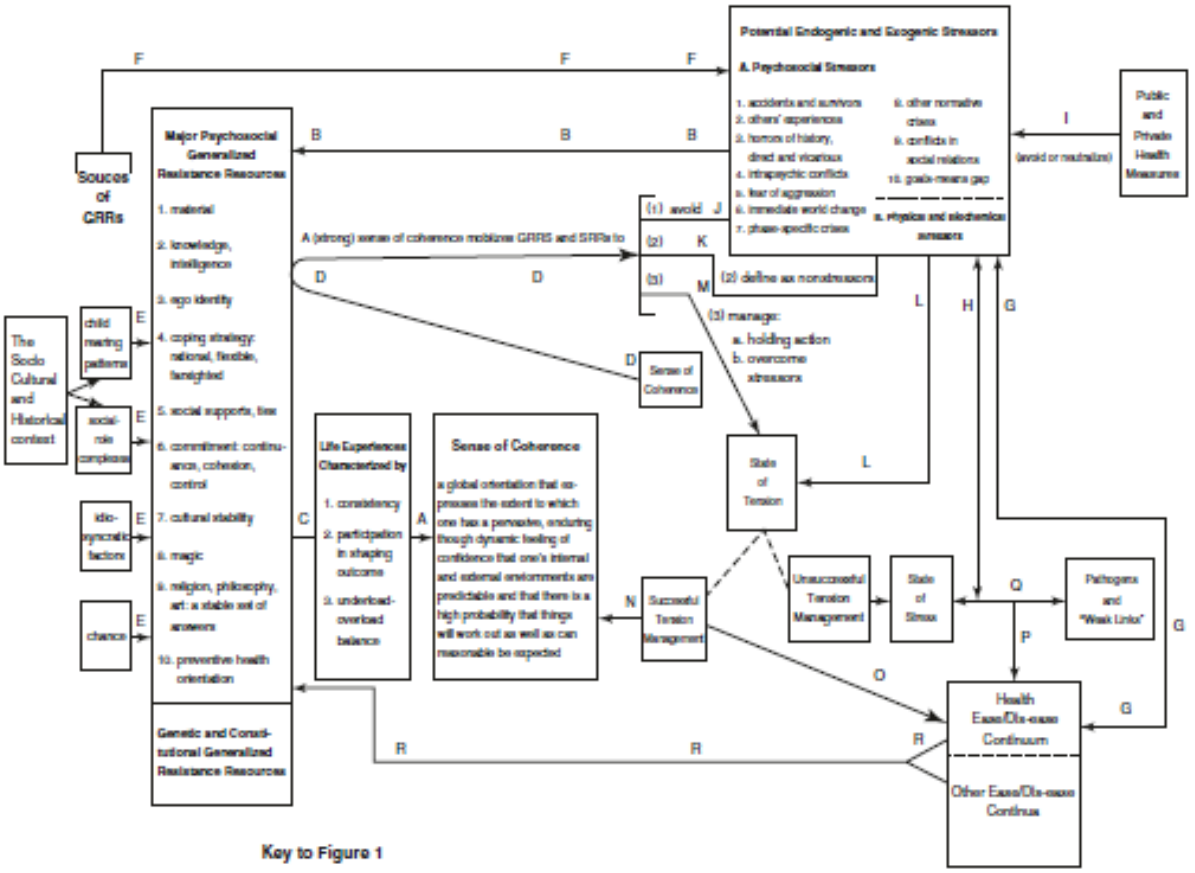
Sense of coherence (SOC) is a multifaceted construct composed of comprehensibility, manageability, and meaningfulness. It is defined as a pervasive, dynamic feeling of confidence that is underpinned by three tenets: 1) Internal and external stimuli are structured, predictable, and explainable; 2) Sufficient resources are available to meet life's demands; and 3) Challenges are viewed as opportunities for growth and engagement (Antonovsky, 1987). According to Eriksson and Lindstrom (2006), SOC also involves an individual's ability to recognise and activate these internal and external resources to cope with adversity. Antonovsky suggested that sense of coherence develops until the age of 30 and remains stable until retirement. However, more recent research by Feldt et al. (2007) and Nilsson et al. (2010) suggests that SOC can continue to develop throughout one's lifespan and may even increase with age. Below is a graphic presentation of the salutogenesis model of health and the various factors that influence an individual's adaptation to adversity.

The study on mental health will also be underpinned by the Salutogenic theory developed by Antonovsky (1987) to understand the mental health of professional nurses during times of crisis. According to the Salutogenic theory, stress and chaos are inevitable, and people are exposed to stressors and disease. Surprisingly, many individuals are able to cope and survive, challenging the previous view of stress as a negative event leading to breakdown. The Salutogenic framework focuses on the origin of health rather than the factors that cause illness (Antonovsky, 1979). The fundamental concepts of salutogenesis are Generalised Resistance Resources (GRRs) and Sense of Coherence (SOC). GRRs are biological, material, and psychosocial factors that facilitate individuals' perception of their lives as consistent, structured, and understandable. Examples of GRRs include knowledge, culture, social support,

intelligence, and ideologies. The GRRs are shaped by life experiences and characterised by consistency, participation in shaping outcomes, and balance between underload and overload. Antonovsky (1979) opines that possessing these resources enhances resilience to adversity.

Figure 2.9:

Salutogenesis Model of Health



Note. *Adapted from Unraveling the Mystery of Health: How People Manage Stress and Stay Well. CA: Jossey-Bass.*

2.16.4 Applicability of the Salutogenesis Health Model to this study:

The Salutogenesis Health Model (Antonovsky, 1987) is considered for this study to be highly appropriate for understanding the mental health and resilience of professional nurses during times of crisis. From the researcher's perspective, the model provides a constructive and strengths-based framework that shifts attention away from disease and psychological pathology and instead focuses on the factors that promote health and well-being. Given the demanding and stress-prone environment in which professional nurses operate, particularly within primary healthcare settings, the researcher believes this health-oriented approach is particularly relevant.

The central constructs of the model General Resistance Resources (GRRs) and Sense of Coherence (SOC) are especially applicable to this study. The researcher view GRRs as encompassing both internal and external resources that enable individuals to cope with persistent stressors. These include knowledge, social support, organisational structures, personal competencies, and spiritual or value-based resources. In the context of this research, I consider workplace spirituality to be a significant organisational GRR, as it promotes meaning, connectedness, ethical values, and a supportive work environment. Such conditions, in one's view, can strengthen nurses' capacity to manage occupational stress effectively.

Furthermore, the researcher finds the concept of Sense of Coherence (SOC) to be particularly relevant to resilience and mental health. SOC reflects the extent to which individuals perceive life events as comprehensible, manageable, and meaningful. From the researcher's perspective, professional nurses who experience their work as meaningful and who believe that adequate resources are available to them are more likely to demonstrate resilience and maintain better mental health outcomes. The meaningfulness component of SOC aligns closely with the principles of workplace spirituality, reinforcing the theoretical compatibility between the model and this study.

Overall, the researcher believes that the Salutogenesis Model provides a strong theoretical foundation for this research because it supports a preventive and health-promoting approach. Rather than focusing solely on psychological distress, the model encourages the identification and strengthening of resistance resources that enhance resilience and promote mental well-being. In the context of professional nurses working in crisis conditions, the researcher consider

this framework particularly suitable for explaining how workplace-based and individual resources interact to support positive mental health outcomes.

2.16.5 Self-Determination Theory as a Framework for Understanding the Logic Change Model

Self-Determination Theory (SDT), developed by Edward L. Deci and Richard M. Ryan, is a broad theory of human motivation that explains how social and environmental factors influence individuals' psychological functioning, well-being, and capacity for growth. SDT is particularly relevant in healthcare contexts, as it provides a framework for enhancing resilience and supporting mental health among professional nurses.

At its core, SDT posits that optimal functioning and well-being are achieved when three basic psychological needs are satisfied: autonomy (a sense of control and self-direction), competence (feeling effective and capable), and relatedness (a sense of connection with others). When these needs are met within the workplace, individuals are more likely to experience intrinsic motivation, psychological resilience, and improved mental health outcomes.

SDT is not a single theory, but a meta-theoretical framework composed of several interrelated mini-theories, including Cognitive Evaluation Theory, Goal Content Theory, Organismic Integration Theory, and Basic Psychological Need Theory. Each of these elaborates on different aspects of motivation, internalisation, and well-being, collectively explaining how supportive environments can foster sustained behavioural change.

In this study, SDT is applied as a theory of change to inform interventions aimed at building resilience and promoting mental health among professional nurses. By creating work environments that support autonomy, enhance competence, and strengthen interpersonal relationships, healthcare organisations can facilitate internal motivation and adaptive coping mechanisms. This, in turn, contributes to reduced burnout, increased job satisfaction, and improved overall well-being.

The inclusion of SDT in this chapter provides a conceptual foundation for the discussion in Chapter Seven, where its related mini-theories are further applied to explain how workplace-based interventions can effectively support nurses' resilience and mental health.

2.17. Key Research Gaps addressed by this study

The preceding literature review highlighted the increasing scholarly interest in workplace spirituality, resilience, and mental health as key factors influencing employee well-being and functioning within demanding work environments. Workplace spirituality has been recognised as an important organisational resource that fosters meaning, purpose, and connectedness, thereby contributing to employees' psychological well-being and overall workplace flourishing (Tigedi, Van der Walt, & Nyetanyane, 2024). Additionally, emerging research in nursing contexts indicates that workplace spirituality can positively influence nurses' resilience by strengthening their sense of purpose and professional identity within healthcare environments.

Resilience is increasingly viewed as a critical personal and organisational resource that enables professional nurses to adapt to stressful and demanding working conditions. Studies have shown that resilience facilitates adaptation to occupational challenges and supports Professional nurses in maintaining psychological functioning despite high levels of stress (Mcizana et al., 2024). However, healthcare professionals continue to face significant workplace stressors, including heavy workloads, staff shortages, and emotionally demanding working environments, all of which negatively affect their psychological well-being (Makhado et al., 2024).

Despite the growing body of research examining professional nurses' mental health, much of the existing literature has primarily focused on the prevalence of psychological distress rather than on protective organisational and psychosocial resources that may support mental well-being. Furthermore, although resilience and workplace spirituality have been studied independently across various organisational settings, limited empirical research has examined the interrelationships among workplace spirituality, resilience, and mental health among professional nurses, particularly in primary healthcare settings.

Within the South African context, professional nurses operate in resource-constrained environments characterised by high patient loads and persistent public health challenges. While some studies have explored resilience among healthcare professionals in South Africa, research examining the organisational and spiritual dimensions that may enhance resilience and

psychological well-being remains limited. More specifically, there is a paucity of empirical studies focusing on professional nurses working in primary healthcare facilities in the uMgungundlovu District, particularly during times of crisis.

Addressing this gap is therefore important to generate context-specific knowledge regarding how workplace spirituality may function as an organisational resource that strengthens resilience and supports the mental health of professional nurses. Such insights may inform the development of workplace interventions, leadership practices, and human resource policies to promote resilience and safeguard the psychological well-being of nurses in primary healthcare settings during periods of crisis.

2.18. Conclusion

The literature reviewed on mental health indicates the importance of individual characteristics, spirituality, cultural factors, and environmental factors in building resilience and promoting mental health among professional nurses. Most studies on workplace spirituality and mental health have focused on individuals receiving mental health services, and those concentrating on professional nurses have primarily been conducted in China and Western countries. It is also evident from the literature reviewed that there are few studies conducted in the South African context that explore workplace spirituality, resilience, and the mental health status of professional nurses. The literature also indicates that during crises, more focus is directed towards providing cures, thereby neglecting the impact of the pandemic on the mental health of professional nurses. Giorgi et al. (2020) contend that prioritising society's physical health over the mental strain generated by the epidemic may increase the likelihood of another pandemic linked to the emergence of mental disorders. This study aims to ascertain nurses' understanding of workplace spirituality and to explore whether workplace spirituality is associated with resilience and mental health in the face of crises.

CHAPTER 3

SCOPING REVIEW METHODOLOGY (REGISTERED PROTOCOL)

*This chapter has been prepared using the **Vancouver referencing style** for publication purposes. The complete list of references cited herein is provided in **Appendix H** of this document.*

3.1 Background

A country's health system is committed to developing an integrated health system that ensures quality healthcare is delivered to all citizens in an efficient and compassionate environment.[1] A 'health system' is defined by the World Health Organisation (WHO) as encompassing all the organisations, institutions, and resources devoted to producing actions whose primary purpose is to improve health. Quality healthcare refers to services that consistently deliver care which enhances or maintains health, is appreciated and trusted by recipients, and is responsive to changing population needs[2] (see Table 3.1 for key concepts and definitions).

For this mission to be realised, it is imperative that the healthcare workforce, which primarily consists of registered nurses, maintains good physical, mental, and psychological health. On 31 December 2019, an outbreak of a new virus known as coronavirus disease 2019 (COVID-19) was reported in China.[4] This culminated in a global epidemic. Information on the spread of COVID-19 was disseminated through local and international media by the WHO. However, the devastating implications of COVID-19 on global mental health have been overlooked, despite the challenges it poses for patients, the general population, policymakers, health organisations, and teams.[5]

COVID-19 is a respiratory syndrome caused by the SARS-CoV-2 virus that has developed into a pandemic.[6] COVID-19 has exhibited a more severe course compared to Human Immunodeficiency Virus (HIV), severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), Ebola, and H1N1 due to its rapid spread, which has resulted in acute morbidity and mortality.[7] One study found that 4.4% to 11% of Professional nurses globally were infected with COVID-19, and 22.8% to 23.2% of Professional nurses were reported to be at risk of developing mental health problems.[5]

To prevent the spread of the virus, public health prevention and infection control measures were implemented. These measures included strict hygiene routines, self-isolation, quarantine, movement restrictions, social distancing, and considerations regarding the mental, social, physical, and economic preparedness of individuals and families.[7] In addressing the spread of

the virus, medical professionals faced a high risk of infection, inadequate protection, overwork, frustration, discrimination, negative emotions from patients, and exhaustion.[8] This situation resulted in mental health challenges such as stress, anxiety, fear, depressive symptoms, and insomnia, which could have a lasting effect on the overall well-being of healthcare workers.[9]

While many individuals have been affected by this pandemic, the situation is particularly aggravated for nurses who are at the forefront of the crisis. Given that nurses constitute the largest segment of the healthcare workforce, it is imperative that their mental health is taken seriously. In 2015, out of the 173,761 health professionals working in the public health system, 77% were nurses, 11% were doctors, and the remainder were distributed among other roles.[10]

Several studies have indicated the adverse effects of the pandemic on nurses' mental health, highlighting that the government has invested more in addressing the psychological impact of the pandemic while sidelining mental health, despite its potential long-term consequences being more significant than the overall physiological effects of the infection for the average citizen.[5, 11] Consequently, it has become essential to investigate how times of crisis, such as the COVID-19 pandemic, impact the physical and emotional well-being of healthcare workers (HCWs) across primary, secondary, and tertiary healthcare settings. One area of investigation is the concept of workplace spirituality and its associated benefits.

3.2 Understanding Workplace Spirituality

Workplace spirituality is a concept that is increasingly attracting the attention of scholars in organisational research. [12, 13, 14] Liberalisation and globalisation are among the factors that have drawn researchers' interest in workplace spirituality due to the competitive demands placed on both employees and employers. Research has demonstrated that issues such as attrition, absenteeism, decreased engagement, declining productivity, and ethical failures within reputable organisations have contributed to the growing interest in workplace spirituality.[14]

To remain competitive, companies need to achieve high profits and larger market share. In doing so, this has resulted in companies setting unrealistic targets, with employees being expected to work overtime and take fewer holidays and breaks.[15] Furthermore, this has led to employees suffering from mental health issues such as anxiety, burnout, and depression. There is significant research supporting the impact of poor mental health on work productivity and patient-centred care. Workplace spirituality has been defined at three levels: individual level, team level, and organisational level.[16]

Spirituality at the Individual Level – This refers to an individual's experience marked by a sense of vitality, fulfilment, and heightened awareness that their personal values are aligned with meaningful work. Meaningful work is defined as those activities at work that are imperative to both employees and the organisation.[17, 18] It also includes a deep sense of connection with others, a bond with something greater than oneself, and moments of transcendence.[19] Alternatively, individual spirituality is defined as the acknowledgement that employees have an inner life that needs to be nourished by engaging in meaningful work.[20] It further acknowledges that employees seek the larger mission of their lives through work; therefore, engaging the souls of employees is the highest form of employee engagement, while organisational spirituality is defined as a "corporate soul" and is indicative of the environment provided by the employer to employees.

Spirituality at the Team Level – This occurs when individuals believe that they are part of a cohesive team where each member is valued and united by shared goals.[21] Cultivating strong interpersonal bonds within a team is essential for nurturing this sense of interconnectedness.[22] Interconnectedness is experienced when employees work cooperatively with one another and are able to freely share information.[23, 24] Within the context of workplace spirituality, this dimension is reflected in the quality of relationships among team members, fostering mutual support, trust, and collective purpose. It operates at the group level, where team dynamics and a spirit of unity contribute to a spiritually enriching work environment.

Workplace Spirituality at the Organisational Level - Workplace spirituality refers to a culture or spiritual climate characterised by the values, purpose, and vision of the organisation.[25] An extended definition describes workplace spirituality as an organisational culture that fosters employees' experiences of transcendence throughout the work process, encouraging their sense of connection to others in a manner that engenders feelings of completeness and joy.[26]

The exploration of workplace spirituality within corporate organisations is well-documented. However, little is known about workplace spirituality in alternative work settings, such as healthcare.[27] Sub-Saharan Africa was deliberately selected as the focus of this scoping review due to the need for contextually relevant evidence on workplace spirituality within the region. During the preliminary literature review conducted for the main PhD study, it became evident that a substantial body of research on workplace spirituality exists internationally. This observation justified the inclusion of a scoping review, alongside the narrative review, to systematically map the available evidence.

Notably, a significant proportion of the existing literature originates from the Middle East and Asian countries, where workplace spirituality is often closely associated with religious practices. While these studies provide valuable insights, their contextual orientation differs from that of sub-Saharan Africa. Therefore, narrowing the scope to the sub-Saharan region was an intentional methodological decision aimed at generating a more context-specific understanding of how workplace spirituality is perceived and experienced by professional nurses, particularly within South Africa. Expanding the scope to a global context would have diluted the focus of the review and limited its relevance to the study setting.

Nonetheless, to ensure a comprehensive analysis, comparisons with studies conducted in similar international contexts were incorporated into the discussion, and their findings were used to enrich the interpretation of results.

3.3 Psychological Constructs Associated with Workplace Spirituality

Awan and Sitwat (2014) identified the following benefits of workplace spirituality:[28]

1. **Enhancement of Self-Esteem and Psychological Well-Being:** Workplace spirituality contributes to the enhancement of employees' self-esteem, which, in turn, promotes better psychological health and life satisfaction.[28]
2. **Stress Reduction and Coping Ability:** For mental health professionals, spirituality provides inner strength and aids in coping with job-related stress and challenging situations.[28]
3. **Increased Job Satisfaction and Personal Growth:** Spiritual experiences at work encourage personal development, a sense of purpose, and meaningful engagement with work tasks, leading to heightened job satisfaction.[28]
4. **Promotion of Inner Security and Self-Realisation:** Workplace spirituality facilitates self-discovery and a sense of security, which can contribute to enhanced self-esteem and overall well-being.[28]
5. **Better Organisational Outcomes:** Organisations that nurture spirituality may observe improved employee satisfaction, enhanced decision-making, and a more positive work environment.

The advantages of workplace spirituality encompass fostering emotional and social support, promoting peace and harmony, and enhancing mental health among employees. Workplace spirituality assists employees in developing their inner selves and finding purpose in their work,

thereby contributing to more effective coping with organisational stress and adversity.[29] It also nurtures a sense of community and meaningful work, resulting in increased satisfaction and well-being. Furthermore, organisations that advocate for workplace spirituality experience improved performance, accelerated growth, and better rates of return, indicating its beneficial impact at both the individual and organisational levels.[30]

3.4 Contribution to the Field of workplace Spirituality

Substantive efforts have been made in researching the physiological impact of the COVID-19 pandemic, inadvertently neglecting the effects on the psychological well-being of nurses. The mental health status of front-line nurses is often at risk, which has a detrimental effect on their ability to care for patients.[6] Furthermore, during the COVID-19 pandemic, extensive research has been conducted globally on health-related issues concerning infected patients. Notably, most researchers have focused on the clinical aspects of the virus infection and the development of a vaccine to eradicate the coronavirus; however, limited research has been conducted on the cognitive, affective, and behavioural dimensions of the crisis affecting healthcare workers, particularly nurses.[31]

Similarly, studies on workplace spirituality have primarily examined its impact on employee engagement, performance, absenteeism, attrition, relationships, and ultimately the overarching goals of organisations.[32]. In 2011, the Joint Commission expected that healthcare organisations would encourage spirituality in the workplace; however, reports indicate that healthcare professionals remain sceptical about embracing this concept.[33] This situation necessitates further investigation to ascertain the relevance of such ideas.

Assessing the impact of workplace spirituality on nurses' mental health during crises, such as COVID-19, requires an initial mapping of existing evidence on workplace spirituality among nurses. To provide a comprehensive overview of nurses' experiences with the benefits of workplace spirituality, this scoping review maps the available evidence on the advantages of workplace spirituality among registered nurses in healthcare facilities in sub-Saharan Africa.

Table 3.1:

Key Concepts and Definitions

Concept	Definition	Example(s)
Quality Healthcare	The World Health Organization (WHO) defines quality of care as the extent to which healthcare services provided to individuals and communities improve desired health outcomes. Therefore, to achieve quality of care, nurses must be well both emotionally, physically, and psychologically.	• *Safe*: Delivering healthcare minimises risks and harm to service users, including avoiding preventable injuries and reducing medical errors. • *Effective*: Providing services based on scientific knowledge and evidence-based guidelines. • *Timely*: Reducing delays in providing and receiving healthcare. • *Efficient*: Delivering healthcare in a manner that maximises resource use and avoids waste. • *Equitable*: Delivering healthcare that does not differ in quality according to personal characteristics such as gender, ethnicity, race, geographical location, or socioeconomic status. • *People-centred*: Providing care that considers the preferences and aspirations of individual service users and the culture of their community.[2]

Concept	Definition	Example(s)
Healthcare Facilities	Healthcare facilities are distributed across various geographical locations and serve a wide range of functions. They provide access to services during emergencies or routine care and strengthen the appropriate and timely delivery of healthcare.	This review will focus on nurses who work in healthcare facilities (HCF). These nurses typically operate in HCF that function 24 hours a day.
According to the Population, Concept, and Context (PCC) framework, the targeted population in this review is nurses, nurse practitioners, and registered nurses.	For the purpose of this review, the term 'nurses' refers to nurse practitioners and advanced practice nurses (also known as registered nurses). The characteristics of these nurses are influenced by the context and/or country in which they operate.	In this instance, a registered nurse is an individual who has acquired the necessary expert knowledge and competencies that qualify them to work in an environment requiring complex decision-making and clinical competencies for expanded practice.
Workplace Spirituality	Workplace spirituality is defined as "the recognition that employees have an inner life that nourishes and is nourished by meaningful work that takes place in the context of community". The dimensions of workplace spirituality that this review will focus on include meaningful and purposeful work, inner life, a sense of community and connectedness, and transcendence, which refers to a profound sense of joy and connection beyond the self or a mystical experience.	Workplace spirituality has been acknowledged for its contribution to promoting work engagement, enhancing work performance, reducing absenteeism, and improving the overall quality of employee well-being.
Context: Sub-Saharan Africa	The study will focus on countries located in the Sub-Saharan region of Africa.	Sub-Saharan Africa refers to the area and regions of the African continent that lie south of the Sahara Desert, including Central, East, Southern, and West Africa.

3.5 Methodology

We will employ the methodologically rigorous scoping review approach proposed by Arksey and O'Malley to conduct a scoping review of both grey and peer-reviewed literature on workplace spirituality and its relationship to the resilience and mental health of nurses working in healthcare facilities in sub-Saharan Africa. The review will be guided by Arksey and O'Malley's scoping review framework,[34] which outlines the following steps:

- Stage 1: Identifying the research question
- Stage 2: Identifying relevant studies
- Stage 3: Study selection
- Stage 4: Charting the data
- Stage 5: Collating, summarising, and reporting results

The recommendations provided by Levac, Colquhoun, and Brien will be utilised to enhance the transparency of each step in the scoping review process.[35]

Stage 1: Identifying the research question

The aim of this scoping review is to map existing evidence on workplace spirituality among nurses in healthcare facilities in sub-Saharan Africa.

The research questions are as follows:

- What are the common benefits of workplace spirituality in the workplace?
- What are the reported trends regarding the promotion of spirituality in healthcare facilities?

The study will utilise the broad population, concept, and context (PCC) framework recommended by the Joanna Briggs Institute for Scoping Reviews to determine the eligibility of the scoping review research questions, enabling the construction of meaningful objectives and clear eligibility criteria for studies to be included in the scoping review. [36, 37, 38, 39] The PCC is illustrated in Table 3.2, and the key inclusion criteria that will underpin the design of the search strategy are presented in Table 3.4 below. Registered nurses, nurse practitioners, and professional nurses will be used interchangeably to broaden our search and accommodate countries that refer to professional nurses, registered nurses (e.g., UK), or nurse practitioners (e.g., USA).

Table 3.2:

PPC Framework

Population	Concept	Context
Professional Nurses	Workplace spirituality	Sub-Saharan Africa
Nurse practitioners	Spirituality at work	Health Facilities
Registered nurses		From 1978 to 2025

Search Strategy

A variety of electronic databases will be systematically searched using two separate strategies to identify relevant studies. These search strategies will encompass studies published from 1978 to 2025, as the objective is to map positive evidence of workplace spirituality from the time when primary healthcare was introduced to the present. Additionally, articles will be identified through the "cited by" search, as well as citations included in the reference lists of the identified articles.

The search strategy will encompass the following search terms: workplace spirituality OR spirituality in the workplace AND professional nurses OR registered nurses OR nurse practitioners OR nurses AND sub-Saharan Africa. This search strategy was developed and piloted by the primary researcher (NPD) to assess the suitability of the selected electronic databases and keywords, and it was piloted on 20 May 2025.

Stage 2: Identifying Relevant Studies

The following electronic databases will be searched to identify relevant studies: Academic Search Complete, PsycARTICLES, PsycINFO, Cumulative Index to Nursing and Applied Health Literature, Scopus, EBSCOhost, PubMed, ERIC, Google Scholar, Health Source Nursing, Sabinet, and Sage Journals. The literature will comprise published peer-reviewed journal articles with primary studies that have a transparent empirical base, utilising various research approaches, including qualitative, quantitative, and mixed methods, as well as grey literature addressing the research questions. World Health Organisation (WHO) and government websites will be consulted to locate relevant policies and information that will assist in answering the research question. To ensure a comprehensive search, databases such

as the Union Catalogue of Theses and Dissertations (UCTD) via SABINET Online and WorldCat Dissertation and Theses via OCLO will be employed to find pertinent literature.

Table 3.3:

Pilot Database Search Results

Date of Search	Key Search	No. of Publications Retrieved	Search Engine Utilised
20 May 2025	Workplace spirituality OR spirituality at work AND professional nurses OR nurses OR registered nurses OR nurse practitioners AND Sub-Saharan Africa, including: Angola, Benin, Botswana, Burundi, and Cameroon.en.wikipedia.org+3twas.org+3francistapon.com+3:	815	PubMed

Stage 3: Study Selection (Inclusion criteria)

This stage involves determining which studies to include in the scoping study. To achieve this, relevant citations will be selected through title, abstract, and full-text screening using the keyword search. The primary researcher (NPD) will conduct a comprehensive database search and screen titles from the previously mentioned database search, with the assistance of the librarian at the University of KwaZulu-Natal (UKZN).

Articles selected at this stage using keywords will be screened to eliminate those with titles that are not relevant to the study. All duplicate studies will be removed. Relevant articles, selected according to the inclusion criteria, will then be transferred to EndNote and shared with other researchers (NC, CZM) for abstract and full article screening. A clear set of inclusion and exclusion criteria, developed at the outset to provide clear guidance, will assist each researcher in consistently determining the relevance of each citation (see Table 3.4).

Table 3.4:

Inclusion and Exclusion Criteria

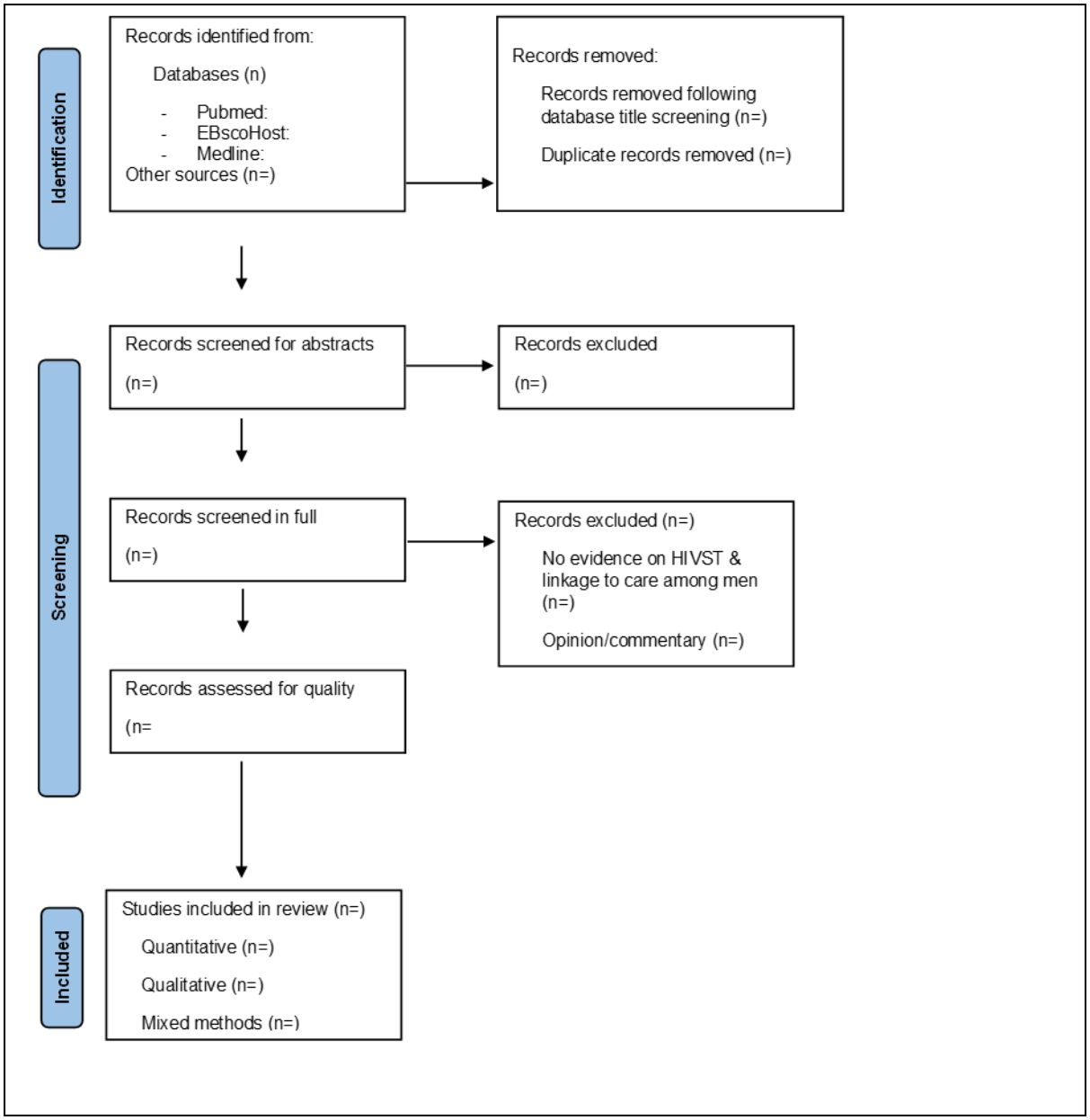
Inclusion Criteria	Exclusion Criteria
• Studies that demonstrate evidence of workplace spirituality or spirituality at work. • Studies conducted within sub-Saharan African countries. • Studies published between 1978 and the present. • Studies focused on registered nurses or nurse practitioners working in healthcare facilities. • All study designs	• Studies lacking evidence of workplace spirituality or spirituality at work. • Studies conducted outside sub-Saharan Africa. • Studies published before 1978. • Studies not focused on registered nurses working in healthcare facilities or studies based on other categories of healthcare workers.

To enhance the full article, search procedure, the reviewers will consult with the librarian to assist in locating and retrieving articles for inclusion in the full article screening. If there is a disagreement between the researcher and the reviewer regarding the articles to be included for full-text screening, a third independent researcher (CZM) will be engaged to assist in resolving the identified discrepancies. [40]

The final screening outcomes will be presented in a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram, as illustrated in Figure 3.1.[41,42]

Figure 3.1:

Example of PRISMA-ScR Chart



Source: The PRISMA-ScR = preferred reporting items for systematic reviews and meta-analyses extension for scoping reviews.[41, 42]

Stage 4: Charting the data

At this stage, the writer will extract key information from the primary reports being reviewed. This phase aims to provide a descriptive summary of the results that correspond to the aims and research questions of the scoping review. A draft of the data charting form will be developed and piloted to assist with the collection and organisation of key information from sources such as author, study title, aims of the study, study design and setting, population, and

relevant findings. This process will be conducted by both reviewers to ensure consensus regarding the nature and extent of information to be extracted from the included studies.

This will be further refined at the review stage, and the charting form will be updated accordingly.

Table 3.5:

Data Extraction or Data Charting Tool

Author and publication year
Type of publication
Aims or research questions
Study design
Country
Healthcare setting
Study population
Findings

Stage 5: Collating, summarising, and reporting the results

To provide a narrative account of the data extracted from the included studies, the data will be analysed using content and thematic analysis. These methods are valuable as they offer a descriptive presentation of data. By identifying common themes within the text, the researcher can conduct a thorough analysis. The data will be extracted around the following themes: meaningful and purposeful work, inner life, resilience, mental wellbeing, and a sense of community connectedness and transcendence. To understand the context, content, population, and research methods of the selected studies, a template with mapping tables and charts will be developed.

Quality appraisal

The Mixed Methods Appraisal Tool (MMAT) will be used to assess the quality of the primary studies selected for the scoping review.[43, 44] The MMAT is an appraisal tool employed during the appraisal stage of systematic mixed studies reviews, which include qualitative, quantitative, and mixed methods studies.

Each study will be assessed according to the relevant section of the MMAT as indicated below:

- Section 1 of the MMAT will be used to evaluate the quality of qualitative studies.
- Section 2 will be used to assess the quality of quantitative randomised controlled trials.
- Section 3 will be utilised for non-randomised studies.
- Section 4 will be applied to descriptive studies.
- Section 5 will be designated for mixed-method research methodology studies.

This tool is further beneficial for examining the suitability of study objectives, the methodology employed, the appropriateness of the study design, data collection, data analysis, the presentation of findings, as well as the discussion and conclusion. The quality of the articles and the inclusion of specific primary studies following data extraction will be determined by the results from the scrutiny of the aforementioned aspects.[43] The Joanna Briggs Institute (JBI) Narrative, Opinion, Text Assessment and Review Instrument (NOTARI) systematic reviews will be employed to assess grey literature. Any issues relating to the suitability of topic selection for inclusion, critical appraisal, data extraction, and synthesis will be addressed using the JBI Reviewer's Manual 2014.[45]

Textual evidence can be appraised across three levels of credibility. Reviewers are therefore expected to evaluate whether the conclusions drawn align with the supporting arguments and classify the findings as **unequivocal** (evidence beyond a reasonable doubt), **credible** (plausible and supported, though open to interpretation), or **unsupported** (lacking sufficient data to justify the conclusion).[45]

3.6 Discussion

Nurses play a critical role in ensuring that professional care is provided to patients and their families. In addition, they are expected to manage their own emotions related to patient care. There are additional demands, such as work overload, lack of resources, and insufficient protective measures during times of crisis, which nurses must confront, potentially resulting in mental health issues. Research indicates that nursing knowledge and competency alone are inadequate; a sense of spirituality at work, or workplace spirituality, is encouraged to help nurses manage these demands. This review aims to map existing evidence on the benefits of workplace spirituality among registered nurses working in healthcare facilities in sub-Saharan Africa.

Chapter 4:

SCOPING REVIEW FINDINGS AND DISCUSSION

4.1 Introduction

This chapter presents a scoping review of the literature. The review details existing evidence of workplace spirituality among registered nurses in healthcare facilities in sub-Saharan Africa. It commences with the study's background, followed by an overview of the study's aims and objectives, and the research questions addressed by the review. Subsequently, the methodology employed for the scoping review is outlined, detailing the steps taken to retrieve the articles reviewed and the inclusion and exclusion criteria that determined each study's suitability. This chapter concludes with a discussion of the results and a critique of the literature concerning the benefits of workplace spirituality.

4.2 Background of Study

The health system encompasses all organisations, institutions, resources, and individuals whose primary purpose is to improve health (Indicators, 2010). A well-functioning health system is defined as one that can respond to the needs and expectations of the population regarding the improvement of individual, family, and community health status, protect the population from threats to their health, and provide equitable access to person-centred care (World Health Organisation, 2010). The World Health Organisation developed a framework with six building blocks to monitor health system performance. These building blocks are service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance (Indicators, 2010). According to WHO (2010), to meet these expectations, the appropriate health workforce, also known as human resources, is essential to ensure the goals of improving population health and responding to the expectations of patients and communities are achieved (World Health Organisation, 2010). Goal number 5 of the 2030 HRH strategy emphasises the importance of building an enabled, motivated, and empowered health workforce. The rationale for this goal is based on the significance of the workforce's health, safety, and wellbeing as essential drivers of quality healthcare and the overall performance and efficiency of the health system (World Health Organisation, 2010).

The nursing profession involves continuous engagement with patients over an extended period (Zaman, Miniharianti & Rabial, 2022). This engagement entails physical, emotional, and mental strain for nurses. They are often exposed to stressful situations, putting them at risk

of experiencing the negative effects of burnout and secondary traumatic stress (World Health Organisation, 2010); however, they frequently neglect their health problems (Schuster & Dwyer, 2020). The emergence of COVID-19 has exacerbated the situation, as nurses have had to cope with unrealistic workloads, insufficient resources, and the mental, emotional, and moral burden of caring for patients afflicted with a new and unpredictable disease (Schuster & Dwyer, 2020). Having nursing staff on hand who are attentive to patients' needs is essential for providing the best possible healthcare services (Winarso et al., 2020). This underscores the importance of recognising the vital role health professionals play in fulfilling the healthcare mandate and the necessity of addressing their well-being.

Workplace spirituality encompasses convictions, ideals, and inner strengths that are fundamental components of individuals' dedication to their jobs. Research by Na'imah et al. (2021) indicates that workplace spirituality extends beyond religious elements; it also pertains to how individuals integrate their values and beliefs into their work environment. It has been identified as one of the strategies that can mitigate nurses' anxiety (Schuster & Dwyer, 2020). Putri and Suhana (2022) elucidate how workplace spirituality influences burnout among nurses caring for COVID-19 patients, suggesting that the burdens of heavy workloads and job pressures can be alleviated through workplace spirituality.

Workplace spirituality is defined as a condition in which nurses find meaning in their work, enabling them to understand and express themselves through their professional experiences (Aiken et al., 2014). In healthcare facilities, workplace spirituality can be perceived through interpersonal, intrapersonal, and work relationships, fostering a sense of community within the workplace environment (Schuster & Dwyer, 2020). To provide a comprehensive overview of nurses' perceptions regarding the benefits of spirituality at work, this scoping review aims to ascertain the available information on the impact of workplace spirituality on nurses' resilience and mental health in sub-Saharan Africa.

4.3 Methods

4.3.1 Methodological Approach

The methodological approach that underpins this review is outlined in detail in Chapter 3. Readers are referred to that chapter for a comprehensive account of the scoping review methodology employed in this study.

4.3.2 Protocol Registration with Open Science Framework

The protocol was registered with the Open Science Framework (OSF) on 28 October 2025 by the primary researcher (NP) and supervisor (CZM): Mahlaba and Madlabana (2025). It is accessible via the following public registration DOI: https://osf.io/v6yzu. Registration was undertaken to enhance transparency, promote research integrity, and safeguard intellectual ownership (Kim, 2022). A preliminary search confirmed that no previous scoping reviews on this specific topic had been published at the time of registration.

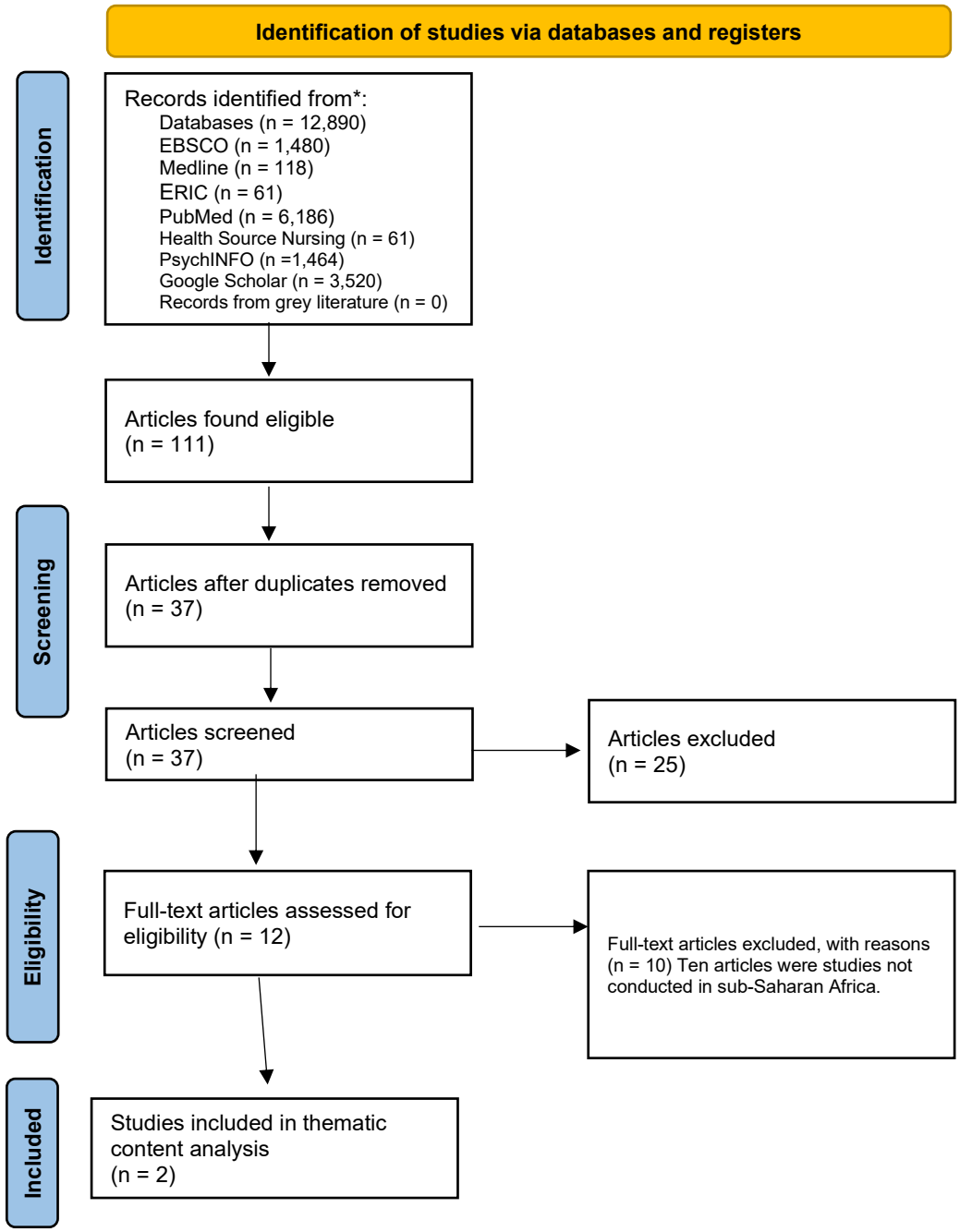
4.4 Results

4.4.1 Screening results

Figure 4.1 presents the screening results for this scoping review. A total of 12,890 studies were retrieved from the database search. Following a comprehensive search and screening of the study titles, a total of 111 studies were deemed eligible for inclusion. During title screening, 74 duplicates were identified and removed, resulting in 37 studies being included for abstract screening. The abstract screening process excluded 24 articles as they did not meet the inclusion criteria for this study. Consequently, 12 articles were retained for full article screening. Following this process, ten articles were excluded, leaving two articles eligible for data extraction and quality appraisal. The reasons for excluding the ten articles post-full article screening were primarily due to their not being conducted in sub-Saharan Africa and a lack of clarity regarding the populations studied (Aakola, 2021; Baber, Baber, & Virgilio, 2024; Baskar & Indradevi, 2023; Batalla et al., 2019; Birnie, 2019; Baldacchino, 2017; Pirkola, Rantakokko & Suhonen, 2016; Rhyu, Lee & Baek, 2023). All screening results are presented in the PRISMA chart below.

Figure 4.1:

PRISMA Scr Flow Chart Showing Literature Search and Selection of Studies



4.4.2 Characteristics of Included Studies

The characteristics of the two included studies are presented in Table 4.1. All included studies reported on the benefits of workplace spirituality among professional nurses in sub-Saharan Africa, published between 1978 and 2025 (;Chandramohan & Bhagwan, 2016; Nkomo, 2013). These two studies were conducted in Africa. One article reported on a study

conducted at an academic hospital (Nkomo, 2013), and the second on a study conducted at a public hospital (Chandramohan & Bhagwan, 2016).

Table 4.1:

Characteristics of Included Studies

Author, Year and Title	Country	Study Aim	Sample/Population	Number of Participants	Research Method/Design	Findings
Nkomo (2013) An exploration of the understanding of spirituality among patients and staff of the Chris Hani-Baragwanath Hospital.	South Africa	To explore the views of healthcare professionals on the subject of spirituality, particularly in relation to their practices at Chris Hani Baragwanath Hospital.	Nursing personnel, social workers, and allied health professionals	48 out of 48, including 12 professional nurses	Qualitative (focus group interviews)	**Understanding of Spirituality –** The understanding of spirituality was consistent across participants, with varying definitions, including personal beliefs, connections with a higher power, and existential questions related to their work. **Impact of Spirituality in Healthcare –** Spirituality was reported to positively influence job satisfaction, commitment, and personal fulfilment among healthcare professionals. **Job Satisfaction –** Healthcare professionals indicated that their spirituality contributed to their motivation and sense of purpose in their work, perceiving their role as a calling that emphasised a deeper connection to their professional responsibilities. **Cultural and Spiritual Competency –** Training for healthcare professionals on spiritual competencies was emphasised to ensure that diverse beliefs are understood and respected.
Chandramohan and Bhagwan (2016) Utilisation of spirituality and spiritual care in	South Africa	To understand and evaluate the role of spirituality and spiritual care in nursing practice among professional	Professional nurses	550	Quantitative	**High Acceptance of Spirituality in Nursing –** Spirituality and spiritual care are recognised as important dimensions of nursing practice. Participants believed that personal spirituality influenced their professional approach.

Author, Year and Title	Country	Study Aim	Sample/Population	Number of Participants	Research Method/Design	Findings
nursing practice in public hospitals in KwaZulu-Natal, South Africa. .		nurses in KwaZulu-Natal.				**Need for Preparedness –** Training on spirituality to ensure preparedness was emphasised. **Ethical and Personalised Care –** The study found that spirituality-based nursing practices were aligned with ethical principles. Nurses reported engaging in various practices, such as praying for patients, showing kindness, and facilitating connections to spiritual leaders, which they considered integral to providing holistic care.

4.5 Summary of Findings

Thematic content analysis was conducted, and the findings are reported according to the following research questions: the perceptions of nurses regarding workplace spirituality, resilience, mental health, and the current trends related to the discouragement of workplace spirituality. The studies included were conducted in healthcare facilities, and the findings underscored the importance of nurses' spirituality, patients' spirituality, and the significance of applying spirituality when providing care to patients. The perceptions of nurses about workplace spirituality encompassed these dimensions, as they form an integral part of their daily work.

Q.1 The Perceptions of Nurses Working in sub-Saharan Africa on Workplace Spirituality.

Nurses perceived spirituality as an integral aspect of their work, enhancing their satisfaction in the tasks they perform daily (Nkomo, 2016). Furthermore, nurses reported that workplace spirituality aids them in finding meaning and a sense of purpose in their roles. Nkomo (2016) noted that nurses view spirituality as a means of seeking meaning in their work and the rationale for engaging in such work. Nurses also regard their profession as a spiritual journey; according to Chandramohan (2016), approximately 89% of nurses who participated in his study affirmed that nursing is part of their spiritual life. This suggests, as noted by Chandramohan and Bhagwan (2016), that personal spirituality significantly influences nurses' professional practice and attitudes towards patient care. Additionally, nurses perceive workplace spirituality as a source of inner peace and personal fulfilment to the extent that they consider their work a calling (Nkomo, 2016). They also believe that spirituality provides support in their daily activities. Embracing multiple views – there is a consensus that recognising and accepting the various interpretations of spirituality among healthcare workers is crucial in fostering a more inclusive environment that respects diverse beliefs (Nkomo, 2016).

Q.2 The Benefits of Workplace Spirituality for Nurses

- **Positive impact** on patient care – Nurses believe that spirituality at work encourages compassionate and holistic care towards patients (Nkomo, 2016). Chandramohan and Bhagwan (2016) also reported that 91% of nurses acknowledged encountering patients with spiritual needs, highlighting their awareness of the spiritual dimensions in patient care and their commitment to addressing these needs.

- **Enhance relationships –** The promotion and understanding of spirituality in the workplace, according to nurses, enhance positive relationships among staff and contribute to a supportive work environment (Nkomo, 2016). Understanding one's spirituality and that of colleagues and patients is perceived as crucial in enhancing knowledge and understanding, which assists them in applying this knowledge in their daily encounters.

Other related psychological constructs:

1) Nurses' perception of the benefits of workplace spirituality on mental health

Healthcare organisations are encouraged to recognise their obligation to address the spiritual needs of both patients and staff (Nkomo, 2016). This trend is also supported by Chandramohan et al. (2016), who advocate for a holistic approach to nursing that includes spirituality as a fundamental aspect of care, thereby enhancing the well-being of both patients and staff.

Q3. The current trends related to workplace spirituality in the SSA context: **Recognition of the importance of spirituality**

The two included studies reported the importance of training and education for professional nurses on workplace spirituality. They recommend that spirituality in the workplace should be incorporated into training curricula, integrating both Western and indigenous belief systems to enhance cultural and spiritual competency in practice (Nkomo, 2016; Chandramohan et al., 2016). Another trend reported by Nkomo (2016) is the creation of a supportive organisational culture. It is indicated that fostering a workplace culture that respects and supports spiritual needs and the free expression of these needs can lead to higher employee commitment, reduced burnout, and improved job satisfaction, indicating a trend towards a more inclusive organisational approach to employee spirituality.

- **Connection to the Organisational Culture –** Nurses feel that the organisational context and culture play a significant role in how workplace spirituality is perceived and realised. A study conducted by Chandramohan and Bhagwan (2016) revealed that 83.1% of nurses perceived that a workplace that ethically accepts practices like praying with or for patients should be acceptable in the nursing context

4.6 Reflection

Spirituality in healthcare organisations appears to be an important element for both patients and nurses, and its positive contribution to the psychological and emotional well-being of staff seems to be one of the main reasons for promoting spirituality in the healthcare system (Nkomo, 2016; Chandramohan et al., 2016). The importance of workshops and seminars to enhance knowledge on the integration of spirituality in the workplace remains crucial to avoid discrimination that might arise from differing beliefs and understandings of spirituality in the workplace (Nkomo, 2016; Chandramohan et al., 2016).

Quality Appraisal

Quality assessments of the two included studies were conducted (Nkomo, 2013; Chandramohan & Bhagwan, 2016). Of the two studies, one (50%) was quantitative (Chandramohan & Bhagwan, 2016), and the other (50%) was qualitative (Nkomo, 2013). During the review process of the quantitative article, discrepancies emerged among the reviewers regarding certain responses. Consequently, a consultation meeting was convened to discuss these differing viewpoints. Following thorough deliberation and reassessment of the article, consensus was reached, and the reviewers agreed on the final interpretations and revisions. The results of the MMAT quality appraisal indicated that 100% of the assessed studies (Chandramohan & Bhagwan, 2016; Nkomo, 2013) scored 100% and were deemed to be of high quality.

4.7 Discussion

This study has mapped the available evidence on the benefits of workplace spirituality among professional nurses in sub-Saharan Africa, as well as its impacts on nurses' resilience and mental health. Additionally, it aims to ascertain trends regarding the promotion of workplace spirituality in healthcare facilities. The findings of this review indicate that there are benefits associated with workplace spirituality for nurses. Job satisfaction, personal fulfilment, and a sense of meaning that nurses experience in their work is among the benefits reported in this study (Nkomo, 2016). Another finding highlights that fostering workplace spirituality increases feelings of acceptance and respect for individual contributions, which boosts organisational performance and cohesion, leading to improved motivation, engagement, and overall well-being among nursing professionals. The findings of this review also reveal that spirituality in the workplace contributes to positive emotions, support, fulfilment, and coping mechanisms, which are crucial for maintaining mental health. Nurses perceive spirituality as a source of

strength that aids them in managing occupational stress, professional pressures, and personal challenges, thereby promoting their mental well-being (Nkomo, 2016; Chandramohan & Bhagwan, 2016). These results clearly indicate that incorporating spirituality can foster a supportive environment, enhance resilience, and reduce feelings of burnout and exhaustion among nurses. The results of this study demonstrate positive perceptions among nurses regarding the benefits of incorporating spirituality in the workplace, which is viewed as a means to enhance service delivery, foster positive relationships, and provide support for both staff and patients. They believe that expressing spirituality freely can improve interpersonal interactions, increase mutual trust, and create a sense of purpose and fulfilment in their roles. Healthcare workers also perceive the promotion of spirituality as a way to view their work as a calling, thereby increasing their motivation and commitment.

Although nine studies were excluded from this review for not fully meeting the inclusion criteria, their relevance to the overarching objectives of the study warrants acknowledgement. Notably, these studies reinforce and complement the findings from the selected literature, thereby offering valuable insights into the broader international context of workplace spirituality in nursing.

The two primary objectives of the current study were:

1. **To ascertain the perceptions of nurses working in sub-Saharan Africa regarding workplace spirituality.**
2. **To ascertain the benefits of workplace spirituality for nurses.**

The findings from the excluded international studies align with these objectives as outlined below:

Objective 1: To Ascertain the Perceptions of Nurses on Workplace Spirituality

The international literature consistently recognises workplace spirituality as a meaningful and relevant concept in nursing practice. Specifically:

- **Workplace spirituality is perceived as enhancing team cohesion and collaboration**, as reported by Birnie (2019), who noted that a spiritually supportive environment fosters a greater sense of teamwork and collegiality among healthcare staff.
- **Spirituality at work is also perceived as a foundation for compassionate behaviour**, as evidenced by Rhyu (2022) and Ribeiro (2020), who found that nurses who

experience spiritual fulfilment in the workplace tend to demonstrate greater empathy, kindness, and patient-centred care.

- Additionally, several studies (e.g., Baldacchino, 2017; Pirkola, 2016; Baskar, 2021) highlight that workplace spirituality is often viewed by nurses as a source of personal meaning and alignment with professional values, contributing to a sense of purpose in their roles.

These findings suggest that, internationally, nurses perceive workplace spirituality not merely as a personal or religious concept but as a relevant and impactful dimension of professional life that enhances interpersonal relationships and fosters a sense of shared purpose within healthcare teams.

Objective 2: To Ascertain the Benefits of Workplace Spirituality for Nurses

A consistent theme across the excluded international studies is the positive impact of workplace spirituality on various dimensions of nurses' professional and personal well-being. Key reported benefits include:

- **Increased job satisfaction and organisational commitment**
  Studies by Baldacchino (2017), Pirkola (2016), and Baskar (2021) found that workplace spirituality contributes to higher levels of job satisfaction and a stronger emotional connection to the organisation, which in turn supports retention and morale.
- **Enhanced employee engagement and well-being**
  The same studies reported that nurses who experience a sense of spirituality in the workplace tend to be more engaged, emotionally balanced, and psychologically resilient, indicating that spiritual well-being may act as a buffer against occupational stress.
- **Improved quality of patient care and reduced staff turnover**
  Spirituality at work was also linked to improved patient outcomes, as spiritually grounded nurses reported greater attentiveness, empathy, and ethical commitment to care (Baskar, 2021; Baldacchino, 2017). These effects were associated with reduced turnover intentions and a more stable workforce.
- **Reduction in burnout and improved resilience**
  Birnie (2019) and Rhyu (2022) documented that spiritual practices and values in the workplace contribute to lower levels of burnout and fatigue by enhancing nurses' ability to cope with the emotional demands of their profession.

- **Promotion of compassionate behaviour and holistic care**
  Ribeiro (2020) found that workplace spirituality fosters behaviours that support compassionate, patient-centred care, which further enhances nurses' sense of professional fulfilment and purpose.

Taken together, the findings from these excluded international studies reinforce the relevance of workplace spirituality as a globally recognised factor contributing to nurses' well-being, resilience, and quality of care. Although these studies were not included in the formal synthesis due to methodological or contextual differences, their alignment with the current study's objectives affirms the broader applicability and significance of workplace spirituality in nursing across diverse cultural and healthcare contexts.

4.8 Strengths and limitations of this scoping review

The strengths of this study include an extensive search for relevant studies, which involved the services of the UKZN librarian and the use of Boolean terms to increase the likelihood of obtaining eligible studies. Additionally, the full article screening tool was piloted, resulting in enhanced reliability. The two included primary studies underwent quality appraisal using an approved tool, the Mixed Method Appraisal Tool (MMAT), for methodological assessment of the included primary studies.

Despite these strengths, there are limitations due to the limited empirical literature on workplace spirituality in sub-Saharan Africa, specifically focusing on nurses in healthcare facilities. When searching for studies on workplace spirituality in sub-Saharan Africa, it appeared that this topic has received attention primarily in the education and corporate sectors. Little is known or investigated regarding workplace spirituality in the healthcare sector. Another limitation of this scoping review is that the study primarily focused on literature from Sub-Saharan Africa. This geographical focus may have limited the inclusion of studies conducted in other regions and excluded relevant literature on workplace spirituality across healthcare facilities in different global contexts. Consequently, the findings may not fully reflect the broader international perspectives on workplace spirituality in healthcare settings. Future research should therefore consider exploring workplace spirituality in healthcare facilities across diverse global contexts to provide a more comprehensive understanding of the phenomenon. These identified limitations in the literature provide a strong motivation for

further research to explore workplace spirituality and related psychological constructs, such as mental health and resilience among Professional nurses. Future studies should investigate these concepts across diverse healthcare settings worldwide to generate a more comprehensive, contextually inclusive understanding of workplace spirituality and its influence on the well-being of professional nurses.

4.9 Recommendations for Future Research

4.9.1 Contextual and Scope Limitations

The researcher recommends that future research should be conducted across a wider array of healthcare settings beyond the current focus on hospitals and healthcare facilities, including clinics, private hospitals, and primary healthcare facilities. Expanding the scope in this manner would allow for a more comprehensive and representative understanding of workplace spirituality and its association with resilience and mental health within the broader South African healthcare context.

4.9.2 Examine Longitudinal and Causal Pathways

Longitudinal and intervention-based studies are also recommended to examine the extent to which the enhancement of workplace spirituality over time contributes to sustained improvements in nurses' mental health and resilience. Such research should also explore the potential impact of these changes on staff retention and the overall quality of patient care.

4.9.3 Investigate Organisational and Policy-Level Influences

There is a critical need for the development and empirical evaluation of workplace spirituality-based interventions, such as reflective practice groups, values-driven leadership training, and mindfulness-based programmes within healthcare settings. Such interventions should be systematically designed and rigorously tested to assess their effectiveness in mitigating burnout and strengthening coping mechanisms among nurses and other healthcare professionals. Implementing evidence-based spirituality-focused strategies may offer valuable insights into promoting psychological well-being and resilience across diverse healthcare environments.

4.9.4 Link to Patient Care Outcomes

Future research should explore the potential impact of nurses' workplace spirituality and resilience on key patient care outcomes, including quality, safety, and satisfaction. Investigating these relationships may yield valuable evidence to support the integration of workplace spirituality into organisational well-being strategies. Such findings could inform healthcare leadership and policy by demonstrating the broader implications of fostering

spiritual well-being among nursing staff for enhancing patient-centred care and overall service delivery.

4.10 Implications for Practice

4.10.1 Recognition of Workplace Spirituality as a Contributor to Mental Well-being

The study highlights that workplace spirituality is positively associated with improved mental well-being among nurses, suggesting that spiritual dimensions play a meaningful role in supporting psychological health in high-stress healthcare environments.

4.10.2 Influence on Leadership and Organisational Culture

Findings suggest that leadership approaches and organisational cultures that acknowledge and support workplace spirituality may foster greater resilience, emotional well-being, and professional fulfilment among nursing staff.

4.10.3 Impact on Patient Care and Service Delivery

The results indicate that nurses who experience higher levels of workplace spirituality may contribute to improved patient care, safety, and satisfaction, implying a potential link between staff spiritual well-being and overall healthcare service quality.

4.10.4 Contribution to Staff Motivation and Engagement

The study reveals that a spiritually supportive work environment may enhance nurses' sense of purpose and motivation, indicating that spiritual fulfilment is intertwined with professional engagement and commitment.

4.10.5 Support for a Holistic View of Workforce Well-being

The study highlights the importance of adopting a holistic approach to healthcare workforce management, recognising that emotional, psychological, and spiritual dimensions are integral to staff well-being and performance.

4.11 Conclusion

The evidence indicates that workplace spirituality plays a significant role in enhancing nurses' resilience, mental health, and overall job satisfaction in healthcare settings across sub-Saharan Africa. Incorporating spirituality into the work environment fosters a sense of purpose, acceptance, and support among nurses, thereby mitigating stress, burnout, and emotional strain. Despite the recognised benefits, there remains limited empirical research specifically focused on this context, emphasising the need for more targeted studies. Promoting an inclusive, value-based approach that respects diverse beliefs could enhance nurse well-being and, consequently,

the quality of patient care. To realise these benefits, healthcare policies should consider strategies that integrate spirituality into organisational culture, thereby supporting nurses' holistic health and professional fulfilment.

4.12 Chapter Summary

This chapter mapped the available evidence on the benefits of workplace spirituality among professional nurses in sub-Saharan Africa, with particular attention to its influence on nurses' resilience and mental health. The review also explored emerging trends in promoting workplace spirituality in healthcare facilities. The findings indicate that workplace spirituality offers several benefits for nurses, including increased job satisfaction, personal fulfilment, and a greater sense of meaning in their work. These factors contribute positively to nurses' overall professional experiences and engagement in their roles.

The review further revealed that fostering workplace spirituality promotes a culture of acceptance and respect for individual contributions within healthcare settings. Such an environment enhances organisational cohesion and performance while improving motivation, engagement, and the overall well-being of nursing professionals. Additionally, the findings highlight that workplace spirituality contributes to positive emotions, emotional support, fulfilment, and effective coping mechanisms. These aspects are particularly important for maintaining nurses' mental health and enabling them to manage occupational stress, professional demands, and personal challenges.

The results also demonstrate that nurses perceive spirituality as a source of strength that enhances their resilience and helps mitigate burnout and exhaustion. Many nurses believe that integrating spirituality into the workplace can create a supportive environment that benefits both staff and patients. Furthermore, participants in the reviewed studies indicated that the freedom to express spirituality can strengthen interpersonal relationships, foster trust among colleagues, and provide a deeper sense of purpose in their work. In this regard, healthcare workers often view their professional roles as a calling, which increases their motivation and commitment to service delivery.

Although nine studies were excluded from the final review because they did not meet the inclusion criteria, their relevance to the broader objectives of the study is acknowledged. These studies nonetheless contribute valuable insights into the international discourse on workplace

spirituality in nursing and reinforce many of the findings identified in the selected literature. Overall, the chapter highlights the significant role workplace spirituality can play in promoting nurses' well-being, resilience, and effectiveness within healthcare environments.

CHAPTER 5:

PRIMARY RESEARCH STUDY METHODOLOGY

5.1 Introduction

This chapter provides a detailed description of the research philosophy, research approach, design, and research methods employed to conduct the study. It outlines the rationale for the research, describes the data collection and sampling methods, and details the instruments used. Additionally, it provides a comprehensive account of the data collection processes and procedures, highlighting the analytical strategies employed and the measures taken to ensure quality data and uphold ethical considerations throughout the study.

The final part of the methodology section covers the proposed intervention mapping for this study. Intervention mapping is utilised to develop, implement, and evaluate an intervention to promote workplace spirituality and enhance nurses' resilience and mental well-being during a time of crisis.

5.2 Recapitulation of Research Objectives and Questions

The aim of the study was to explore professional nurses' perceptions of workplace spirituality, resilience, and mental health during a crisis, and to identify recommended actions that primary healthcare (PHC) management should consider improving frontline workers' preparedness in such situations. To achieve this aim, a constructivist paradigm guided the study, utilising a qualitative research approach. Data collection was conducted through three focus group interviews from three community healthcare centres in the uMgungundlovu district. These interviews, facilitated using semi-structured interview schedules, gathered insights into nurses' perceptions and experiences of workplace spirituality, resilience, and mental health during a crisis, drawing from their experiences with the COVID-19 pandemic and similar crises.

As outlined in Chapter 1, the central research question guiding the qualitative primary study is as follows:

- What are professional nurses' perceptions of workplace spirituality, resilience, and mental health during a crisis?
- What are the nurses' experiences of workplace spirituality, resilience, and mental health during a crisis?

- What do nurses recommend as actions that PHC management may consider towards improving frontline workers' preparedness during a health-related crisis? This is indicated in detail in Chapter 1.

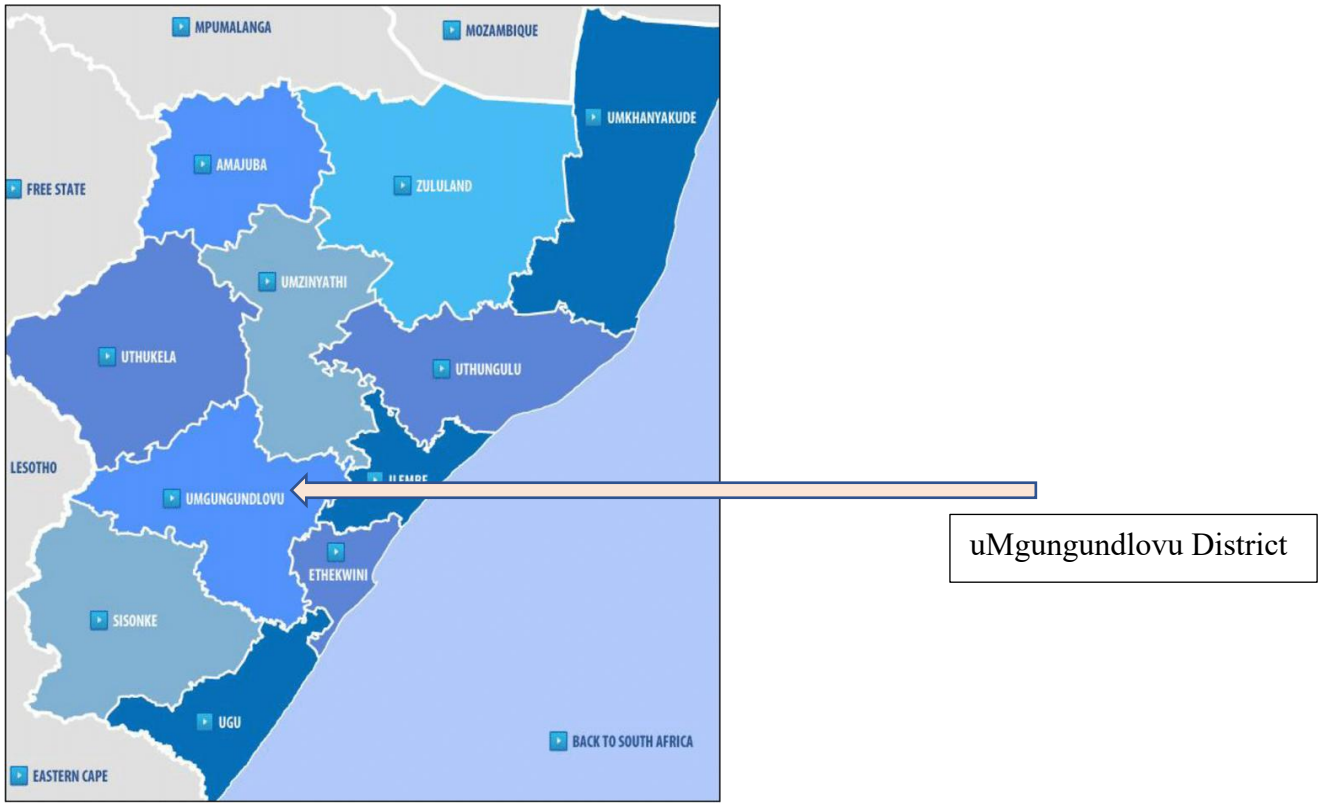
5.3 Research Setting

5.3.1 Research Site

This study was conducted in KwaZulu-Natal (KZN), one of South Africa's nine provinces. According to Statistics South Africa (2024), population estimates by province for 2024 indicate that KZN is home to the second largest population, with an estimated 1.234 million (19.6% of the total population). The province consists of nine district municipalities: Amajuba, iLembe, Sisonke, uGu, uMkhanyakude, uMgungundlovu, uMzinyathi, uThukela, uThungulu, and Zululand. This study was conducted in the uMgungundlovu District Municipality, which is one of the pilot sites for the national health insurance (NHI). There are three community healthcare centres (CHCs) in the uMgungundlovu Health district, namely, Bruntiville, East Boom, and Imbalenhle. The population sampled was drawn from 46 fixed clinics, 17 mobile clinics, and one state-aided clinic.

Figure 5.1:

KwaZulu-Natal Province



5.3.2 uMgungundlovu District Municipality

The uMgungundlovu District Municipality is classified as a Category C municipality in the KwaZulu-Natal Midlands. According to the Local Government, a category C municipality has municipal executive and legislative authority in an area that includes more than one municipality. It comprises seven Local Municipalities, namely Msunduzi, Impendle, Umshwathi, Mkhambathini, Mpofana, Umngeni, and Richmond Local Municipality. The community survey reported that the uMgungundlovu District has a total population of 1,095,865 and covers a geographical area of 9,603 square kilometres (Community Survey, 2016). Table 4.2 below provides the dependency ratio per municipality (2016).

Table 4.2:

Per Municipality Dependency Ratio

Municipality	**2016 Dependency Ratio**
Impendle	29,526
Mkhambathini	57,075
Mpofana	37,391
Msunduzi	679,039
Richmond	65,540
Umngeni	109,867
Umshwathi	111,645
TOTAL	**1,095,865**

The uMgungundlovu District delivers health services through 18 mobile clinics, two satellites, 54 clinics, three CHCs, two district hospitals, one regional hospital, one provincial tertiary hospital, three specialised psychiatric hospitals, and two specialised TB hospitals.

5.4 Research Paradigm

The concept of a research paradigm was first introduced by Thomas Kuhn (1962) in his seminal paper, "The Structure of Scientific Revolutions". A paradigm is defined by Kivunja and Kuyini (2017) as a philosophical way of thinking. Guba and Lincoln (1994) described a paradigm as a basic worldview that guides the researcher. Okesina (2020) defined it as the researcher's philosophical orientation or perspective that influences what should be studied, how it should be studied, and how the results are interpreted. Furthermore, Bertram and Christiansen (2020) noted that a paradigm also determines what is considered acceptable within a professional community. A paradigm comprises three main components: ontology, epistemology, and methodology.

Although many paradigms have been discussed in the literature, there is ongoing debate regarding their classification. For instance, Shah and Al-Bargi (2013) and Scotland (2012) divided research paradigms into three categories: critical theory, interpretivism/constructivism, and positivism. Guba and Lincoln (1994) added post-positivism as a fourth category.

By contrast, Saunders et al. (2019) categorised paradigms into five groups: positivism, postmodernism, interpretivism, initial realism, and pragmatism. The predominant paradigm for this study is constructivism, which will be discussed in the following paragraph.

5.4.1 Social Constructivism

Social constructivists assert that individuals seek to understand the environment in which they live and work, interpreting their experiences subjectively and assigning meaning to particular items or concepts (epistemology). The primary aim of constructivism or interpretivism is to comprehend the subjective nature of human experience (Guba & Lincoln, 1989). This indicates a deliberate attempt to grasp the perspective of the researcher or research observer. Krauss (2005) posited that the constructivist paradigm ensures that the focus remains on understanding people and how they perceive the world. Consequently, constructivist researchers begin with individuals and strive to understand how they interpret their surroundings, with their actual words serving as evidence of reality. This implies that people's interpretations of reality are based on the meanings they assign to their lives, and that meaning can be uncovered through conversation or language.

The ontology of constructivism is relativism (also known as relativist ontology), which assumes that knowledge can be produced or acquired from the perspective of the individual directly involved. It supports the notion that multiple realities exist in relation to any phenomenon under study (Ugwu et al., 2021). Subjectivism, the epistemology of

constructivism, asserts that knowledge is shaped by context and that both the researcher and research participants are engaged in the process of knowing (Nguyen, 2019). In other words, subjective epistemology presupposes that the researcher interprets the data using their own reasoning, which is influenced by their interactions with the participants.

Morgan (2007) and Lincoln and Guba (1985), and Santos et al. (2018) identified the following characteristics within the constructivist paradigm:

- The acknowledgment that the social world cannot be understood solely from the individual perspective.
- The recognition that context is crucial for knowledge and understanding.
- The belief that realities are multiple and socially constructed.
- The belief that causes and effect are mutually interdependent.
- The necessity to understand the individual rather than universal laws.
- The belief that contextual factors must be considered.
- The belief that individuals' words are evidence of realities.

These characteristics advocate for the utilisation of a qualitative approach in research projects.

Using the constructivist paradigm, the researcher aims to address questions regarding nurses' perceptions of workplace spirituality, resilience, and mental health, as well as to comprehend their recommendations for enhancing preparedness during crises. The constructivist paradigm is particularly suitable for this study, as it allows the researcher to gain an in-depth understanding of workplace spirituality, resilience, and mental health among professional nurses during a time of crisis from their own perspective.

5.4.2 Research Approach: Qualitative

Yin (2017) argued that defining a qualitative approach is challenging due to its broad applicability across various academic disciplines and professions. Yin (2017) asserted that qualitative research involves studying the meanings of people's lives as expressed under real-world conditions. Fundamentally, qualitative research poses open-ended questions such as "how" and "why", the answers to which are difficult to quantify (Tenny, Brannan & Brannan, 2017). Qualitative research employs questions that are generally inductive in nature, and these questions tend to be open-ended (Leavy, 2017). Tenny et al. (2017) noted that one of the strengths of qualitative research lies in its capacity to describe human behaviour patterns and processes that can be challenging to measure. While it may be difficult to precisely quantify

phenomena such as sensations, attitudes, and actions, the qualitative method enables participants to articulate their thoughts, feelings, and experiences at specific moments or during significant events.

5.4.3. Justification for qualitative research approach:

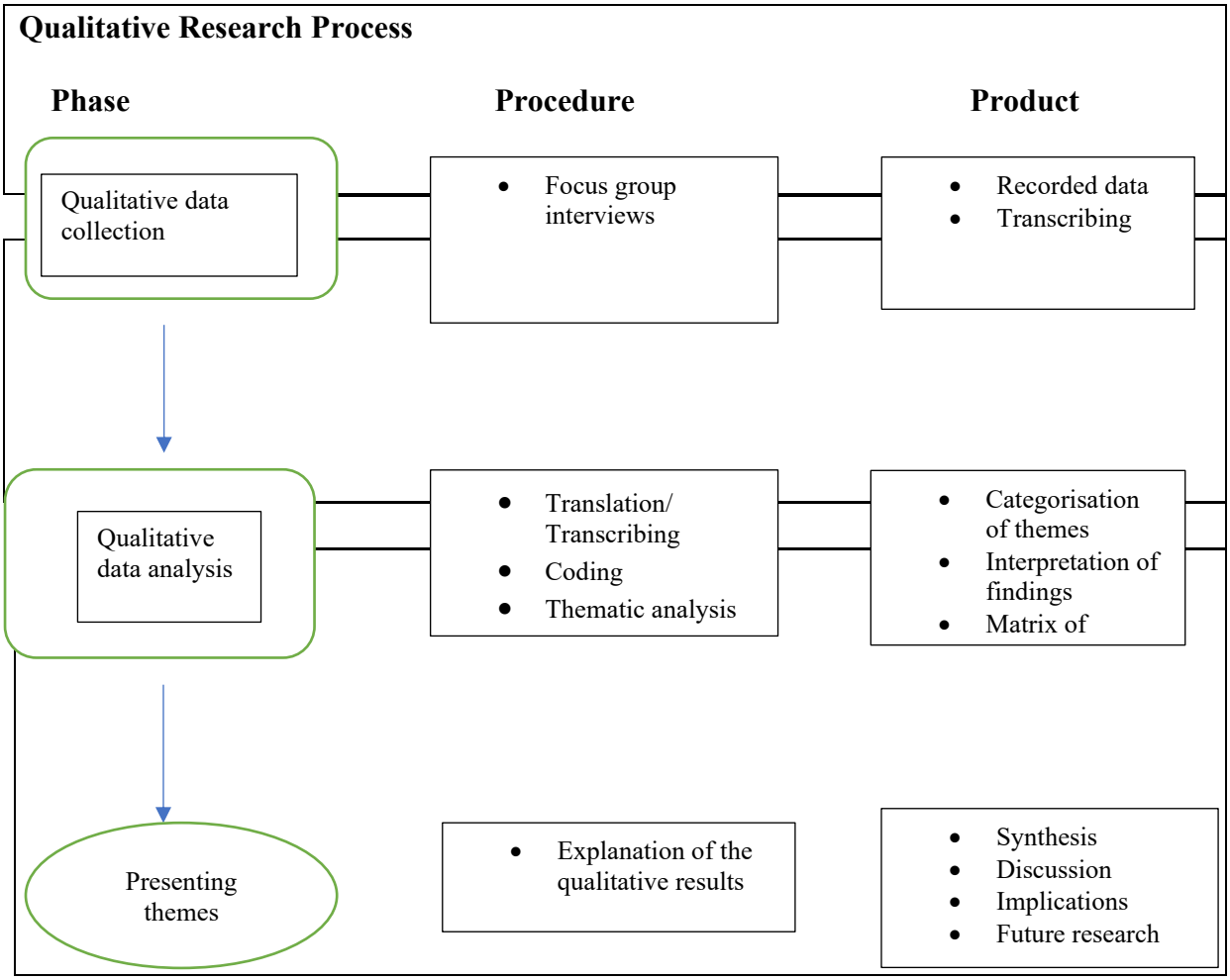
A qualitative approach is particularly appropriate when investigating complex, context-bound phenomena that require in-depth understanding rather than numerical measurement (Creswell & Creswell, 2018; Patton, 2015). Given that the study sought to understand subjective experiences in primary healthcare settings, the qualitative design enabled rich, detailed insights into participants' perspectives. Given the study's focus, the qualitative approach was deemed most appropriate for achieving its objectives. It facilitated an in-depth understanding of these subjective experiences.

5.5 Research Design

The emphasis of research designs is on gathering, analysing, and documenting data, drawing from various fields and applied throughout the research process.

Figure 5.2:

Qualitative Research Process



5.5.1 Sample and Sampling Technique

The study was conducted in three health facilities within the uMgungundlovu Health District, namely, Bruntville, East Boom, and Imbalenhle clinics. Participants were selected using purposive and snowball sampling methods. Purposive sampling allows researchers to deliberately select participants who have specific knowledge or experience relevant to the research problem (Creswell & Poth, 2018). Each Community Health Centre (CHC) was purposefully chosen to capture potential contextual variations across key organisational dimensions, including organisational culture, organisational climate, leadership style, and the availability of support structures. Recognising that workplace spirituality is not a standalone construct but is deeply embedded in the broader organisational culture and leadership practices, the inclusion of multiple CHCs aimed to enhance the study's ability to capture diverse perceptions. Leadership style, as both a reflection and a driver of organisational culture, plays a critical role in shaping employee experiences – particularly in relation to resilience and well-

being. As Schein (2010) posits, leaders are the ‘architects of culture,’ especially during periods of organisational establishment or transformation. Given the influence of leadership on both organisational culture and employee outcomes, it was essential for this study to gather contextually rich data from various CHCs. This multi-site approach strengthens the transferability of findings by ensuring that the results are not limited to a single institutional context but instead reflect a broader spectrum of organisational environments within the district.

5.5.2. Rational for the use of the focus group

In selecting an appropriate data collection method for this study, focus group discussions were considered particularly suitable because they generate rich, in-depth qualitative data through interactive dialogue among participants. The interactive nature of focus groups enables participants to build on one another’s ideas and experiences, thereby facilitating deeper exploration of shared perceptions, attitudes, and experiences. This method was therefore considered appropriate for exploring professional nurses' collective experiences of workplace spirituality, resilience, and mental health within their work environments. Through group interaction, participants can reflect on and respond to one another’s viewpoints, often leading to insights that might not surface in individual interviews (Nyumba et al., 2018; Krueger, 2014).

In addition, focus groups were considered advantageous for this study because they allow the researcher to gather multiple perspectives within a relatively short period while observing group dynamics and interactions. This is particularly valuable when exploring workplace experiences, as participants may recognise shared challenges and coping strategies through the discussion. In this research, the group setting enabled professional nurses to collectively discuss their experiences of workplace conditions and how these experiences influence their resilience and mental well-being.

While the benefits of focus groups informed their selection as a data collection method, the potential limitations of this approach were also carefully considered during the research design and data collection. One commonly identified limitation is that group dynamics may influence participation, as more dominant individuals may overshadow quieter participants (Biswas, 2025). To address this, the researcher adopted a facilitative role during the discussions, encouraging balanced participation and ensuring that all participants had an opportunity to

share their views. Probing questions were also used to invite input from participants who appeared less vocal, thereby promoting inclusive engagement.

By acknowledging these potential limitations and implementing strategies to mitigate their effects, the researcher ensured that the focus group discussions provided a credible and meaningful method for collecting qualitative data. Consequently, the use of focus groups enabled the study to capture a range of perspectives and shared experiences, thereby contributing to a deeper understanding of workplace spirituality, resilience, and mental health among professional nurses.

5.5.3. Rationale for the Use of Three Focus Groups

The decision to conduct three focus group discussions (FGDs) was strategically informed by both methodological and practical considerations. Each focus group was held at a different Community Health Centre (CHC) within the district to reflect contextual variation across organisational settings. This approach allowed the identification of common themes while enabling a comparative analysis of differences arising from distinct organisational cultures, leadership styles, or support structures. The inclusion of three facilities provided sufficient breadth to capture variation across sites without overextending the study's scope, thereby balancing the need for depth of discussion within each group and breadth of representation across the district. Each focus group consisted of eight participants, which aligns with Krueger and Casey's (2015) recommended size range of 6 to 10 participants. This size was small enough to ensure that each nurse could meaningfully contribute to the dialogue while also being large enough to capture a diversity of perspectives within each healthcare facility.

From a qualitative research standpoint, the number of focus groups was also guided by considerations of data saturation. Guest et al. (2017) argue that in studies involving relatively homogenous participant groups, such as nurses operating within a shared professional context, saturation can often be achieved within two to four focus groups. Given that all participants in this study were nurses or nursing professionals, three focus groups were deemed sufficient to reach thematic saturation while enabling cross-facility comparison. Moreover, practical and ethical constraints within the healthcare setting further influenced this design. Staffing limitations, shift work patterns, and patient care responsibilities necessitated a manageable number of data collection sessions to avoid disruption of essential services and to respect participants' time and availability.

Finally, the inclusion of multiple CHCs contributed to a richer and more nuanced understanding of workplace spirituality and its perceived influence on resilience, mental well-being, and organisational functioning. By drawing insights from different institutional contexts, the findings offer enhanced transferability and relevance, not only to individual facilities but to the broader district health system. This strategic design ensures that the study's outcomes are both contextually grounded and analytically robust.

5.5.4. Selection Criteria

To be eligible to participate in the study, nurses needed to be registered as professional nurses. The definition of a "Professional Nurse" provided earlier is a paraphrased summary of official definitions and requirements outlined by the South African Nursing Council (SANC) and the Nursing Act, 2005 (National Department of Health, 2005). While the summary captures the essence of the official descriptions, it is not a direct quote from a single source. For instance, the Nursing Act, 2005 (Act No. 33 of 2005) defines a "professional nurse" as, "a person registered as such in terms of section 31".

Additionally, the scope of practice and responsibilities of a Professional Nurse are detailed in SANC's documents, which outline the roles and expectations of nurses in various healthcare settings.

The nurses were expected to have worked during a time of crisis and with five years or more of experience. The sample consisted of professional nurses and operational managers. The data collection took place over five days.

5.5.5. Research Instrument

The data collection process was conducted using a semi-structured interview schedule. The interview schedule was developed using open-ended questions that were informed by the aims of the research, as well as the constructs of interest. This approach, as advocated by Breakwell (2012), facilitated the collection of rich and detailed descriptions of the phenomenon under study. By employing open-ended questions, the researcher adhered to an open inductive approach to data collection and analysis. This methodology, as outlined by Breakwell (2012), enabled the exploration of the phenomenon in depth. The interview schedule included open-ended questions regarding nurses' perceptions of spirituality, workplace spirituality, resilience, and mental health during times of crisis. Additionally, it explored recommendations for managers and professional nurses to improve crisis preparedness. The interview schedule was

approved by the research supervisor and the University ethics committee prior to use. A copy of the interview schedule can be found in Appendix 1.

5.5.6. Data collection

Documentation of the ethical clearance, ethical approval from the Department of Health and gatekeeper approval is provided in **Appendix A**, **Appendix B**, and Appendix **D**, respectively. The study adhered to all ethical principles outlined in the University's research policy, including voluntary participation, informed consent, confidentiality, and the right to withdraw without penalty.

The researcher contacted the three facility managers of the different clinics to discuss proposed dates for data collection, the study's purpose, and its potential benefits to the facility. Initial agreements were reached, with the first clinic scheduled for 16 October and the second for 17 October.

Prior to the first data collection session, the researcher followed up with the facility manager to ensure everything was arranged. However, the facility manager informed the researcher that he would not be on-site on 16 October but had delegated responsibility to the nursing manager in charge. Upon arrival at the clinic, the researcher was told that no one was aware of the arrangements, and participants were not ready. The researcher met with the manager in charge, who requested a briefing on the study and an explanation of the inclusion criteria for the unit managers. After the meeting, the unit managers requested that the data collection be rescheduled for the following week to allow time to prepare the nurses. To adhere to ethical guidelines and ensure informed consent, the researcher agreed to the postponement, allowing participants to make voluntary decisions regarding their participation. The rescheduled data collection was set for the following Monday.

On the rescheduled date, the researcher arrived at the clinic in the morning, and the nursing manager provided the study venue. Before proceeding, the nursing manager allowed the researcher to present the study to potential participants. During the presentation, the researcher explained the study's purpose, rationale, and participants' rights, including the right not to participate, the right to confidentiality and anonymity, and the right to withdraw without any prejudice. The researcher also requested permission to record the interviews, stating that the recordings would be used solely for transcription. Eight participants attended the session, which was scheduled for 45–60 minutes, though it lasted 1 hour and 10 minutes due to full participation and engagement. During data collection, the researcher observed that two nurses appeared emotional due to post-traumatic stress exposure. The researcher offered a 5-minute

break, but the nurses requested that the session continue, noting they would stay behind afterwards. The researcher offered a debriefing session as a registered psychologist and wellness specialist. The researcher further recommended psychosocial support.

A similar situation occurred at the second CHC. The facility manager and nursing manager agreed to conduct data collection on 18 October. However, upon arrival, the researcher learned that the nursing manager had delegated arrangements to a subordinate, causing a delay. After waiting for over three hours, the nursing manager informed the researcher that data collection could not proceed due to staff shortages and requested rescheduling for the following week. Upon returning on the new date, the researcher found the clinic unprepared, and the session began two hours late with six participants. During the session, one participant became very emotional while recalling her experiences during the COVID-19 pandemic. The researcher requested a five-minute break to allow the participant to regain her composure. The session resumed once the participant and others were relaxed. A debriefing session was provided, and appropriate referrals were made.

5.5.7. Reflexivity During the Focus Group Discussions

Reflexivity refers to a continuous, critical process through which researchers engage in self-awareness and self-examination to understand how their identities, experiences, assumptions, and social positions shape the research process and the construction of meaning. It involves an ongoing journey of learning and unlearning, whereby researchers recognise their active role in co-creating knowledge with participants (Palaganas et al., 2017). Reflexivity requires careful consideration of the dynamic and intersecting relationships between the researcher and participants, including factors such as race, socio-economic status, age, and cultural background, which may influence data generation and interpretation (Berger, 2015). As a foundational component of qualitative research, reflexivity enhances the rigour, credibility, and trustworthiness of findings by encouraging researchers to critically monitor the impact of their biases, beliefs, and personal experiences (Teh & Lek, 2018). Despite being a longstanding and often challenging practice, reflexivity remains essential for maintaining a balance between subjective insight and broader analytical understanding in qualitative inquiry (Mitchell et al., 2018).

Throughout the focus group discussions, the researcher maintained a reflexive stance to ensure that personal beliefs, assumptions, and positionality did not influence data collection. Reflexivity requires continuous self-awareness of how the researcher's background, values,

and perspectives may shape interactions with participants or the interpretation of responses. Although the researcher identifies as a Christian, the study included participants from diverse religious and spiritual backgrounds, including those who believed in ancestral practices and those who identified as Muslim. The researcher remained consciously aware of this diversity and intentionally created an inclusive and respectful environment in which participants could freely express their own beliefs and perceptions without fear of judgment or bias.

During the discussions, care was taken not to impose personal views or spiritual interpretations on participants' responses. Instead, open-ended questions were used to encourage participants to articulate their own understandings of workplace spirituality, resilience, and mental health. Neutral probing techniques were applied to deepen responses while maintaining objectivity and respect. This approach helped ensure that the discussions reflected the participants lived experiences rather than the researcher's assumptions.

The researcher also reflected on her role as a facilitator rather than a participant in the discussions. By maintaining professional boundaries, actively listening, and encouraging balanced participation, the researcher aimed to minimise power imbalances and support an environment of openness and trust. This reflexive stance contributed to the credibility and integrity of the data collection process and ensured that the findings were grounded in participants' authentic perspectives.

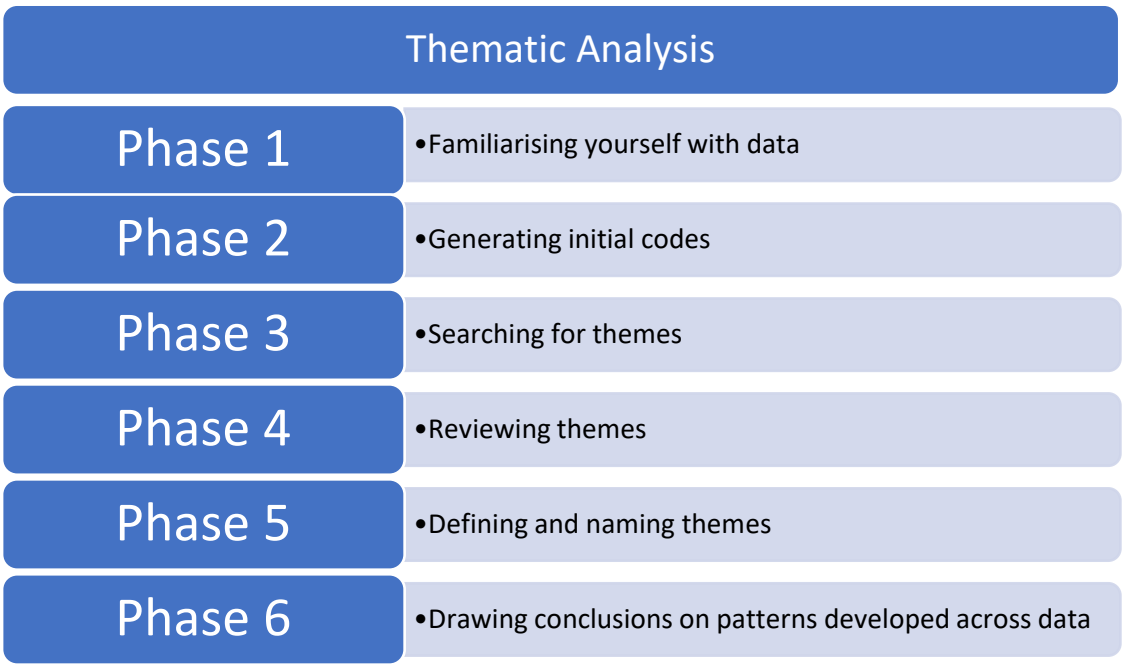
5.5.8. Data Analysis

To maintain anonymity and confidentiality, all interviews were coded exclusively by the researcher. The audio recordings were transcribed verbatim, and every effort was made to minimise bias and distortion. Thematic analysis was employed to analyse the data (Nowell, Norris, White, & Moules, 2017). Thematic analysis is the process of identifying recurring patterns of meaning within a data set, such as texts, focus groups, or interviews (Braun & Clarke, 2006). Thematic analysis is widely recognised as a rigorous and flexible method for analysing qualitative datasets, allowing researchers to generate meaningful themes aligned with research objectives (Braun & Clarke, 2006; Braun & Clarke, 2021). This approach enabled a structured interpretation of participants' narratives while maintaining methodological transparency.

The accessibility and theoretical flexibility of this method, which allows for analysing qualitative data through patterns of meaning across data content, make it popular in qualitative research (Clarke & Braun, 2017). The following are the six steps that the researcher followed when analysing the data.

Figure 5.3:

Six Phases of Data Analysis



Phase 1: Familiarising Myself with the Data

The researcher listened to the voice recordings multiple times to become acquainted with the data. While engaging with the recordings, the researcher was actively involved in the process of seeking meanings and patterns. This phase prepared the researcher for coding. Braun and Clarke (2006) emphasised the importance of becoming familiar with all aspects of the data before commencing coding. The researcher took notes and developed preliminary ideas for coding. Although the interviews were conducted in English, some participants alternated between their native language and English; however, the researcher was able to translate as needed for transcription.

After listening to the recordings several times and becoming familiar with the data, the researcher selected relevant portions of the interviews, omitting unrelated content. Brady (2015) and Lamba et al. (2022) highlighted the significance of selecting pertinent parts of interviews and excluding irrelevant sections, which aids in making transcripts more concise

and easier to analyse. Transcription was performed using a Word document, a process that further assisted the researcher in becoming acquainted with the data. Bird (2005) argues that transcription should be regarded as a key phase of data analysis within interpretative qualitative methodology, where meanings are constructed, rather than as a mere mechanical act of transcribing spoken words (Lapadat & Lindsay, 1999). Through repeated reading and re-reading of the interview transcripts, the researcher became increasingly familiar with the data. Initial analyses of the interviews were conducted manually by reading and re-reading the transcribed interviews and highlighting key words and phrases. At this stage, it was crucial not to impose the researcher's own interpretation on the data. The initial coding of the first interview was guided by the broad domains outlined in the interview schedule.

Phase 2: Generating Initial Codes

This phase commenced after the researcher had familiarised herself with the data in the previous step. An initial list of interesting data points was generated, and the researcher focused on making notes and highlighting significant recurring statements and phrases within the transcripts. Naeem et al. (2023) assert that the backbone of analysis lies in the identification of keywords during coding, which they believe facilitates the conversion of raw data into insightful and manageable units.

In coding the transcripts, long pauses, laughter, and utterances were noted, which added meaning to the participants' experiences. Kitzinger (1995) suggests that when coding the transcript of a group discussion, it is beneficial to employ special categories for certain types of narratives, such as anecdotes and jokes, as well as for types of interaction, such as 'questions', deferring to the opinions of others, 'censorship', or changes of 'mind'.

Phase 3: Searching for Themes

The researcher examined the coded data and generated meaningful statements and phrases. At this stage, the researcher critically analysed the codes to understand their interrelations and grouped them into overarching themes. These themes provide meaning and identity to frequently mentioned experiences and their manifestations (Braun & Clarke, 2014). The researcher also focused on codes that appeared unrelated, as their relationships served as the foundation for identifying patterns (Rogers, 2018). During this phase, the researcher explored the relationships between codes, themes, and sub-themes, resulting in the formulation of main themes and sub-themes.

Phase 4: Reviewing Themes

The researcher reviewed and refined a set of potential themes as identified in the previous phase. During this review, it became apparent that some themes did not form coherent patterns, and they were reworked until they more accurately represented the coded data. It is important to note that coding is an ongoing process; therefore, the themes evolved as the data set was re-read multiple times. The researcher reviewed the coded extracts from all collated extracts for each theme and ensured that they formed a coherent pattern. After confirming that the themes encapsulated the essence of the coded data, the researcher checked the validity of the themes and the accuracy of the thematic map to ensure they reflected the overall meaning of the data.

Phase 5: Defining and Naming Themes

The themes were further defined and refined, with the researcher interpreting the keywords, codes, and themes to conceptualise them more clearly. Leidner et al. (2018) emphasise that interpretation is crucial as it illustrates how concepts were developed from the data.

Phase 6: Finalising and Reporting

In this phase, the researcher discussed the significance of each theme, supported by relevant data. The researcher then compiled a report in the qualitative results section, presenting the voices and perspectives of the participants.

5.6. Determining Validity and Reliability in Qualitative Research

Qualitative research focuses on individuals' experiences and perceptions of the world and is inherently interpretive and descriptive in nature (Unger & Tracey, 2013). Rather than striving for impartiality, it acknowledges the researcher's influence on the study and aims to fully comprehend phenomena rather than merely counting the number of individuals who hold a particular opinion (Lincoln & Guba, 1985; Tenny & Brannan, 2017). Since qualitative research is interpretive, robust validation techniques are essential to preserving its integrity and credibility. Validity and reliability are two essential components of any research project. Researchers argue that these elements are critical to ensuring quality and rigour in qualitative research (Cypress, 2017). Soysal (2024) highlights the importance of carefully considering the validity and reliability of qualitative studies, especially in a scientific community that may be sceptical of such research findings, where the researcher's subjectivity could potentially skew data interpretation.

To address concerns regarding the reliability and validity of qualitative research, Lincoln and Guba (1985) introduced the concept of trustworthiness. Trustworthiness refers to the quality, genuineness, and authenticity of qualitative research findings (Cypress, 2017). This is

the criterion used to assess the quality of a research design (Yin, 1994). The concept of trustworthiness is measurable through four main criteria: credibility, transferability, dependability, and confirmability.

5.6.1. Credibility

Credibility is the qualitative counterpart to internal validity in quantitative research, aiming to ensure that participants are accurately identified and described (Schurink et al., 2011). Tracy (2013) emphasised that the strength of qualitative research lies in its credibility, which is vital for effectively exploring a problem. Credibility can be achieved through the collection of rich data using audit trails, triangulation of data collection methods, peer debriefing, and member checking (Schurink et al., 2011). In this study, credibility was established by engaging with participants until data saturation was achieved. Furthermore, transcripts were shared with participants via telephonic discussions to verify their accuracy.

Credibility in qualitative research refers to the extent to which findings accurately reflect participants' experiences and perspectives. Tobin and Begley (2004) emphasised that credibility is achieved when there is a clear "fit" between participants' views and the way the researcher interprets and presents them. In addition, Lincoln and Guba's framework for trustworthiness (as cited in Nowell et al., 2017) recommends strategies such as member checking, peer debriefing, triangulation, and prolonged engagement to enhance the credibility of findings.

In this study, credibility was strengthened through prolonged engagement with participants until data saturation was achieved, ensuring the collection of sufficient, rich data. After transcription of the focus group discussions, participants were given the opportunity to verify the accuracy of the transcripts through telephonic follow-ups, thereby engaging in member checking. This process allowed participants to confirm that their views were correctly captured and interpreted, enhancing the trustworthiness of the findings.

5.6.2. Transferability

Transferability refers to the extent to which the research findings can be applied in other contexts and studies (Schurink et al., 2011). Tracy (2013) underscored the importance of incorporating discipline, reflexivity, rigour, and dependability into the investigative process to make the study applicable in various contexts. Nowell et al. (2017) concur with this notion, indicating that although the researcher may not always anticipate how findings might be

transferred, providing a thick description enables others to assess the applicability of results to their own cases. In this study, transferability was enhanced through purposive sampling methods and the provision of detailed, descriptive, and robust data, including comprehensive accounts of nurses' perceptions and experiences regarding workplace spirituality, resilience, and mental health during times of crisis.

5.6.3. Dependability

Dependability in qualitative research is closely related to the notion of reliability in quantitative research (Lincoln, 1985). Korstjens and Moser (2018) defined dependability as the stability of findings over time. Dependability was achieved through documentation of all steps in the research process and through supervision of the study throughout. All interview materials, including audiotapes, transcripts, field notes, findings, interpretations, and recommendations, were organised and accessible for review (Soysal, 2024).

5.6.4. Confirmability

Confirmability reflects the researcher's commitment to self-criticism and reflexivity, ensuring transparency in the research process (Leavey, 2018). Confirmability represents the extent to which other researchers can verify the sources of findings and determine whether they would arrive at similar conclusions using the same procedures (Schurink et al., 2011). In this study, confirmability was established by maintaining a reflective journal during the research process to document notes and introspections that would be beneficial and pertinent throughout the study. The researcher actively employed reflexivity and bracketing to manage biases, assumptions, and presuppositions that could influence the study. Cypress (2017) cautioned that presuppositions may persistently resurface, even when efforts are made to set them aside, emphasising the importance of continuous self-awareness in qualitative research.

5.7. Data Management and Storage

All data collected for this study is securely stored. The qualitative data (audiotapes and transcribed interview materials) have been preserved on a CD for safekeeping. The electronic copies of qualitative data are securely maintained on the researcher's computer, which is encrypted with a password known only to the researcher. The researcher has ensured that all data is kept securely to maintain confidentiality and to prevent possible access by any third party. The data collected will be retained for a period of five years, after which it will be destroyed.

5.8. Adhering to Ethical Protocols

Ethical protocols were strictly adhered to throughout the research process. This section outlines the procedures and principles that guided the study to ensure ethical compliance.

5.8.1. Ethical Clearance and Gatekeeper's Letter

Ethical approval to conduct this research was granted by the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics Committee (HSSREC/00006842/2024). Additional approval was obtained from the KwaZulu-Natal Provincial Health Department (NHRD Ref: KZ 202406 002). A signed gatekeeper's permission letter from the district manager authorised the researcher to conduct the study within the specified area.

5.8.2. Informed Consent

Participants were provided with an information sheet detailing the scope of the study and a consent form outlining their rights. Before data collection commenced, the researcher, together with the participants, reviewed the consent form and allowed them the opportunity to ask questions and seek clarification. The purpose of the study and its potential benefits to the department were explained in detail. The researcher assured participants that confidentiality and anonymity would be strictly maintained. Furthermore, no names would appear in the study or its outcomes, such as publications or conferences. Coded identifiers would be used during transcription. Additionally, all collected data would be securely stored to prevent unauthorised access.

The researcher also indicated that the data collected would be kept in a secure location to ensure that no one else would have access to it. Participants were informed of their right to withdraw from the study at any point without facing prejudice or repercussions. Before commencing data collection, the researcher sought explicit permission to use a voice recorder for transcription purposes, explaining its sole purpose. Upon receiving consent, participants were asked to sign the consent form to confirm their agreement.

5.9. Conclusion

In this chapter, the research questions guiding this study were revisited and reaffirmed. The chapter detailed the investigative approach employed to select and implement the research methodologies. These methods, when effectively employed, will provide a rich understanding of nurses' perceptions and experiences of workplace spirituality, resilience, and mental health during a time of crisis. The researcher provided a rationale for the activities chosen to derive the interpretations and findings, which will be presented in the subsequent chapters.

The thematic data analysis process was discussed, followed by an explanation of how the collected data will be stored. Finally, the ethical considerations adhered to during the research were thoroughly discussed. The findings of this study will be presented in the next chapter.

CHAPTER 6:

QUALITATIVE RESEARCH FINDINGS AND DISCUSSION

6.1 Introduction

This chapter presents the results and discussion of the qualitative research study.

The global impact of mental health, particularly among professional nurses during crises, warrants significant attention. This issue cannot be overlooked (Stuijfzand et al., 2020). Muz and Erdogan (2021) assert that nurses often face unfamiliar tasks when caring for patients during crises, which can heighten psychological distress characterised by uncertainty, social isolation, and concerns for the safety of both patients and their families. Given these challenges, the role of workplace spirituality, nurses' resilience, and mental health should not be underestimated. As discussed in the first chapter, this study employed a two-phase approach with corresponding objectives. The objectives of the qualitative phase were to explore and understand nurses' perceptions and experiences regarding:

- Workplace spirituality, resilience, and mental health.
- Recommendations for management on how to enhance frontline workers' preparedness during a crisis.

6.2 Results

6.2.1 Characteristics of the Sample

Participants were selected from three community clinics in the uMgungundlovu District (see Table 6.1). The demographic characteristics of the professional nurses who participated in the study are provided in Table 6.2.

Table 6.1:

Participants Distribution per Sub-district

Name of Sub-district	Number of Professional Nurses Interviewed	Percentage %
Bruntiville Community Clinic (Mpofano)	7	36.8%
East Boom Community Clinics (Umsunduzi)	6	31.5%
Imbalenhle Community Clinic (Imbali)	6	31.5%

Total number of participants	19	100%

The study initially aimed to conduct three focus group interviews, each comprising six participants. However, at one of the selected community clinics, an additional participant expressed a strong interest in contributing to the discussion and was subsequently included. As a result, a total of nineteen participants took part in the focus group interviews.

Table 6.2:

Demographic Characteristics of Professional Nurses

Demographics	**Professional nurses (n=19)**	**Percentage**
African	18	95%
Indian	1	5%
White	0	0%
Mixed race	0	0%
Gender		
Male	2	11%
Female	17	89%

As shown in Table 6.2, the majority of the participants were Black and female. All participants were aged between 18 and 65 years, and all reported having worked during a time of crisis.

6.2.2 Themes Emerging from the Study

Several themes emerged from the data.

Table 6.3:

Themes and Sub-themes

Research Objectives	**Research Questions**	**Main Themes**	**Sub-themes**
To explore nurses' perceptions and experiences of workplace spirituality during a crisis.	What are nurses' perceptions and experiences of workplace spirituality?	Understanding workplace spirituality.	• Respect for spiritual and religious diversity • Inner being. • Transcendence

Research Objectives	Research Questions	Main Themes	Sub-themes
		Perception and experience of workplace spirituality during a crisis	• Interconnectedness • Meaningful work • Alignment with organisational goals
To explore nurses' perceptions and experiences of resilience during a crisis.	What are nurses' perceptions and experiences of resilience?	Understanding resilience.	• Self-efficacy • Sense of purpose • Optimism and hope
		Factors contributing to resilience	• Positive mindset • Social connectedness and support networks • Spiritual beliefs
To explore nurses' understanding and perceptions of mental health during a crisis.	What are nurses' understanding and perceptions of mental health during a crisis?	Understanding mental health.	• Mental Health as a state of emotional and psychological distress
		Coping strategies for maintaining mental health during a crisis	• Personal capacity to cope • Self-awareness and personal potential • Self-confidence as a coping mechanism
		Factors contributing to positive mental health	• Health and coping strategies • Work-life balance. • Social and professional support • Cultural beliefs
To ascertain nurses' recommended actions that PHC management may consider to improve frontline workers' preparedness during times of crisis.	What are nurses' recommended actions that PHC management can consider to improve frontlines workers' preparedness during times of crisis?	Recommendations for improving preparedness during a crisis.	• Interconnectedness • Human resources • Financial resources • Psychological support and special leave • Spiritual spaces for reflection and renewal • Access to on-site psychological support

The main themes and sub-themes reflect the nurses' understandings and perceptions of workplace spirituality during a crisis. Each theme and sub-theme is discussed comprehensively below.

Data were coded according to community healthcare and occupation, as indicated below:

BPN = Bruntiville professional nurse

EPN = East Boom professional nurse

IPN = Imbalenhle professional nurse

6.2.3 Theme 1: Understanding Workplace Spirituality

This theme explores nurses' conceptualisations of workplace spirituality, as derived from their personal accounts and reflections.

6.2.3.1 Respect for Spiritual and Religious Diversity. Many participants from their respective interview groups highlighted the importance of respect for spiritual and religious diversity as a key aspect of spirituality in the workplace. For instance, in interview one, seven participants were involved, four of whom (57%) mentioned this aspect; in interview two, six participants were involved, with four (66.6%) acknowledging it; while only two participants (33%) from interview three raised this point. The participants conceptualised respect for spiritual and religious diversity as the ability to recognise and appreciate that each individual's beliefs and spiritual practices hold personal significance and value. They emphasised the importance of accepting and accommodating the beliefs of others, even when those beliefs differ from or do not align with one's own. This sentiment is captured by the following participants:

BPN 3: *"I can say is a sense of understanding each other's beliefs and not being judgmental"*

EPN 3: *"It's understanding other people's beliefs"*

BPN 7: *"Spirituality for me is more about understanding that we might believe in different things, but at the end we are serving one God, it is important that no belief is superior to the other."*

There was also a common understanding among participants that spirituality in the workplace involves awareness and understanding of each other's beliefs, including those who believe in God and those who adhere to ancestral rituals. Some participants in one group interview were particularly direct, with one stating: "Even *isangoma* have their own spirituality". Participants expressed it as follow:

BPN 6: *"In this hospital, we have the mosque; there are arrows that point. If you want to pray, go to the mosque."*

EPN 5: *"Mhm … spiritual beliefs, it can either be believing in God or Ancestors."*

EPN 3: *"To me spirituality it is about Christianity."*

A similar view was also expressed by IPN 1 as illustrated below:

IPN 1: *"The first thing that comes to mind when we discuss about spirituality is God."*

For most participants, spirituality in the workplace involved praying and using the Bible, as the majority of nurses came from a Christian background.

6.2.3.2 Transcendence: "This is More Than a Job". The second sub-theme that emerged was transcendence. Participants in the third group of interviews indicated that part of their profession involves working beyond their personal achievements or interests by pursuing a higher purpose. They reflected on their experiences during the COVID-19 pandemic, recalling a period marked by rapidly increasing infections and patient mortality. Despite the risks to their own health and safety, they chose to prioritise the well-being of their patients above their own. For them, the focus shifted from self-preservation to fostering hope and healing in others. This selfless commitment to patient care was described by participants as their lived experience of transcendence.

EPN 1: *"I feel happy when my patients feel better."*

BPN 3: *"Give the patient a sense of hope, it's what makes me happy."*

IPN 1: *"With me, I understand that I have to go beyond thinking of myself to assist my patients. I check if my patients are compliant (making healthy and safe decisions)."*

BPN 7: *"Trusting me with their lives makes me want to do all that I can to help my patients."*

EPN 5: *"It's the divine power that helps us to serve our patients the way we do."*

6.2.3.3 My Inner-being is Nurtured. The third sub-theme that emerged from the first question was inner-being. Respondents in all interview groups believed that understanding spirituality is closely related to the inner being, which participants described as inner awareness, values, and feelings that form a significant part of professional identity and spirituality as a professional nurse. This is illustrated below:

BPN 3: *"I can say is to attend to the inner aspects of my beings."*

IPN 5: *"It is that connection with your inner-being, the inner person".*

EPN 6: *"It is the sense of protection that you feel from within, that peace that you feel from within, which makes you to feel fine and relieved."*

BPN 7: *"I can say, it is also the place where you get comfort, like if you will get into trouble, there is that inner thing that says you must not go there or you must not do that*",

IPN 1: *"Spirituality is a sense of direction that you get from the inner you."*

6.2.4 Theme 2: Perception of Workplace Spirituality

This study explored nurses' perceptions of workplace spirituality *various dimensions, including the individual dimension, which was addressed through questions regarding their understanding of spirituality, as well as the group and organisational dimensions*.

The first theme that emerged when nurses were asked about their perceptions and experiences of workplace spirituality was interconnectedness, followed by meaningful work and the alignment of individuals' values with those of the organisation, which will be discussed in detail below:

6.2.4.1 Interconnectedness or Sense of Community. Respondents provided statements such as "understanding one another, understanding each other's roles, sharing responsibilities, and delegation of duties." These statements were consistent among most participants in the first group (71%), while both the second and third groups had 66% of respondents expressing similar sentiments. There was also a common understanding among participants that perceptions of workplace spirituality encompass "team building, celebrating birthdays together, and working towards a common purpose". These sentiments were generally evident across all groups, with 57% from the first group, 83% from the second group, and 66% from the third group. Additionally, overarching statements included: "We pray together, we have each other's contact numbers; if there is a good spirit amongst us, even if I say something wrong, they gently inform me that I'm wrong."

These sentiments are captured by the participants below:

BPN 1: *"Even when one is not at work, we will call them to check on them since we have contact numbers for each other. When we see someone is not present, and there is a work pressure we the other group will go and fill the gap by assisting."*

BPN 2: *"Even when one has lost their relatives through death, we pay contributions."*

BPN 4: *"Yah, like celebrating others birthdays or go out as a team."*

EPN 3: *"Sharing of responsibilities."*

EPN 5: *"Helping each other when required*."

IPN 4: *"For me it about working together as a team."*

6.2.4.2 Meaningful or Purposeful Work. This theme was particularly evident in the nurses' responses when asked about their work and what motivated them to come to work, revealing what they found significant and purposeful in their roles. Most participants perceived meaningful work as the sense of fulfilment derived from performing their duties with passion

and experiencing joy upon achieving positive outcomes. In their responses, 50% of the participants from the second group indicated that they derive fulfilment from coming to work. Below are some of the expressions:

EPN 5: *"Understanding your role, the outcomes of the facilities you are working for, the mission and vision of the facility is fulfilling."*

EPN 3: *"Achieving your own goals, seeing improvements in the patients and general wellbeing of the patients makes me see my value."*

EPN 1: *"Connecting with the actual work."*

Some participants expressed sentiments related to their beliefs in God during the third group interviews:

IPN 6: *"We are there for the reason, because God works through us to help our people in this profession, we are doing exactly what God created us to fulfil, we are for purpose of helping our people."*

IPN 4: *"I always say that we are for the purpose."*

6.2.4.3 Alignment of Individual's Value with the Organisational Value. Respondents were asked to share their opinions regarding their personal values in relation to those of the organisation. Thirteen participants (76%) indicated that, generally, their alignment depends on the reasons that motivated them to work for the organisation. They noted that it is not solely about themselves; therefore, their values may not matter. In cases of misalignment, they will need to find personal ways to cope; otherwise, it could lead to burnout and depression. Most participants stated that the pledge they took when joining the profession is what they adhere to while conducting their duties. Below are their expressed views:

BPN 1: *"And as health workers, we want to achieve total health from the patients, so, for the total health, we must allow the patient to exercise their spirituality because if spirituality is lacking, that is not the total health."*

BPN 3: *"Some of us do not believe in abortion, but because we are here and made the pledge, we have to care for those patients who are coming for abortion, we cannot go against it, it is not for ourselves to judge, but for us to work for what we came in for."*

IPN 3: *"If your values are misaligned with the department's values then it means you are in the wrong place."*

BPN 7: *"You will easily burnout and you will develop depression because of frustration."*

6.3 Resilience

The second construct of the research question focused on resilience. Participants were asked to share their perspectives on resilience, including their understanding of the concept and the factors they perceived as contributing to its development. Below are the themes and sub-themes that emerged during the discussion:

6.3.1 Theme 1: Understanding Resilience

This theme explores nurses' conceptualisations of resilience as reflected in their narratives, particularly during periods of crisis. The first sub-theme, **self-efficacy**, highlights nurses' confidence in their abilities to adapt, cope, and perform effectively despite challenging circumstances.

6.3.1.1 Self-efficacy. The first question was based on the respondents' understanding of resilience. Those who participated in this question indicated that resilience meant the ability to cope, to keep pushing no matter how difficult it is, the ability to recover quickly, and to accept and move on. Some thought of resilience as meaning to believe in what you or achieve: "You are resilient if you, no matter there are circumstances on the way, to keep on pushing because you will not rest until you succeed." This is captured by the participants below:

BPN 2: *"If you are resilient, you must believe in what you do or achieve. You are resilient if, no matter what circumstances are on the way, you keep pushing because you won't rest until you succeed. I cannot be beaten by others, no ways … [laughs] … that mentality makes me to push on."*

BPN 2: *"You push no matter what."*

BPN 5: *"Resilience is the ability to cope in situation."*

BPN 2: *"Ability to recover quickly."*

EPN 3: *"Having personal strength."*

EPN 5: *"It about endurance."*

6.3.1.2 Sense of Purpose. This sub-theme highlights participants' emphasis on the importance of understanding their purpose for choosing the nursing profession**.** According to the participants, having a clear sense of purpose served as a motivating factor that enabled them to persevere despite challenges. When describing the concept of resilience, participants suggested that an awareness of one's underlying reasons for being in the profession fosters resilience when confronted with adversity. This is narrated below:

BPN 1: *"And also knowing our roles and understanding what is my role, I will know what, I must do."*

BPN 2: *"Just focus and ignore other things, stick to your goals."*

EPN 2: *"Commitment, I am still committed to do what I must do, that keeps me resilient."*

EPN 4: *"Batho Pele, principles knowing that I am here for the patients keeps me resilient."*

IFN 6: *"For me sticking to my pledge keeps me focus and helps me to push on."*

6.3.1.3 Optimism and Hope. The third sub-theme that emerged from nurses' conceptualisations of resilience is **optimism and hope**. Participants in this study emphasised that sustaining an optimistic outlook and a hopeful attitude enables individuals to cope effectively with challenges and adversities. The following excerpts illustrate participants' perspectives on how optimism and hope contribute to the development of resilience.

BPN 2: *"If you are resilient, you must believe in what you do, or achieve. You are resilient if, no matter there are circumstances on the way, you keep pushing because you won't rest until you succeed. If your intentions are good, there is nothing that can take you back because intentions are good and you want to see whatever you want to see."*

IPN 4: *"You can be resilient, if you are optimistic and if you try to understand the situation."*

BPN 4: *"Recognise the situation, accept and learn to live with it."*

IPN 2/4: *"I always believe that I was born to conqueror."*

EPN 4: *"I always tell myself that, this too shall pass."*

6.3.2 Theme 2: Contributing Factors to Resilience

Another central theme that emerged from the data was the contributing factors to resilience. While participants acknowledged the presence of mental health challenges, many also identified key elements that helped them cope and remain resilient in the face of adversity. These contributing factors were not only internal or individual but were strongly influenced by the social, environmental, and cultural contexts in which they lived. Participants highlighted how supportive relationships, access to safe or stable environments, and cultural beliefs or practices provided strength, meaning, and emotional grounding during difficult times. These findings suggest that resilience is not solely a personal trait, but a dynamic process shaped by multiple external influences. Below is the narrative of contributing factors from the participants' perspectives.

6.3.2.1 Positive Mindset. One of the key sub-themes that emerged under the broader theme of contributing factors to resilience was the role of a **positive mindset**. Participants described how maintaining optimism, focusing on solutions rather than problems, and adopting a hopeful outlook enabled them to cope with workplace stress and emotional challenges. This perspective was often expressed through statements reflecting determination, forward-thinking, and a refusal to be overwhelmed by adversity. Such narratives suggest that a positive mindset not only helps mitigate the psychological impact of difficult situations but also strengthens individuals' capacity to recover and adapt – core elements of psychological resilience.

EPN 3: *"Developing a positive mindset helps when dealing with a crisis."*

EPN 5: *"Team work and co-operation also helps in developing a positive mindset. If a team is willing to assist in executing the work and in find solution helps a lot."*

BPN 2: *"There are people that are born positive and their positiveness contribute to dealing resilience."*

IPN 3: *"You will find a person who always believe that there is always a solution to any problem while others are afraid and frustrated about because of the challenging event."*

IPN 6: *"Yah … and those people help us to also develop the positive mind sent, instead of focusing on the problem we know fight to get a solution."*

6.3.2.2 Social Connectedness and Support Networks. The second sub-theme, **social connectedness**, as expressed by participants, underscores the vital role of interpersonal relationships in strengthening psychological resilience. Participants in this study identified social connectedness and social support as essential nurturing factors that contribute to the development and maintenance of resilience. They emphasised the significance of fostering constructive interpersonal relationships within the workplace. According to participants, social connectedness and supportive networks are built upon mutual respect, compassion, the sharing of knowledge, and a willingness to assist colleagues during periods of increased workload. The following excerpts illustrate participants' views on how social relationships contribute to the enhancement of resilience.

IPN 6: *"When my husband was admitted in the ICU during COVID. My daughter and my colleagues supported me and their presence gave kept me stronger."*

BPN 5: *"During a crisis it is important to have at least one person who you can confide to, no matter what others may be saying, but if I have this person, I can push through."*

EPN 2: *"During time of COVID-19 we were counselling each other, and assisting with medication secretly and this showed that we care about our peer."*

IPN 2: *"Phone calls that we make to each other, sending WhatsApp messages and providing counselling to each other made us to easily go through the difficulties we were facing. Providing medication secretly."*

6.3.2.3 Spiritual Beliefs. The third sub-theme identified under factors influencing resilience is **spiritual belief**. Participants emphasised that spiritual beliefs play a pivotal role in shaping their interpretations of and responses to adversity. They reported that spirituality provides a sense of meaning, hope, and inner strength, thus supporting emotional stability during challenging circumstances. For many participants, spiritual beliefs functioned as an important coping mechanism, fostering perseverance and sustaining a constructive outlook in the face of difficulties. The following excerpts illustrate how participants articulated the influence of spirituality on their resilience.

EPN 6: *"Your faith is what keeps you going."*

IPN 4: *"Prayer day in and day out, every moment I had, I prayed and I can say it kept me strong and positive."*

BPN 4: *"For me, I was literally paranoid coming in contact with the patient who has COVID-19, when I got home, there will always be a bucket outside, I will soak my clothes into that bucket I was highly stressed It created paranoia in the house but through God, prayer and God's protection, none of us had COVID-19."*

EPN 6: *"When God is on my side, I am happy I believe that He can change anything is possible with God."*

6.3.2.4 Cultural Background. The fourth sub-theme identified under factors influencing resilience is **cultural background**. Participants reflected on how their upbringing and the cultural values instilled by their families shaped their resilience in the face of adversity. They highlighted how those cultural beliefs and practices influenced how they coped with and responded to challenging situations. The following excerpts illustrate participants' perspectives on the role of cultural background in fostering resilience.

BPN 4: *"I know that at my home, they are relying on me, if I fall down, then the whole family is finished."*

Sharing a similar perspective from African culture, **IPN 4** reported:

"In an African culture, we have been told that men don't cry, and you need to fight as a man, no matter the challenges you are facing, so that keeps us resilient."

A female nurse articulated cultural beliefs that reinforced patriarchal societal views regarding women and their roles within society. This participant stated:

BPN 6: *"I grew up knowing that women need to be submissive, you do not argue with elders or question male figures, and this is now affecting the way I approach difficult situations, and resulting in me dying alone inside."*

6.4 Mental health

The third construct explored in this study is nurses' mental health during times of crisis. Mental health is a crucial component of overall well-being and encompasses emotional, psychological, and social dimensions that influence how individuals think, feel, and behave. It determines how people handle stress, relate to others, and make life choices, particularly during challenging or crisis periods.

In this study, participants were requested to share their understanding of mental health, reflecting their perceptions and interpretations of what constitutes a healthy mental state. They were also asked to describe how they coped during times of crisis to prevent or manage experiences of mental distress or illness. Furthermore, participants were encouraged to identify factors contributing to positive mental health, including personal, social, and environmental influences that promote resilience and psychological well-being.

By exploring these aspects, this construct aims to provide a comprehensive understanding of how individuals conceptualise mental health, the strategies they employ to maintain it during adversity, and the conditions that foster or hinder mental wellness within their lived contexts. Below is how the participants responded:

6.4.1 Understanding Mental Health

When asked about their understanding of mental health during times of crisis, participants across all interview groups provided limited responses. In the first group, approximately 87% of participants associated mental health with experiences of fear, instability, and mood swings**.** In the second group, only 33% of participants responded to the question, describing mental health during crisis as a state of being mentally and physically exhausted, with references to anxiety and fatigue**.** While some respondents discussed the strategies they used to cope mentally during crises, others addressed the role of culture in coping. Interestingly, several participants expressed that cultural practices were not considered relevant during a crisis, stating, for example, "forget about culture", and "decisions are taken not based on culture." These responses suggest a general lack of depth in participants' conceptualisations of mental

health during crisis, with some variation in coping mechanisms and attitudes towards cultural influences. Below is how participants expressed their understanding of mental health:

6.4.1.1 Mental Health as a State of Emotional and Psychological Distress. A prominent sub-theme that emerged from participants' responses was **mental health as a state of emotional and psychological distress**. This sub-theme reflects how individuals conceptualise mental health not as an abstract or purely clinical issue, but as a deeply personal experience marked by emotional instability, psychological suffering, social isolation, and internal conflict. Participants described symptoms such as depression, anxiety, mood swings, and loneliness, highlighting the complex and multifaceted ways in which mental health is understood and experienced.

BPN 1: *"Being unstable, because you asked yourself so many questions, some you don't have answers for."*

BPN 4: *"Feeling of regret, a feeling of why you are here."*

BPN 2: *"Having flashbacks."*

BPN 1: *"Loneliness – Sometimes you feel rejection, like I am all by myself, there is no support, you feel alone, and helpless."*

BPN 6: *"Burnout, depression, bipolar, today I am happy, tomorrow I am crying, mood swing, you become emotional, a small thing makes you very angry, you cry."*

IPN 4: *"High anxiety levels, high levels of depression, panic, using ant-depressant, I don't feel powerless because of my past experiences.*"

Participants were asked to describe how they cope with crises that could potentially lead to mental health challenges. The primary objective of this question was to explore the various coping strategies employed by nurses when confronted with situations of psychological distress or crisis.

6.4.2 Coping Strategies for Maintaining Mental Health During Crisis

A key sub-theme that emerged in response to how participants coped with difficult situations to protect their mental health was **coping strategies for maintaining mental health during crisis**. Participants described a range of coping mechanisms that enabled them to navigate emotionally taxing environments. These included drawing strength from past experiences, maintaining a determined and proactive mindset, engaging in spiritual practices such as prayer, and relying on supportive relationships with colleagues and family members.

The narratives highlight the importance of both **internal resources**, such as resilience and faith, and **external supports**, in sustaining mental well-being during times of crisis.

6.4.2.1 Personal Capacity to Cope. Participants were asked whether they believed they possessed the personal capacity to cope with adversity that could impact their mental health. This question aimed to explore whether they had internal resources or coping mechanisms they could draw upon when faced with challenges to help prevent feelings of helplessness.

EPN 3*: "It depends on your coping mechanisms."*

EPN 1: *"It gives the fighting spirit to stand on your own."*

BPN 2: *"The past experiences help to withstand the pressure. During crisis I don't normally feel defeated and I always heads on."*

EPN 4: *"The only thing that helped me to remain stable was prayer."*

IPN 2: *"I felt like I was paranoid, I was praying for everything and every time I get I just pray."*

6.4.2.2 Self-awareness and Personal Potential. The participants highlighted the importance of being true to oneself, acknowledging and understanding one's strengths and limitations. Below are how participants expressed themselves:

IPN 2/5/7: *"Past events has helped us to gain more strength and be emotionally prepared to for further events."*

IPN 3: *"I always have this, that I was born a conqueror."*

BPN 3: *"Acceptance of the situation is key, if you don't accept the situation, you will go through depression, accept and deal with the situation."*

BPN 4: *"Your need to be stubborn for you to say heads-on".*

6.4.2.3 Self-confidence as a Coping Mechanism. Participants highlighted self-confidence as a key internal resource for managing difficult situations. They expressed that a strong belief in one's own abilities contributes significantly to coping with adversity. This sense of self-assurance was seen as enabling individuals to approach challenges with greater composure and reduced psychological strain, as they trusted in their capacity to navigate and overcome the difficulties they faced.

BPN 6: *"Past experiences teaches you to stand for yourself and be resilient when faced with difficulties."*

BPN 4: *"I have develop the mentality of telling myself that, I will cross that bridge when I get there."*

EPN 3: *"I can say, COVID has made me to be strong for future challenges, I have develop a strong muscle now I'm confident that I will be able to over any situation in my life without my mental wellbeing being affected."*

IPN 1: *"I believe I do have what it takes to face negative situation in my life."*

EPN 2: *"I also believe that life experiences have taught me to strong and because of that I believe I personal have what it takes to face adversity in life, though situation differs."*

6.4.3 Factors Contributing to Mental Health

6.4.3.1 Health and Coping Strategies. Participants emphasised the importance of adopting healthy behaviours and effective coping mechanisms, such as physical activity and prayer, in maintaining mental well-being and managing stress. Below is how participants expressed their views:

EPN 6/5/2/4: *"Prayer was the only thing that kept me stable."*

EPN 2: *"I remember a time where it was even difficult to pray, I will go into the shower and lean against the wall and just say Jesus, Jesus, Covid was difficult to deal with."*

IPN 3: *"When I feel too stressed I normally listen to music that will calm me down."*

IPN 4: *"I will exercise and it helps me to deal with stress."*

EPN 1: *"Meditation on the word of God kept me in peace."*

6.4.3.2 Work-Life Conflict. The ability to maintain a balance between professional responsibilities and personal life was consistently mentioned as critical to mental health. Participants noted that when work demands encroach on personal time, it leads to burnout and emotional exhaustion.

EPN 2: *"I remember when I was emotionally and mentally exhausted, my manager couldn't care, I was summoned to come to work because of the workload."*

EPN 5: *"We were working awkward hours with little or no breaks and it felt like no-one cared about us."*

EPN 3: *"I remember, I was diagnosed with COVID, and I had to recover from home, but my boos called me back to work, I was so scared that I will die and my kids will not have a mother, I was not given time to recover."*

6.4.3.3 Social and Professional Support. The presence of supportive relationships, both in personal and professional contexts, was identified as a protective factor. Emotional support from family, friends, and colleagues provided participants with a sense of belonging and validation, reducing feelings of isolation.

BPN 4: *"Sometimes you feel rejection Like I am all by myself, there is no support, you feel alone and helpless."*

BPN 5: *"You become emotional, a small thing makes you very angry, you cry."*

BPN 1: *"When you have no-one to talk to you easily feel helpless and depressed."*

EPN 2: *"Team spirit from colleagues helps in maintaining a positive mental state."*

BPN 5: *"Support I received from colleagues was amazing and it what kept me strong."*

BPN 1: *"For me, appreciation and support from colleagues is what I can recall to have played a positive role on my mental well-being and resilience."*

BPN 5: *"My children and my husband played a crucial role in proving emotional support."*

EPN 2: *"Support and love from my family."*

EPN 7: *"Support from your doctors, my doctor was even calling me and checking if I were coping."*

IPN 5: *"Having a support system from my colleagues and family."*

6.4.3.4 Cultural Beliefs. Cultural values and norms were identified as influential factors in shaping individuals' perceptions of mental health, help-seeking behaviours, and coping strategies. Participants indicated that the prevailing cultural stigma associated with mental illness often affected their openness to discussing or addressing mental health concerns. The following excerpts illustrate participants' perspectives on this issue.

BPN 2: *"We as woman, we were told that you must listen to your husband and not question him, this has an impact when we have to speak out for ourself, leading to us dying inside."*

BPN 1: *"Also in church, if you are a Christian, you are not allowed … you must always respect, you do not have the right to express your feelings."*

BPN 3: *"Culturally, mental illness is regarded as being mad, people with mental illness are not taken seriously."*

BPN 5: *"You are educated, you have a house and a car but they say you are mad … which is not making sense".*

6.5 Recommendations for Improving Preparedness During Crisis

The final objective of this study was to obtain recommendations from nurses regarding strategies that managers can implement to enhance nurses' preparedness during crises. These recommendations were informed by the challenges participants reported while discussing workplace spirituality, resilience, and mental health during times of crisis. The recommendations will be organised into distinct sub-themes for analysis.

Interconnectedness

As discussed in Chapters 2 and 6, interconnectedness plays a vital role in enhancing employee resilience and promoting mental well-being by fostering a sense of purpose, belonging, and psychological safety. However, findings from this study revealed that nurses perceived a lack of managerial support during the COVID-19 crisis. Participants emphasised the importance of managerial support, particularly during times of crisis, noting that such support is essential for fostering teamwork, mutual encouragement, and the successful attainment of departmental objectives. The following excerpts illustrate nurses' experiences and perspectives regarding the lack of support they encountered during the COVID-19 pandemic.

EPN 3: *"I remember when I was diagnosed with COVID-19, I was very scare thinking that I was gone die and leave my kids behind, the painful part during that time was the constant calls from my manager asking me to come back to work and I remember I how weak I was that time."*

Similar feelings were share by three participants, **BPN 4, IPN 2 & 6:** *"We were very stressed during COVID-19, people we dying from left and right and none of our manager even thought of how this affected us as nurses."*

Despite these challenges, many nurses emphasised their ongoing commitment to the professional values enshrined in their nursing pledge. This commitment underpinned their continued respect for patient values, even in the face of organisational challenges.

Implications for Human Resources for Health

Participants underscored the significant impact of staffing shortages during periods of crisis, observing that inadequate nurse-to-patient ratios contributed to increased workloads, elevated stress levels, and emotional exhaustion. This imbalance not only compromised the quality of patient care but also weakened nurses' resilience and overall mental well-being. Accordingly, it is recommended that healthcare managers adopt proactive human resource

planning strategies, including maintaining adequate nurse staffing levels, implementing flexible deployment mechanisms, and establishing contingency workforce plans to mitigate work overload during periods of heightened demand. Strengthening human resource capacity is therefore essential for fostering a supportive work environment that enhances psychological resilience and aligns with the principles of workplace spirituality. The following excerpts illustrate nurses' perspectives regarding these challenges.

BPN 1: *"We were working awkward hours because of the shortage of staff and that come with exhaustion and fatigue."*

EPN 3: *"We were compelled to come back to work while we were not feeling well, and we were told that more staff is needed to we need come back to work."*

Financial Resources

A recurring concern among participants was the lack of essential protective equipment, particularly during the COVID-19 crisis. Nurses reported experiencing significant anxiety and fear due to inadequate access to personal protective equipment (PPE), such as masks, which they perceived as a fundamental safety measure. The absence of such resources was interpreted as a lack of organisational commitment to their health and safety. This not only heightened their vulnerability to infection but also negatively impacted their mental well-being. Therefore, it is recommended that healthcare institutions allocate sufficient financial resources to ensure the consistent availability of critical protective equipment. Investing in basic safety provisions is not only a practical necessity but also a reflection of organisational values that prioritise the well-being, dignity, and psychological security of professional nurses.

IPN 5: *"We were exposed to COVID-19, we were given mask that was not strong enough to protect us and we told that there are no funds to get us PPE."*

Psychological Support and Special Leave

Participants expressed the need for more robust emotional and psychological support systems within the workplace, particularly during times of crisis. Many nurses reported experiencing overwhelming stress and emotional strain, with minimal acknowledgement or intervention from management. As a result, they recommended the introduction of special leave provisions specifically designed to accommodate employees struggling with mental health challenges. Such leave would serve as a formal recognition of the psychological toll associated with high-pressure healthcare environments, particularly during crises such as the COVID-19 pandemic and natural disasters. Implementing this measure could provide nurses

with the necessary space to recover and cope more effectively with adversity, while simultaneously fostering a culture of care, compassion, and psychological safety aligned with the principles of workplace spirituality. Below is what the participants indicated.

IPN 3: *"I for one, I would have appreciated if we were given a support of psychological services, may to be referred to wellness services where we can debrief."*

EPN 2: *" I would appreciate if managers can consider giving us special leave when they see that we are stressed or depressed, I think there should be flexibility in the department's policies."*

Spiritual Spaces for Reflection and Renewal

Participants recommended the establishment of dedicated spaces within the healthcare environment for spiritual and emotional restoration. These spaces would be accessible for activities such as prayer, meditation, scripture reading, and moments of silence. Nurses indicated that, following exposure to stressful or traumatic events, having a quiet, sacred space would allow them to reconnect with their inner selves, process their experiences, and regain emotional and spiritual strength. Such spaces are considered essential in supporting workplace spirituality, promoting resilience, and fostering overall mental well-being. Providing accessible and inclusive spiritual spaces reflects an organisational commitment to holistic care, not only for patients but also for staff, and reinforces a culture that honours diverse belief systems and the need for inner renewal in high-stress professions.

IPN 3: *"We will appreciate if we can be provided with a place where we can go and pray, reflect and recharge after a stressful event."*

BFN 6: *"A place of prayer will give us the opportunity to connect with our inner being which helps us to regain hope and strength during difficulties, if managers can consider providing that for us."*

EPN 5: *"We do understand that not everyone believe in prayer but having that private place will allow even for the moment of salience for those who did not believe in prayer."*

Access to On-site Psychological Support

Participants strongly recommended the appointment of in-house psychologists to provide immediate and professional mental health support, particularly during times of crisis. Nurses highlighted the need for structured psychological services, including regular debriefing sessions, to help process traumatic experiences, manage stress, and maintain emotional resilience. The availability of an on-site psychologist was viewed not only as a practical

intervention to support mental well-being but also as a symbolic gesture of genuine care and concern from management. Such support would contribute to a psychologically safe work environment, reinforce organisational commitment to employee welfare, and align with the core tenets of workplace spirituality by addressing the holistic needs – emotional, psychological, and spiritual – of healthcare professionals.

BPN 7: *"We would have appreciated if at least they arranged a psychologist that was going to be within the centre to provide emotional support."*

IPN 2: *"I also believe that the service of the psychologist would have assisted us in dealing with the trauma we went through during COVID-19."*

6.6 Discussion

This study aimed to explore professional nurses' perceptions and experiences of workplace spirituality, resilience, and mental health during a time of crisis, as well as to identify their recommendations for management in preparing for future crises. This section discusses the key findings of this research in relation to existing literature on workplace spirituality, resilience, and the mental health of nurses during challenging times. Conducted in the KwaZulu-Natal province, a region with a predominantly African population, this study provides valuable insights into the unique experiences of nurses within this cultural context. Workplace spirituality offers a holistic view of individuals in their journey to find meaning and purpose in their work, the desire to connect with others and be part of the community, and the alignment of organisational goals and values with individual value propositions. The current study proposed the theoretical tenets of Humanistic Organisational Theory (HOT), comprising the following premises: person-organisational fit, a people-centric approach, community of people, stakeholder management, value-based management transcendence, and positive organisational scholarship. These tenets can be utilised to understand nurses' desire to seek the dimension of workplace spirituality at play in their organisation. The HOT perspective focuses on the importance of human dignity, human needs, and motivation, contrasting with the mechanistic or technical view often adopted in managing employees (Maslow & Herzberg, 1968). Similarly, workplace spirituality is concerned with the accomplishment of the highest level of human needs, viewed as spiritual needs that involve searching for deeper meaning, connection, purpose, and the experience of feeling good at work (Petchsawang & McLean, 2017). Both workplace spirituality and HOT prioritise well-being, trust, and deep respect as human values that will create an environment where spirituality can thrive, allowing employees to connect their personal beliefs and values with their work (Mitroff & Denton, 1999).

6.6.1 Interconnectedness

The findings of this study on nurses' understanding, experiences, and perceptions of workplace spirituality during a time of crisis indicated that a majority of participants felt that spirituality at work was more prominently expressed among peers. They reported that during COVID-19, they were there for one another, ensuring mutual support. Caring for each other during difficult times was perceived as an indication of spirituality; the inner connection they felt for one another suggested a deeper bond. This experience was reported by nearly all participants. They also noted that when one individual fell ill or was diagnosed with COVID-19, they took it upon themselves to ensure that the affected person received full support through calls and WhatsApp, and they even facilitated access to medication. The connection they shared fostered a sense of being cared for and created a familial atmosphere. This phenomenon has been previously highlighted by Israa and Suneel (2018) and Mahoney and Graci (1999), who emphasised the significance of belongingness, interconnectedness, and community, expressed through acts of service to others. This aligns with the concept of compassion as indicated by Shrestha et al. (2023), which entails showing empathy and a desire to alleviate the suffering of others. Participants reported that they would also assist with workloads in wards when their colleagues were off sick. This reflects the sense of collaboration noted by Shrestha et al. (2023), where teamwork is essential in achieving organisational goals. Interconnectedness is a concept akin to Ubuntu, which is central to African spirituality and highlights the interrelatedness of humanity. Ubuntu is founded on the premise that individuals exist through and with others, underscoring the importance of networks and community in providing support (Ohajunwa & Mji, 2018; Mji, 2012). It is characterised as an African attribute that prioritises the common good, people, community, and respect, serving as the cornerstone of strong interpersonal relationships (Magezi, 2020). Ubuntu also promotes a sense of communal harmony and collective well-being, which is central to many spiritual traditions, emphasising interconnectedness, compassion, and communal welfare (Kobe, 2021). The enthusiasm reported by nurses when their patients recovered from illness and adhered to medication reflects the principles articulated in the aforementioned concepts, representing spirituality, where nurses embody the concept of Ubuntu, extending beyond the self to consider others, including the community they serve.

Notably, Eastern philosophical traditions share a common understanding of spirituality as a sense of unity in creation, emphasising the existence of a singular ultimate reality expressed through multiple manifestations (Nandram et al., 2019). They mention concepts *such as*

svadharma, meaning individual duty, and *lakasangraha*, referring to the welfare of society, as integral to Vedic spirituality. Buddhists believe that virtues like compassion and mindfulness, along with the practice of letting go of the self, are essential for achieving happiness and relief from pain (Kjonstad, 2020). The interconnectedness of all beings is considered important for achieving enlightenment (Segal & Segall, 2020). This aligns with the findings of this study, wherein nurses during the COVID-19 pandemic sacrificed their well-being to ensure the well-being of their patients and colleagues. The connection they shared with their patients and colleagues transcended the self, and they were willing to go the extra mile to assist those diagnosed with COVID-19. The fulfilment they experienced from witnessing their patients' improvement and the support they provided to one another as colleagues were reported to have sustained them and helped them fulfil their professional mandate. The compassion shared during these times of crisis corresponds with one of the themes reported by Shrestha (2023) in his study on workplace spirituality, where he defined compassion as the expression of empathy, awareness, and a desire to alleviate the pain of others. Although interconnectedness was primarily experienced among peers rather than with managers, it appears to be a dimension that was strongly expressed by the nurses as a manifestation of spirituality in the workplace.

Akmal (2024) observed that a common understanding of the interconnectedness of all aspects of existence exists across various belief systems, demonstrating a holistic perspective on reality. For instance, Hinduism's concept of Brahman emphasises the interrelated nature of all things, while Buddhism's concept of dependent origination highlights the mutual dependence of all phenomena. Taoism's concept of the Tao showcases a profound awareness of interconnectedness.

6.6.2 Transcendence

For the participants, self-transcendence extended beyond selfishness or self-interest regarding any benefits. This sits at the pinnacle of Maslow's pyramid model, above the level of self-actualisation (Venter, 2016). It is characterised by feelings of love, understanding, happiness, and gratitude. Maslow ranked self-transcendence as the most important need, as it involves a desire to connect with a higher power or divine forces and to attain a state of consciousness beyond human capabilities.

This dimension of workplace spirituality was notably expressed in this study. A few participants perceived their work as a calling. One participant, who viewed the nursing profession as a calling, attributed this to a sense of vocation bestowed upon her by deceased

elders through prophecy; for her, this represented a higher power beyond her immediate understanding.

Some participants indicated that the service they provide, their responsibilities towards their patients, and their commitment to serving others, as well as the positive contributions they make, are what enhance their appreciation for their work. This aligns with Oliver et al.'s (2018) concept of self-transcendence, which transcends personal interests, encompassing the pursuit of a higher purpose, connection with divine forces, or serving others to identify with something beyond the ego. A crisis often prompts individuals to question many aspects of their lives and seek logic in every decision and situation. This was observed by the researcher when participants expressed the emotions they experienced during COVID-19, noting that they persevered due to their understanding that their work extends far beyond self-interest.

Beliefs were strongly articulated in this study as a crucial element that supported nurses during COVID-19. The beliefs expressed centred on trust in God and ancestors. During challenging times, when nurses faced despair and perceived their lives to be at risk, prayer emerged as a significant factor in fostering their resilience. Belief in God and the act of praying provided them with strength; consequently, they recommended that the department consider establishing a designated prayer space, even referencing a local hospital that has a mosque for Muslim prayers. Participants also suggested that individuals who do not believe in prayer could observe a moment of silence to connect with their spiritual beliefs. This aligns with the Eastern perspective, where spirituality is viewed as intertwined with religion. The reliance on faith and prayer during difficult times directly informs the nurses' recommendation for the establishment of a prayer space within the healthcare facility. Additionally, it was evident in this study that nurses perceived spirituality as having a connection to religion. References to prayer, reading the Bible, and belief in God clearly indicate a religious context. This aligns with the notion that spirituality is closely linked with various religious and philosophical traditions, such as Hinduism and Taoism, as documented in several studies conducted in the Middle East (Rassool, 2000; Khan & Ahmad, 2014; Heydari et al., 2016). In the South African context, this extends to include ancestral beliefs, as highlighted by the findings of this study.

As this study was conducted in KwaZulu-Natal, which is predominantly inhabited by African people, it is not surprising that the results emphasised the importance of connecting with higher powers, which are believed to promote well-being. This aligns with the findings of Ohajunwa and Mji (2018), who regarded African spirituality as the interconnectedness with a higher power. Similarly, Singh and Bhagwan (2020) viewed African spirituality as one that acknowledges the presence of unseen spirits (ancestors), accessible through prayer and other

ritual activities. Prayer and ancestor veneration were strongly identified as elements that provide a sense of direction during a crisis. It is noteworthy that the results of this study concur with those reported by Weathers (2018) regarding the Islamic beliefs and values associated with spirituality, highlighting the close relationship between religion and spirituality, along with Eastern practices such as meditation and connection to the divine. These practices are considered essential in cultivating inner peace (Ewest, 2024; Akmal, 2024). The next theme reported is 'Inner Being,' which is closely related to transcendence.

6.6.3 Inner Being

Inner being is well defined by Ashmos and Duchon (2000) in their conceptualisation of spirituality at work as the recognition that employees possess an inner life that nourishes and is nourished by meaningful work conducted within a community context. The findings of this study indicated the important role of connecting with the inner being to maintain inner peace. Participants reported that the inner being serves as an inner voice that guides and protects one from danger. Other participants indicated that the inner being assists them in navigating stressful experiences, providing them with strength. This is corroborated by Olupana (2020), who argued that spirituality involves internal strength, emotional management, and a positive mindset that influences one's behaviour towards others and the environment. Inner peace was also confirmed by Ariani (2021) as a component of spirituality at work achieved through the exploration of one's inner beliefs, values, experiences, and practices, which also provide harmony and fulfilment (Ariani, 2021). Prayer, moments of salience, and self-connection were reported as helpful practices during times of crisis. Participants recommended that human rights be incorporated into organisational policies and respected, as they contribute to nourishing their inner selves. This suggests that during times of crisis, connecting with the inner being and silencing external distractions to focus on oneself plays an important role in recovery following difficult periods. The Eastern perspective of spirituality reported by Weathers (2018) also confirmed that practices such as meditation, mindfulness, self-awareness, harmony, and connection to the divine are important in promoting inner peace (Miller & Ewest, 2018; Akmal, 2024).

The researcher noted that a few participants indicated the importance of this dimension of workplace spirituality. However, when it was highlighted by these individuals, the remaining participants appeared to agree.

6.6.4 Meaningful Work

Nurses emphasised the importance of feeling valued by their superiors, peers, and the patients they serve. They expressed that this sense of value plays a crucial role in their professional development. Additionally, they noted that when patients express appreciation following their recovery, it reinforces the significance of their role. According to the participants, the primary mandate of nurses is to facilitate the attainment of total health in their patients' lives, thereby rendering their work meaningful. Esievo et al. (2019) suggest that meaningful work is rooted in an individual's deep-seated emotions regarding the connection between their work and life's ultimate purpose. This sense of meaningfulness appears to have inspired the nurses to demonstrate resilience during crises, as witnessing patients' recovery and adherence to medication fosters their motivation in their roles.

One participant revealed that when contributions are valued by managers, it translates to adding value to the organisation, enhancing personal growth, and contributing to meaningful work, which, according to the participant, promotes a learning culture. This observation is supported by Steger (2016), who indicated that meaningful work is a belief held by employees regarding the significance of their work, which, according to this study, was expressed through management's appreciation. Although it was one participant who highlighted the importance of being valued in relation to meaningful work, the writer opines that this should be taken into consideration, as it may influence others in how they perceive spirituality in the workplace. In addition to the insights provided by this participant, others indicated that during COVID-19, work was challenging, but they persevered due to their responsibilities towards their patients. They derived fulfilment from the hope they instilled in their patients and from witnessing their patients' improvement, which was meaningful to them. This finding aligns with Abbobaker's (2021) conclusions, which demonstrated the critical role of workplace spirituality in enhancing employees' psychological well-being through meaningful work. The joy participants experience when providing care to patients and seeing their recovery underscores the importance of their work. This is further supported by Widodo and Suryosukmono (2021), who view meaningful work as a pathway that adds harmony to a busy work routine, making employees feel at ease in the workplace and aiding the organisation's performance. This study revealed that when nurses understand their roles, the nature of their work, and how it contributes to the strategic objectives of the facility, it enhances their sense that their day-to-day activities add meaning to both themselves and the organisation as a whole. This perspective is supported by Hakimi et al. (2013), who believe that providing employees with a deeper

understanding of what makes work creative, meaningful, and purposeful is crucial for improving their performance and fostering greater creativity and productivity in the workplace.

6.6.5 Alignment with Organisational Values

In this study, participants perceived managers as representatives of the organisation or health department. Experiences and perceptions of managers and leadership were interpreted as expressions of the organisational values. Hisam and Sanyal (2021) opined that organisational values are the guiding principles or moral standards that are deeply embedded in the ethos and culture of an organisation.

The findings of this study indicated that almost all participants expressed disappointment regarding the lack of management support during COVID-19. One participant conveyed deep emotion over the absence of support from managers, a sentiment echoed by all participants. They indicated that managers were very harsh and showed little concern for those diagnosed with COVID-19, focusing instead solely on completing tasks and ensuring that the needs of patients were met. These findings further support Kim's (2021) assertion that substantial investment has been directed towards research on the psychological impact of crises, particularly the pandemic. Kim highlighted the importance of considering the psychological well-being of professional nurses. However, this stands in contradiction to the views of the pioneers of workplace spirituality (Ashmos and Duchon, 2000), who advocate that workplace spirituality acknowledges and embraces employees' inner lives, sustained and nourished by meaningful work in a communal environment. Participants reported that they were expected to work even while ill, with no time allowed for rest, and found the working hours to be excessive. When one of the nurses was diagnosed with COVID-19, some nurses reported that managers could not even offer basic medication to the nurse, knowing she needed to go into quarantine; instead, it was the other nurses who attempted to provide assistance to their colleague.

This finding does not support the premises of the humanistic management theory that underpins this study, which emphasises a people-centric approach by ensuring that individuals are placed at the centre of management practices to recognise their importance, contributions, and value (Mele, 2016). Mele opined that this has a positive influence on individuals' perceptions of their belonging and meaningful work. Conversely, when employees feel that management is unsupportive and that they are not valued, it can lead to a sense of meaninglessness in their work and feelings of isolation.

The participants indicated that the last time they engaged with senior officials from the Department of Health was when COVID-19 was declared a pandemic and when they were

preparing for the challenges ahead. The findings of this study revealed that a lack of acknowledgment for their efforts and achievements, as well as inadequate compensation, demotivated the nurses. It also conveyed a sense of being uncared for and disrespected by immediate managers and senior leadership from the Department of Health. Humanistic theory and workplace spirituality emphasise the importance of well-being and respect, which were not felt by the nurses during the COVID-19 pandemic. Mitroff and Denton (1999) opined that organisations that adopt human values such as well-being, respect, and trust foster an environment where spirituality can thrive, allowing employees to connect their personal beliefs and values with their work. Srivastava and Gupta (2022) also support the promotion of workplace spirituality and indicate that it enhances employee resilience and assists them in navigating crises.

When asked about their expectations regarding compensation, all participants indicated that they would have appreciated a salary increase or a one-off payment as a gesture of appreciation; this is a new theme that has emerged from this study. The participants reported that they were given leave days as a form of reward for their hard work during COVID-19, but they felt that the Department could have done better than that. They went as far as to say that words of appreciation would have been welcome, and that leadership reaching out to them with a simple thank you for their efforts and dedication during these difficult times would have made a significant difference, but none of that occurred. When they were asked what truly motivated them to come to work, they indicated that the fulfilment they experienced when witnessing their patients recovering from illness made their work feel meaningful.

Regarding nurses' values and their perception of the impact of misalignment between their values and those of the organisation, it was evident that nurses understood the pledge they took upon entering their profession, which indicated that their values do not take precedence over those of their patients. This implies that there are certain expectations that nurses accepted when they began their careers; however, support from individuals in managerial or leadership roles was still recognised as essential for assisting them in fulfilling the organisational mandates associated with that pledge. From the writer's perspective, support from managers, based on these findings, would have enhanced the motivation and dedication of nurses in delivering the expected service to patients and contributed to a greater sense of worthiness and belonging. Hisam and Sanyal (2021) suggested that employees who identify with their employer's values and share them personally feel a greater sense of loyalty to the organisation, and they tend to work more happily and are more motivated to contribute to the company's success. However, the findings of this study do not fully support the previous research, as

participants reported a lack of support from management and senior authorities within the Department of Health. Additionally, some of the values they were expected to uphold contradicted their personal beliefs, yet they were still willing to sacrifice their values in respect of the pledge they took. Indeed, other participants indicated that when one's values are not aligned with those of the organisation, it suggests that the person is in the wrong organisation. They identified the following outcomes of value misalignment: burnout, spiritual disconnection, poor performance, increased absenteeism, and unplanned resignation. Respect was another value that participants indicated as a marker of workplace spirituality. Respect was perceived in relation to discipline, with the understanding that when a manager must discipline an employee, it should be done respectfully and not in front of other colleagues. Participants felt that engaging with their managers could sometimes be challenging due to the perceived inappropriateness of the managers' approach.

Another new finding that emerged from this study, when participants expressed their understanding of spirituality, was the importance of inclusion. According to the participants, inclusion pertains to an organisational culture that respects all belief systems, not only in principle but in practice. They reported that an organisation that encourages spirituality should not view one belief as superior to another; rather, everyone's beliefs should be respected. They expressed this sentiment when referring to having a mosque, which they described as a place to visit when one wishes to have a moment of solace or to pray and read the Bible as a means of reconnecting with one's inner self. Participants also recognised that not everyone believes in prayer; some of their colleagues prefer to connect with their inner selves through meditation or moments of silence. The nurses felt that all these practices should be accommodated to ensure that every belief is respected.

6.6.6 Resilience

The stance this study took when defining resilience was a multidimensional one, where resilience is defined as an individual's ability to successfully access the psychological, social, cultural, and physical resources necessary to maintain their well-being, as well as their ability, both individually and collectively, to advocate for these resources to be made available and experienced in ways that are culturally meaningful. This study explored nurses' resilience during crises; however, the nurses' responses were primarily centred around their experiences of COVID-19, likely because COVID-19 was still a recent and impactful event in their minds. The theoretical framework used to anchor this study was the Salutogenic Model of health, which emphasises an individual's ability to utilise both internal and external resources, referred

to as general resistance resources (GRR) by Antonovsky (1979), to manage stressors. GRR is defined as the physical, biochemical, artefactual-material, cognitive, emotional, valuative attitudinal, interpersonal-relational, and macrosocial cultural characteristics of an individual, group, and society that are effective in avoiding and combating a wide variety of stressors.

The current study found that resilience involves an individual's belief in their capacity to overcome difficulties, with personal strength serving as a key indicator of resilience. This aligns with the concept of self-efficacy, introduced by Rotter (1996), and defined as an individual's belief that they possess the necessary capabilities to succeed in any situation. Individuals with strong self-efficacy have been shown to experience less psychological and physiological strain in stressful situations (Rotter, 1966). Terms such as "pushing back", "recovering quickly", and the presence of inner strength and unwavering confidence were used by nurses when asked to share their perceptions of resilience. This is consistent with observations by Garcia-Dia et al. (2013), who attributed variations in adaptive responses to internal psychological resources, including personal abilities and strength. These results also align with the concept of sense of coherence, a central tenet of the Salutogenic Model. Sense of coherence is defined as a pervasive, dynamic feeling of confidence underpinned by the belief that internal and external stimuli are structured, predictable, and explainable; that sufficient resources are available to meet life's demands; and that challenges are viewed as opportunities for growth and engagement (Antonovsky, 1987). Participants strongly believed in their ability to overcome life's challenges, with self-belief a core aspect of their understanding of resilience. Hope and optimism were also considered significant contributing factors. Nurses emphasised the importance of acknowledging a situation, accepting it, learning to live with it, and moving forward to avoid breakdown. This aligns with the ecological perspective on resilience, which emphasises the role of external factors and views resilience as a dynamic process rather than a static trait (Metais et al., 2022). Metais highlighted the importance of an individual's engagement in an adaptive process during times of crisis, considering both harmful and beneficial factors, consistent with this study's findings, which showed nurses actively engaging and adapting to the challenges they faced.

This confirms Antonovsky's (1987) definition of general resistance resources (GRR) within the salutogenesis model, encompassing both internal and external resources for managing ubiquitous stressors, including physical, cognitive, emotional, interpersonal-relational, and microsocial cultural characteristics effective in stress avoidance and combat.

Participants further indicated the importance of clarity regarding their professional roles and motivations for being in the nursing profession. Commitment and a sense of purpose were also regarded as mechanisms that enhance resilience during times of crisis. Batho Pele and a commitment to the nurse's pledge were mentioned once again as mechanisms nurses use to remain focused during adversity; according to this study, this has resulted in enhanced resilience. This finding supports the importance of a sense of purpose, defined by Joshua et al. (2021) as a clear understanding of meaning in one's work, which can provide motivation and resilience in challenging circumstances.

Social connectedness and a support network emerged as strong promoters of nurses' resilience during the COVID-19 pandemic. The findings of this study highlight the importance of supporting one another during difficult times and how such support can contribute to overcoming adversity. The support was primarily expressed by family members and colleagues. Participants indicated the importance of having someone to confide in, referring to that person as a source of strength. Words of encouragement were also considered important in lifting one's resilience during difficulties; being acknowledged was reported as a sign of solidarity and recognition. Collaborative work towards a common goal during the crisis positively influenced nurses' resilience. Consistent with the findings on workplace spirituality, social support, and a sense of belonging play a crucial role in enhancing resilience, with the care expressed among nurses often resembling familial bonds. This supports Curtin et al.'s (2022) antecedent of "connection with others" and McDonald et al.'s (2016) emphasis on utilising support networks and feeling connected to the nursing profession and workplace for emotional support and coping. Participants also noted that solidarity in the face of adversity helps maintain resilience, driven by a desire not to be the weakest link. However, a consistent finding was the lack of leadership support, which was reported to increase stress rather than enhance resilience.

Another finding reported was the impact of culture on resilience. This study indicated that culture, specifically African culture, has taught males to be resilient at all times. They grew up understanding that they need to fight for themselves and that they must be strong. This was also evident in the work environment during a time of crisis, where they persisted with the understanding that men must be resilient. It was indicated that this cultural belief did not imply that males do not have feelings; however, the male participants in this study indicated that when they needed to express their emotions, they ensured it was done in private rather than in public. Females, on the other hand, reported that their experience with culture in relation to resilience was rather suppressive. They stated that females were not given the freedom to fully express

their emotions and were always expected to be quiet. These findings were more general; however, one can see how these cultural beliefs affected the resilience of female nurses in the workplace. During the COVID-19 pandemic, nurses reported that they were forced to return to work even though they were still not feeling well after being diagnosed with COVID-19. They exhibited powerlessness towards their authorities and returned to work, compromising their well-being. Spiritual resources emerged strongly in this study as a source of resilience during crises. Nurses reported that prayer and their faith in God sustained them during COVID-19. They indicated that their resilience levels during this period were tested; however, their trust in God and the belief that nothing is impossible with God kept them strong. This indicates that nurses were able to access both internal and external resources to mitigate the impact of stress during COVID-19. When nurses were asked for their recommendations to management regarding what could have assisted them in remaining resilient during crises, they expressed that they would have appreciated if management had arranged for a psychologist to provide emotional support. Understanding their mandate as nurses and the pledge they took when joining the nursing profession, COVID-19 was reported to have challenged their resilience. However, it was strongly indicated that emotional and psychological support would demonstrate that managers cared for their well-being.

6.6.7 Mental Health

The findings of this study on nurses' understanding of mental health revealed that participants generally perceived mental health as a state associated with emotional and psychological distress. Participants emphasised that an inability to manage emotions during times of crisis could contribute to the development of mental illness, thereby underscoring the importance of emotional stability in coping with stressful situations. These findings are consistent with those of Htay et al. (2021), who reported that nurses experienced significant difficulties in managing the psychological impact of the COVID-19 pandemic, which often manifested as insomnia, anxiety, and depression. The present study's findings also align with the concept of emotional well-being, identified as a core component of mental health. Emotional well-being refers to an individual's capacity to regulate emotions, express feelings appropriately, and maintain a positive outlook on life, all of which are essential for sustaining mental health and fostering resilience during periods of crisis (Robertson et al., 2020).

Furthermore, the findings indicated that understanding and maintaining a realistic perception of one's own strengths and limitations, combined with confidence in one's ability to face challenges, are critical for promoting positive mental health. This perspective is

consistent with the World Health Organisation's (2001) definition of mental health as the ability to cope effectively with the normal stresses of life and adapt to adversity. Similarly, the results support the notion of psychological well-being, another key component of mental health, as described by Robertson et al. (2020). Psychological well-being encompasses attributes such as self-acceptance, which involves recognising and embracing personal strengths and weaknesses. Individuals who exhibit high levels of self-acceptance are better equipped to cope with life's challenges, as this awareness promotes resilience, adaptive coping, and overall psychological stability.

The results also indicated the importance of high self-confidence, emphasising the impact of believing in one's capability to cope and survive after being exposed to a stressful event. This is further supported by the salutogenesis theory, which posits that Generalised Resistance Resources (GRR) – including biological, material, and psychosocial factors – facilitate individuals' perceptions of their lives as consistent, structured, and understandable (Antonovsky, 1979). This aligns with the definitions of self-efficacy proposed by Rotter (1966) and Bandura (1997), which refer to an individual's personal conviction regarding their capacity to successfully execute actions leading to desired outcomes. The findings further highlighted the importance of maintaining a positive mindset when analysing life situations, with participants believing that a positive outlook enhances resilience and sustains mental health, while a negative mindset can lead to depression. This was corroborated by Ortiz et al. (2022), who noted that mental health can be influenced by personality factors, coping strategies, and past stress or trauma. This indicates that remaining positive amidst challenges can contribute to healthier mental well-being.

Makhado et al. (2024) and Zhang et al. (2020) reported that previous trauma can influence how nurses respond to adversities. They suggested that those with prior exposure may experience heightened psychological pressure due to the accumulation of past traumas. However, the findings of the current study do not support this notion; nurses reported that age and life experience appear to be contributing factors to the development of resilience, and they expressed belief in their own strength to cope with adversity. Some reported that, due to past adversities, they have learned that challenging events will come and will eventually pass. Knowledge, culture, social support, intelligence, and ideologies are examples of GRR, which are shaped by life experiences characterised by consistency, participation in shaping outcomes, and balance between underload and overload (Antonovsky, 1979). The current study supports these findings, as nurses indicated that life has taught them to engage positively with situations

rather than focus on the negative aspects. To illustrate this, phrases such *as "we have learnt to wear a crocodile skin, I will cross the bridge when I get* there" were used to emphasise that they have endured significant challenges and that no situation will easily break them, with COVID-19 having made them even stronger in facing adversity.

The findings of this study revealed that relationships with family, friends, colleagues, and the wider community play a crucial role in enhancing and sustaining mental health. Strong social connections and support networks were found to significantly increase resilience against mental health challenges (Onwubu et al., 2023). Consistent with this, the study identified social support as one of the key factors contributing to positive mental health outcomes. Conversely, a lack of social support appeared to negatively impact nurses' mental well-being, with participants reporting experiences of loneliness, isolation, and hopelessness. These feelings were perceived to exacerbate psychological distress and reduce overall emotional stability.

These findings are supported by Ortiz-Calvo et al. (2022), who observed that social support mitigates the adverse effects of stress and trauma experienced by nurses, and that emotional support serves as a protective factor by enhancing resilience.

In addition to social support, the study also highlighted the importance of spirituality in mitigating the effects of mental distress. Participants reported a strong reliance on prayer, which they found to be a source of strength and hope during the COVID-19 pandemic. For many, a connection with God provided comfort, meaning, and a sense of purpose, which collectively enhanced their resilience during times of crisis.

These findings are consistent with the work of Shozi (2021), who noted that spirituality plays a significant role in shaping individuals' thoughts, emotions, and behaviours. According to Shozi, spirituality offers a framework of meaning that guides people both in daily life and during major crises. This meaning, often derived from religious, cultural, and spiritual practices, can foster resilience and provide psychological protection against stress and adversity. Similarly, the present study demonstrates how cultural beliefs and spiritual values influence nurses' coping mechanisms, shaping their capacity to remain resilient in the face of professional and personal challenges.

The findings of this study also highlighted the importance of adopting healthy coping strategies in maintaining and promoting mental well-being. Participants reported that engaging in physical exercise was particularly beneficial in managing stress, which, if left unaddressed, could potentially lead to the onset of mental illness. Others identified listening to music as an effective means of calming emotions and alleviating psychological tension, while several participants emphasised that prayer was a crucial coping mechanism they relied upon during

times of crisis. Additionally, taking time off work was regarded as essential for recovery and for preventing exhaustion or burnout.

However, despite acknowledging the significance of rest and self-care, participants reported that they were often not provided with adequate time to recuperate. Instead, they were expected to work prolonged hours or return to duty even when unwell. This lack of rest was perceived to have a negative impact on their mental well-being, leading to increased emotional exhaustion and decreased resilience.

Closely related to these findings, work–life balance emerged as a significant factor influencing mental health. Participants indicated that during periods of crisis, they were frequently required to work extended shifts with minimal opportunities for rest or personal time. This sustained workload resulted in fatigue, emotional strain, and diminished morale, all of which were perceived as detrimental to their overall mental health. Participants emphasised that without a healthy balance between professional responsibilities and personal well-being, nurses are at greater risk of developing mental health problems. They further underscored the importance of organisational support, adequate staffing, and policies that promote rest and self-care, as these factors are essential for fostering psychological resilience and sustaining mental wellness.

Notably, this sub-theme of work–life balance appeared to be unique to the present study, as it did not prominently feature in the literature reviewed. This suggests that work–life balance may represent an emerging or context-specific factor influencing the mental health of nurses, particularly in high-stress environments or during times of crisis.

Building upon these findings, the final sub-theme explored in this study relates to the influence of cultural beliefs on mental health and resilience – a dimension that further illustrates how socialisation and cultural expectations shape nurses' coping mechanisms and overall psychological well-being. Although limited literature exists on the specific influence of cultural beliefs on the mental health of nurses, the findings of this study highlight the significant role of socialisation and gender norms in shaping mental health outcomes. Male participants reported that from a young age, they were socialised to be resilient and self-reliant. This belief, rooted in cultural expectations that "a man must fight his own battles", was perceived to strengthen their resilience and help them cope with mental health challenges.

In contrast, female participants described a different experience. They indicated that traditional socialisation emphasised submissiveness and compliance, which they perceived as limiting their ability to express themselves freely in both personal and professional contexts.

According to the findings, this social conditioning had a negative impact on their mental well-being, as it often led to feelings of powerlessness and emotional suppression.
Overall, these findings underscore the influence of cultural and gender-based socialisation on nurses' mental health and resilience, suggesting that deeply ingrained cultural norms can either foster psychological strength or contribute to emotional vulnerability, depending on how they shape individuals' coping mechanisms and self-expression.

6.7 Chapter Conclusion

This chapter presented and discussed the findings of the study in relation to the research objectives and the existing body of literature. The study highlighted the significant role of workplace spirituality in fostering resilience and supporting the mental health of professional nurses, particularly during times of crisis. Participants articulated their perceptions of workplace spirituality, resilience, and mental health with clarity and depth, reflecting their lived experiences in the healthcare environment. Although the alignment between individual and organisational values was not perceived as a factor directly influencing resilience, participants identified the professional pledge as a guiding principle that provided focus and motivation amidst challenging circumstances. The findings further indicate that workplace spirituality plays a vital role in promoting resilience and enhancing nurses' mental well-being. Moreover, the concept of workplace spirituality was found to be closely associated with religion and the diverse belief systems held by individuals. Overall, participants demonstrated a shared understanding of the meanings of resilience and mental health, underscoring their interconnectedness within the context of nursing practice.

CHAPTER 7:
INTERVENTION MAPPING

7.1 Introduction

This chapter presents the formative design of an intervention to enhance psychological resilience and mental health among professional nurses by promoting workplace spirituality. The intervention was designed using the Intervention Mapping framework, a systematic approach to planning theory- and evidence-based health promotion programmes. Intervention mapping provides a stepwise process that links empirical evidence, behavioural theory, and stakeholder input to create structured, context-specific interventions. While the Intervention Mapping (IM) protocol encompasses six steps, this thesis focuses on the systematic development of the intervention (Steps 1–4). The subsequent stages of adoption, implementation (Step 5), and evaluation (Step 6) are proposed as critical directions for future research to test the feasibility and efficacy of the developed framework in clinical settings.

Grounded in an ecological perspective, intervention mapping recognises that health behaviours and outcomes are shaped by complex interactions between individual, interpersonal, organisational, and community-level factors. Therefore, the framework facilitates a comprehensive analysis of the problem, identifies behavioural and environmental determinants, specifies programme objectives, and aligns theoretical methods with practical applications.

This chapter outlines the application of the first four steps of the intervention mapping process (Eldredge, 2016).

1. **Needs Assessment and Logic Model of the Problem**: This step involves identifying key issues affecting nurses' mental health and resilience and defining the scope and goals of the intervention.
2. **Logic Model of Change**: This step focuses on establishing specific behavioural and environmental outcomes, performance objectives, and determinants of change across multiple ecological levels.
3. **Selection of Theory-Based Methods and Practical Applications**: This step guides the design of intervention strategies based on Self-Determination Theory and other behavioural change models.

4. **Programme Production**: These steps outline the development of training materials, tools, and activities tailored to the needs and constraints of professional nursing environments.

Steps 5 (adoption and implementation) and 6 (evaluation planning) are not covered in this chapter, as the intervention has not yet been implemented. Instead, the focus remains on the formative development of the intervention, which incorporates both the insights of professional nurses and relevant theoretical and empirical literature.

By following this structured approach, the chapter aims to illustrate how workplace spirituality can be operationalised as a practical and meaningful strategy to support nurses' resilience, well-being, and capacity to deliver compassionate, high-quality care, particularly during times of crisis.

7.2 Background and the Rationale

According to the World Health Organization (WHO, 2007), a well-functioning health system effectively addresses the needs and expectations of its population. This includes enhancing the health outcomes of individuals, families, and communities, safeguarding against health threats, mitigating the financial burdens of morbidity, and ensuring equitable access to people-centred healthcare services. In alignment with this vision, South Africa is pursuing comprehensive health sector reforms through the development and implementation of the National Health Insurance (NHI) system and a restructured primary healthcare (PHC) service delivery model. Nevertheless, the country's progress is significantly hindered by persistent inequalities and the underperformance of its healthcare system. The conditions of employment, as well as the health, safety, and well-being of the health workforce, are essential drivers of quality healthcare and the overall performance and efficiency of the health system (Ngwaru et al., 2019).

Healthcare institutions are increasingly prioritising quality of care and client satisfaction. Simultaneously, a paradigm shift is occurring that emphasises understanding the needs of employees, particularly their well-being, motivation, and job satisfaction – elements rooted in a culture of care and compassion (Paal et al., 2018). This aligns with Goal 5 of the 2030 Human Resources for Health Strategy, which aims to *"build an enabled, productive, motivated and empowered health workforce."* Two of the outputs of Goal 5 include 1) tracking, measuring, and reducing health workers' risks, burnout, attrition, and unscheduled absence, and 2) applying, tracking, and measuring innovative tools and programmes aimed at maximising

health worker supportive productivity, performance, engagement, wellness, and morale in the workplace.

Considering these imperatives, workplace spirituality, grounded in principle-based conduct that shapes the organisation's ethical climate, has the potential to serve as a strategic organisational asset. It enhances employee well-being while simultaneously improving overall productivity and service quality (Vasconcelos, 2011). Within this framework, spirituality refers to the integration of personal beliefs, core values, and inner strengths that significantly shape an individual's sense of purpose and dedication to their work. Na'imah et al. (2021) highlight that workplace spirituality extends beyond religious dimensions and encompasses how individuals express and align their personal values and beliefs within the workplace setting. Putri (2022) explores the impact of workplace spirituality on burnout, particularly in the context of caring for COVID-19 patients. Their findings suggest that workplace spirituality serves as a protective factor against burnout amid intense workloads and demanding roles. Through a spiritual lens, nurses tend to perceive their work as meaningful and purposeful, viewing the delivery of quality healthcare not merely as a duty but as a profound life endeavour.

Workplace spirituality manifests across three interrelated levels: the individual level, the organisational level, and a combination of both (Petchsawang & McLean, 2017). At the individual level, workplace spirituality refers to a person's internal experience characterised by a sense of vitality, joy, and alignment between personal values and meaningful work. It also encompasses a sense of connectedness to others, a greater purpose beyond the self, and a feeling of transcendence (Kinjerski & Skrypnek, 2004; Petchsawang & McLean, 2017). At the organisational level, workplace spirituality is reflected in the organisation's spiritual climate or culture, which is grounded in shared values, a sense of purpose, and a unifying vision (Houghton et al., 2016). Similarly, Giacalone and Jurkiewicz (2003) describe workplace spirituality as a framework of organisational values embedded within the culture, which nurtures employees' experiences of transcendence through their work, fostering a deep sense of connection, fulfilment, and joy.

Workplace spirituality plays a vital role in fostering meaningful connections among colleagues, guiding individuals in discovering their life purpose, and aligning personal beliefs with organisational values (Mitroff & Denton, 1999). The World Health Organization (WHO) defines mental health as a holistic state of physical, mental, and social well-being, rather than merely the absence of illness (WHO, 2011, as cited in Francis, 2014). Within this context, workplace spirituality contributes to the development of employees' emotional and spiritual well-being and strengthens collaborative efforts among team members. It fosters a sense of

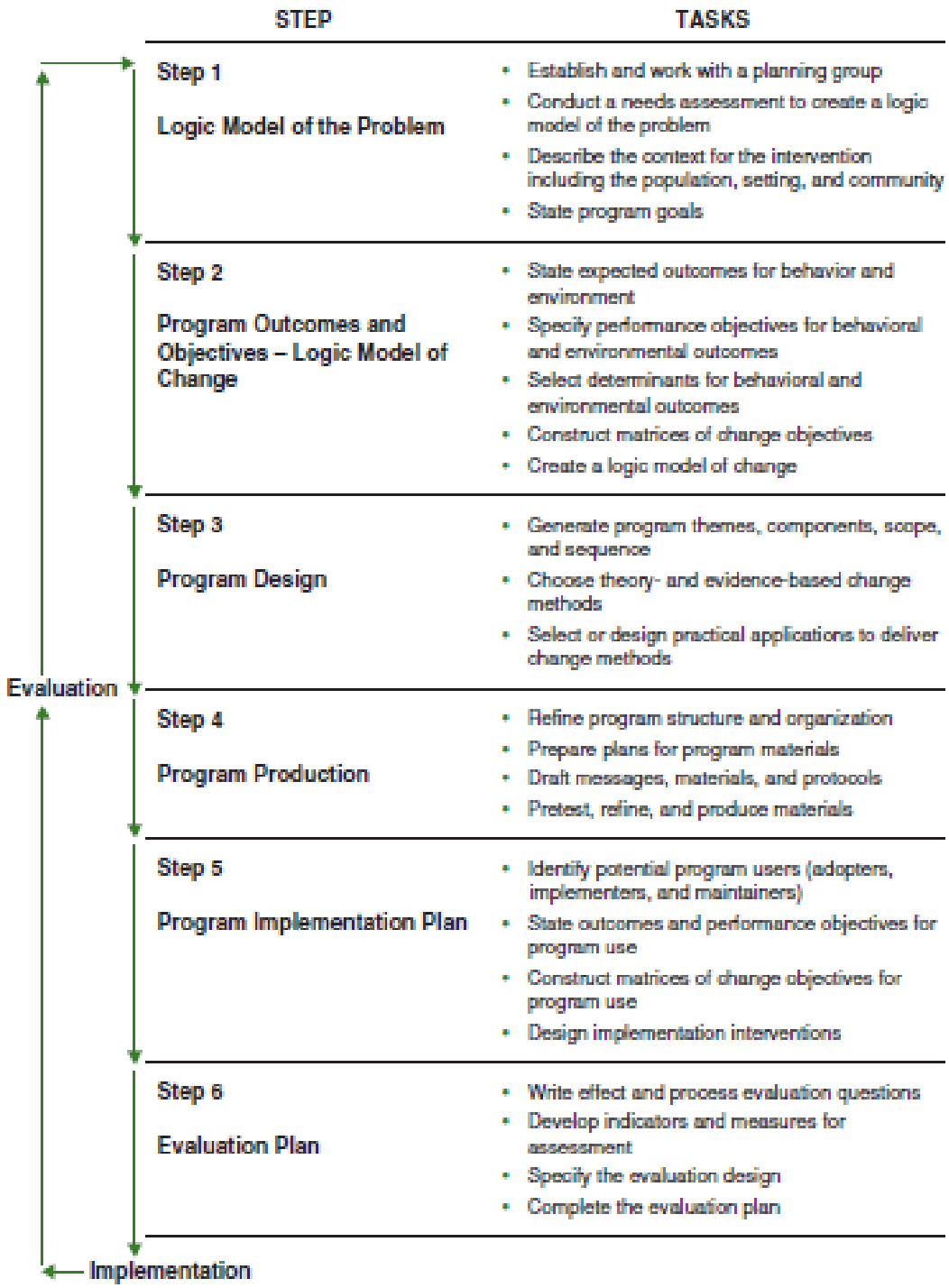
peace and harmony in the workplace, which in turn supports mental health (Honiball et al., 2014). Additionally, it fosters social support networks, which are known to have a positive influence on health outcomes. Spirituality in the workplace also equips employees with the internal resources to cope with stress in demanding organisational environments (Edward, 2005). Moreover, it fosters a sense of coherence, empowering individuals to understand their life's purpose and confront adversity, thereby promoting overall mental well-being. Furthermore, a study conducted by Fezil et al. (2024) highlights that workplace spirituality strengthens nurses' resilience on the job. It allows nurses to forge a deep emotional connection with their professional environment by integrating personal beliefs, values, and inner strength. This inner resource cultivates a sense of meaning, purpose, and belonging, which helps them manage occupational stress and difficulties. The study found that higher levels of workplace spirituality correlate with increased resilience, as it encourages nurses to view challenges constructively, remain dedicated, and uphold their values even in demanding situations. This spiritual grounding fosters a resilient mindset, enabling nurses to effectively navigate and recover from workplace pressures.

7.3 Intervention Mapping

Intervention mapping is a structured, step-by-step framework for designing behaviour change interventions. It relies on theory and evidence to support an ecological perspective in addressing health issues and promoting community involvement in the intervention process (Eldredge et al., 2016). The six steps of intervention mapping are: (1) assess needs and develop a logic model of the problem, (2) develop matrices of behavioural change objectives for the programme, (3) identify theory-based methods and practical applications to be applied in the programme, (4) produce programme components and materials, (5) plan for programme adoption, implementation, and sustainability, and (6) plan for evaluation. However, steps 5 and 6 are not covered in this chapter, as the intervention has not yet been implemented. The methods below outline the four steps and describe how they were applied in developing the intervention: workplace spirituality as a pathway to psychological resilience and mental health in nursing.

Figure 7.1:

Six Steps of Intervention Mapping



Step 1: Logic Model of the Problem

Step 1 comprised establishing a planning group, conducting a needs analysis informed by the PRECEDE planning model (which outlines factors associated with the problem), defining the context of the intervention in terms of population, setting, and stating programme goals.

Task 1: Establish and work with a planning group

The majority of the programme development across the four steps was conducted by a small project team. This included NP, NC, and CZM, in collaboration with professional nurses. NP and CZM are also Industrial Psychologists with an extensive understanding of mental health and employee wellness.

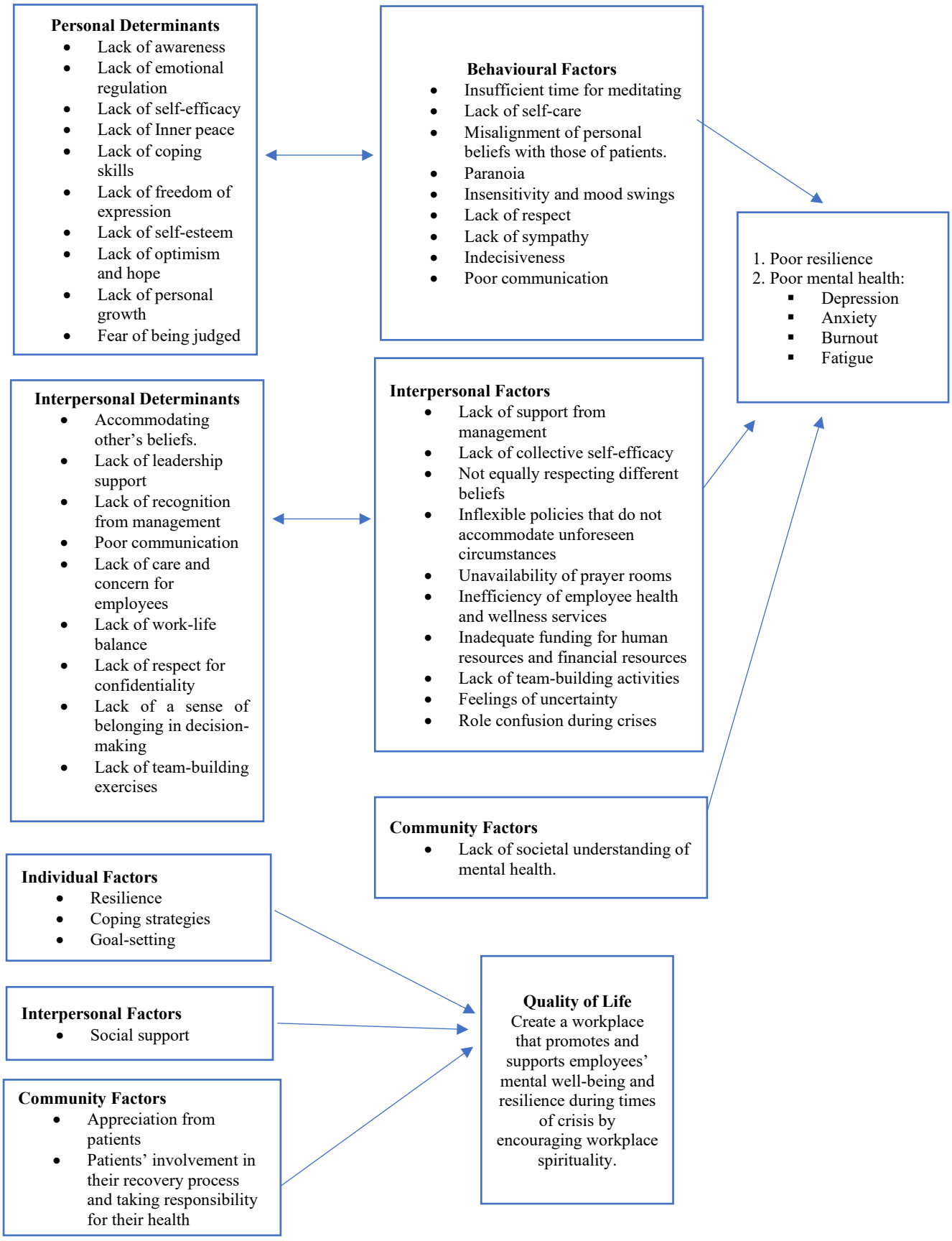
T**ask 2: Conduct a Needs Assessment to Create a Logic Model of the Problem**

The needs assessment, as the initial step of the intervention mapping process, aimed to determine: 1) the prevalence of mental health issues among nurses during crises, 2) their level of resilience, and 3) whether workplace spirituality can assist in enhancing resilience and mental well-being when faced with adversity.

The PROCEED model was employed to guide the assessment process by identifying existing knowledge related to the problem and the context of healthcare facilities, as well as determining areas where additional information was required. This model supported the planning team in clearly defining the issue, understanding the ecological levels influencing it, and identifying key stakeholders who hold relevant insights and perspectives concerning both the problem and potential solutions (Foster-Fishman et al., 2007). The model is depicted in Figure 7.2 below:

Figure 7.2:

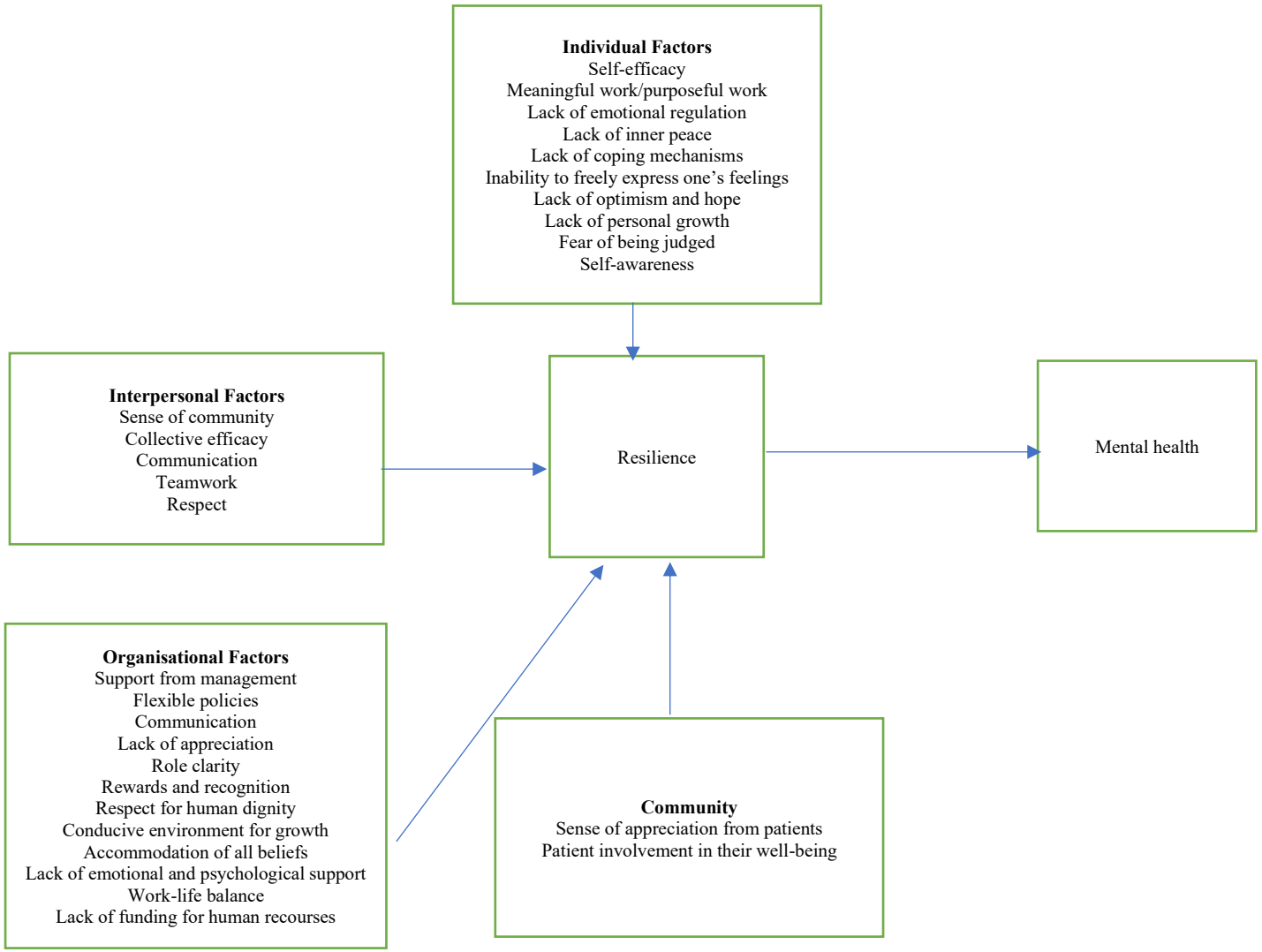
PRECEED Model



This assessment was conducted through a multi-faceted approach, including a literature review, scoping review, and qualitative inquiry. The qualitative inquiry provided nurses with the opportunity to express their experiences and perceptions regarding workplace spirituality, resilience, and mental health during a crisis. They also offered recommendations on management strategies to enhance resilience and mental health during such times. The findings of the literature review are discussed in Chapter 2 of this thesis, the scoping review findings are presented in Chapter 4, while the nurses' perspectives are outlined in Chapter 6. The inclusion of qualitative research facilitated the involvement of nurses in assessing their needs. This approach helped establish rapport with participants by listening to their narratives about their lived experiences, as suggested by Bartholomew et al. (2006). The qualitative study outlined individual, interpersonal, organisational, and community factors that impacted nurses' resilience and mental health during crises, as depicted in Figure 7.3 below.

Figure 7.3:

Individual, Interpersonal, Organisational, and Community Factors Impacting Nurses' Resilience



Step 2: Programme Outcomes and Objectives – Logic Model of Change

This step involved the identification of expected outcomes, performance objectives (POs), and determinants for behaviour and environment, the development of a matrix of change objectives, and the construction of a logic model of change for the programme. According to the social ecological model, health is a function of individuals and the environments in which they live, including family, social networks, organisations, communities, and societies (Berkman et al., 2014). The focus of the social ecological model is on the interrelationships between individuals (biological, psychological, behavioural characteristics) and their environments. The change objectives derived from the needs analysis were prioritised for intervention at the individual, societal (interpersonal), organisational, and community levels.

In light of the needs analysis, it became evident that the intervention for nurses should primarily focus on self-development to enhance their psychological capital for coping with adversity, alongside health education related to physical and mental health issues, coupled with the necessary skills development. Support from management emerged as a significant deficiency, contributing to an environment that is not conducive to promoting nurses' resilience and mental well-being. The involvement of patients in their discovery journey and the appreciation they show for the services nurses provide are also essential.

To ensure the effectiveness of the intervention, various scholars (Fernandez et al., 2019; Kok et al., 2008; Sabater-Hermandez et al., 2016) advocate for identifying change needs across ecological levels. For example, at the individual level, this includes focusing on characteristics such as knowledge, skills, beliefs, and attitudes that may influence behaviour. The target audience for this intervention guideline at the individual level are nurses, who are the primary beneficiaries of the intervention, and at the interpersonal level, their colleagues. The organisational level includes management, and lastly, at the community level, patients and the wider community who receive services from nurses. Behavioural outcomes for this intervention are grounded in the literature review in Chapter 2, Scoping Review findings in Chapter 4 and study findings in Chapter 6 of this thesis, with subsequent performance objectives identified for each behavioural outcome.

The logic model of change represents the systematic transition from the identified problem in Step 1 to a theoretically grounded solution. In alignment with the formative nature of this intervention design, this model serves as a theoretical blueprint for transforming empirical

findings into actionable change strategies. While the initial needs assessment highlights the neglect of nurses' spiritual and emotional well-being during crises, the logic model of change identifies the specific pathways through which workplace spirituality can be operationalised to restore resilience.

The model is built on the premise that mental health outcomes are significantly improved when specific individual and environmental determinants, such as self-efficacy, social connectedness, and management empathy, are modified through targeted activities. As a formative design, the model focuses on the causal chain moving from the mobilization of resources through inputs to the realization of a sustained organisational culture of well-being in the long-term outcomes.

Empirical traceability

To ensure rigorous traceability, each objective and activity within this model is a response to the sub-themes emerging from the qualitative findings in Chapter 6. This evidence-to-action bridge ensures the intervention is context-specific to the professional nursing environment in KwaZulu-Natal.

At the individual level, the model addresses the emotional distress and loneliness reported by nurses by targeting the nurturance of the inner-being and self-efficacy, as detailed in findings 6.2.3.2 and 6.3.1.1. This is achieved through value-based reflection and coping skills training that validates the nurse’s sense of transcendence. At the interpersonal level, the design responds to the high value that nurses place on interconnectedness and social support networks, as found in findings 6.2.4.1 and 6.3.2.2. Consequently, the change objectives focus on peer-led emotional validation and formalising the informal support systems, such as the WhatsApp groups, that nurses utilised to maintain strength during the pandemic. At the organisational and policy level, the model addresses specific recommendations for spiritual spaces for renewal, special leave, and inclusive leadership outlined in 6.4. This is achieved by specifying changes in management behaviour through Emotional Intelligence training and advocating for flexible, wellness-oriented human resource policies.

The logic model detailed in Table 7.1 outlines the causal chain from inputs to long-term impact. However, in accordance with the formative design phase of this thesis, the model emphasises the theoretical alignment of activities with outcomes. In this phase, the primary goal is to

establish a logical, evidence-based framework. The actual practical implementation and the experimental validation of these pathways are proposed as critical future research directions beyond the scope of this chapter.

Table 7.1: *Logic Model of Change*

Inputs (resources and staff)	Activities and participation	Outputs (short-term)	Outcomes (medium to long-term)	Empirical traceability (Chapter 6)
Staff and tech: IT support, survey links, internet connectivity, laptops. **Facilitation: trained facilitators, reflection guides, quiet space.** **Training tools: coping skill guides, stationery, journals, flipcharts.** **Peer Support: Boardrooms, WhatsApp groups, journals for feedback.** **Manager Tools: Digital cards, feedback posters, EQ assessment tools.** **Work-Life Policy: Facilitators, HR policy drafts, awareness campaigns.**	**Baseline survey:** engage nurses and managers to gather input on beliefs and values. **Value-based reflection:** structured activities to promote self-awareness and professional purpose. **Coping skills training:** Practical demonstration of stress management (mindfulness, prayer, breathing). **Peer discussion groups:** facilitate shared experiences and co-development of coping strategies. **EQ and empathetic leadership:** Reminders for managers (Pause, Listen, Validate) and EQ assessments. **Work-Life Balance Advocacy:** Awareness campaigns and review of flexible work/leave policies.	Developed and administered baseline survey; enhanced understanding of spiritual perceptions. Implementation of workshops; increased awareness of personal vs. professional alignment. Nurses trained in somatic and spiritual coping, improved knowledge of stress techniques. Active engagement in peer support; nurses foster supportive relationships and collaborative trust. Managers complete EQ training; implementation of staff expectation feedback loops. Increased awareness of self-care; HR begins policy reviews for flexible scheduling.	**Medium:** strengthened dialogue between management and nurses. **Long:** integration of insights into HR policies. **Medium:** enhanced sense of meaning and connectedness to roles. **Long:** reduced professional drain and burnout. **Medium:** confidence in employing coping strategies during crises. **Long:** sustained improvement in psychological well-being and resilience. **Medium:** Established culture of teamwork and mutual emotional validation.	Finding 6.2.3.1: addresses the need for *respect for spiritual and religious diversity* (God vs. ancestors). Finding 6.2.3.2: directly targets transcendence (nursing as more than a job) and inner-being. Finding 6.3.1.1 and 6.3.2.3: addresses self-efficacy and the use of spiritual beliefs (prayer) as a buffer. Finding 6.2.4.1 and 6.3.2.2: responds to the need for interconnectedness and social support networks. Finding 6.4.1.1: directly addresses reported feelings of loneliness, rejection, and lack of support. Finding 6.4 (recommendations): responds to nurses' call for special leave and human resources support.

	Long: Improved job satisfaction; established social support safety net. **Medium:** managers demonstrate empathy, improved staff trust and psychological safety.	
	Long: embedded leadership culture grounded in Emotional Intelligence. **Medium:** reduction in burnout; managers proactively adjust workloads.	
	Long: sustained organisational culture of well-being and safety.	

Behavioural outcomes refer to the actions that individuals are expected to perform after the intervention, specifically the self-development and health education components of the programme. Outlined below are the expected behaviour outcomes for the self-development and health education components of the intervention.

Self-Development Outcomes – Nurses are Expected to:

- Articulate and demonstrate alignment between their professional role, personal values, and sense of life purpose through compassionate care, ethical decision-making, and commitment to patient well-being.
- Exhibit confidence in employing appropriate coping strategies to manage work-related stress, take proactive steps to address stressors, and maintain composure and effectiveness in high-pressure situations.
- Practice resilience in the face of adversity by cultivating self-awareness, mindfulness, self-care, and forming positive relationships.
- Apply somatic, cognitive, and multimodal techniques to effectively manage workplace stress and enhance coping skills.
- Fully participate in a health and wellness programme focused on holistic physical and mental well-being.

Health Education Outcomes – Nurses are Expected to:

- Identify minor and major health problems and seek timely healthcare.
- Practise relaxation, meditation, breathing exercises, prayer, and yoga mindfulness when feeling overwhelmed.
- Identify personal physical goals and develop feasible plans to achieve those goals.
- Plan and ensure adequate sleep.

Interpersonal Outcomes:

- Nurses actively foster supportive relationships with peers by engaging in regular collaborative communication, offering assistance and feedback, and demonstrating trust and respect in team interactions.
- Nurses collaborate effectively with team members during challenging situations, demonstrating unity and mutual support, and remaining focused on delivering quality patient care in alignment with the nursing mandate.

Organisational Outcomes:

- Managers consistently provide emotional support and express concern for nurses' well-being through active listening, regular check-ins, and responsive action, leading to enhanced staff trust and psychological safety.
- Management develops and implements flexible workplace policies that acknowledge and accommodate the diverse beliefs and values of nurses, as demonstrated by inclusive decision-making and culturally sensitive practices.
- Management regularly expresses appreciation for nurses' efforts through verbal recognition, written acknowledgements, or incentives, leading to increased motivation and a positive work environment.
- Management actively fosters a culture of personal and professional growth by providing learning opportunities, encouraging skill development, and supporting nurses' career advancement through regular mentorship and feedback.
- Management clearly communicates roles, responsibilities, and procedures during crises, enabling nurses to perform their duties with confidence and coordination, thereby reducing role confusion and improving response effectiveness.
- Managers consistently demonstrate respect for human dignity by promoting fairness, encouraging respectful communication, and addressing discrimination or mistreatment, thereby fostering a supportive and inclusive work environment.
- Managers implement staffing strategies and scheduling practices that support nurses' work-life balance by ensuring adequate rest periods and allocating sufficient human resources to manage workload during crises.

Community Outcomes:

- Patients consistently demonstrate awareness and appreciation of nursing care by providing positive feedback, engaging respectfully with nurses, and acknowledging the quality of service received.
- Patients actively engage in their recovery process by following care instructions, participating in treatment decisions, and consistently collaborating with healthcare providers to enhance their health outcomes.

Performance or Behavioural Objectives

Performance objectives refer to the specific actions or behaviours that individuals at risk, or relevant environmental agents, are required to undertake in order to achieve the intended change (Eldredge et al., 2016). According to Eldredge et al. (2016), performance objectives specify what needs to be accomplished, enabling planners to transition from general behavioural and environmental factors to a detailed plan of actions that will promote the desired health behaviour.

Table 7.2:

Matrix of Individual Change Objectives Pertaining to Self-Development

Determinants	**Performance Objectives**	**Change Objectives**
Self-awareness and internalised values	To assist nurses in reflecting on and articulating their personal values, emotions, strengths, and limitations, and apply this self-awareness to guide professional conduct and interpersonal interactions in the workplace.	Nurses will enhance their ability to reflect on and articulate their personal values, emotions, strengths, and limitations, utilising this self-awareness to guide their professional behaviour and interactions with others.
Resilience and coping skills	To assist nurses in developing resilience in the face of adversity.	Encourage nurses to maintain perspective when faced with adversity. A constant reminder of the nursing pledge to focus nurses on their mandate. To equip nurses with effective coping strategies, including meditation, prayer, yoga, and mindfulness.
Awareness of the importance of using health and wellness services to improve personal well-being and job performance	Nurses will demonstrate an understanding of the importance of utilising health and wellness services by identifying how these services contribute to their personal well-being and enhance job performance.	Nurses will increase their awareness of the significance of using health and wellness services to enhance their personal well-being and job performance.
Goal setting	To assist nurses in developing personal goals and plans to achieve their physical health goals.	Nurses will improve their ability to formulate clear personal physical health goals and create feasible, actionable plans to achieve these goals.

Table 7.3:

Matrix of Interpersonal Change Objectives

Determinants	Performance Objectives	Change Objectives
Support Systems/ interconnectedness	The nurse regularly engages in collaborative communication with peers, provides assistance and constructive feedback, and demonstrates trust and respect during team interactions.	Nurses will increase the frequency and quality of their collaborative communication, willingness to offer assistance and feedback, and demonstration of trust and respect in interactions with peers
Collective efficacy	The nurse actively collaborates with team members during challenging situations by offering support, maintaining team cohesion, and consistently focusing on delivering quality patient care in line with professional responsibilities.	Nurses will enhance their ability and willingness to collaborate with team members during challenging situations, provide mutual support, and remain focused on delivering quality patient care aligned with their professional role.

Table 7.4:

Matrix of Organisational Change Objectives

Determinants	Performance Objectives	Change Objectives
Expectations of emotionally intelligent management	Managers consistently provide emotional support and express concern for nurses' well-being through active listening, regular check-ins, and responsive action, leading to enhanced staff trust and psychological safety.	Managers will enhance their knowledge, skills, and willingness to provide emotional support by actively listening to nurses, conducting regular check-ins, and responding effectively to staff well-being needs.
Understanding the broader culture of the organisation regarding inclusion, openness to diversity, and responsiveness to staff needs.	Managers will engage nurses in inclusive policy discussions, assess staff needs related to cultural and personal values, and implement flexible workplace policies that reflect and respect this diversity.	Managers will enhance their knowledge, skills, and commitment to engaging in inclusive decision-making and developing flexible workplace policies that respect the diverse beliefs and values of nursing staff.
Awareness of different forms of recognition (verbal, written,	Managers will consistently recognise nurses' contributions by providing timely verbal praise, written acknowledgements, or appropriate incentives to reinforce	Managers will enhance their knowledge, skills, and motivation to provide nurses with regular and meaningful recognition

Determinants	Performance Objectives	Change Objectives
incentives) and when/how to use them effectively.	positive performance and promote a supportive work environment.	through verbal, written, and incentive-based methods.
A workplace environment that supports ongoing learning, career development, and open feedback.	Managers will provide regular learning opportunities, facilitate skill development activities, and conduct mentorship sessions with constructive feedback to support nurses' personal and professional growth.	Managers will enhance their ability and commitment to facilitating learning opportunities, skill development, and mentorship with effective feedback to support nurses' personal and professional growth.
Understanding of roles, responsibilities, and crisis management processes.	Managers will clearly communicate roles, responsibilities, and procedures to nursing staff during crises, ensuring nurses understand their duties and coordinate effectively to reduce role confusion and enhance response effectiveness.	Managers will enhance their knowledge, communication skills, and confidence in clearly conveying roles, responsibilities, and procedures during crises to ensure nurses understand their duties and collaborate effectively.
Managers' personal commitment to human dignity, equity, and ethical leadership is essential.	Managers will consistently promote fairness, practise respectful communication, and promptly address instances of discrimination or mistreatment to foster a supportive and inclusive work environment.	Managers will increase their awareness, skills, and commitment to promoting fairness, engaging in respectful communication, and addressing discrimination or mistreatment to create a supportive and inclusive work environment.
Managerial values prioritising work-life balance and staff health are vital.	Managers will develop and apply staffing strategies and scheduling practices that ensure nurses receive adequate rest periods and that sufficient human resources are allocated to manage workload effectively during crises.	Managers will enhance their knowledge, skills, and commitment to designing and implementing staffing and scheduling practices that support nurses' work-life balance by ensuring adequate rest and appropriate workload distribution during crises.

Table 7.5:

Matrix of Community Change Objectives

Determinants	Performance Objectives	Change Objectives
Awareness	Patients will provide positive feedback, engage respectfully with nurses, and	Patients will increase their awareness of the value of nursing care and their

Determinants	Performance Objectives	Change Objectives
	verbally or non-verbally acknowledge the quality of nursing care received.	willingness to express appreciation through respectful engagement and constructive feedback.
Perceived self-efficacy	Actively participating in discussions and decisions regarding their treatment options	Patients develop the knowledge, confidence, and communication skills necessary to actively participate in discussions and decisions about their treatment options.

Step 3: Theoretical Methods and Practical Applications

Following the identification of performance and change objectives in Step 2, this step focuses on selecting evidence-based theoretical methods and translating them into context-specific practical applications. Theoretical methods are generalised techniques derived from behavioural science theories and supported by empirical research, which are designed to influence behavioural and environmental determinants of change (Kok et al., 2004). These methods provide the conceptual foundation for intervention strategies that aim to modify individual behaviour and organisational practices. The programme is a multi-level health promotion initiative aimed at strengthening the psychological resilience and mental well-being of professional nurses, with a central focus on fostering workplace spirituality as a core intervention strategy.

Given this intervention's focus on self-development, mental health education, and workplace behaviour, the **Self-Determination Theory (SDT)** and relevant behaviour change models were selected to guide method selection and application design. These models support the development of intrinsic motivation, emotional resilience, and psychological well-being, all of which are central to the intervention's objectives.

Theoretical Foundation: Self-Determination Theory (SDT)

Self-Determination Theory (SDT) is a comprehensive metatheoretical framework for understanding human motivation, psychological development, and well-being (Deci & Ryan, 1985). It encompasses a family of six interrelated mini-theories that collectively explain how social and contextual factors influence motivation, performance, and mental health across diverse life domains, including occupational settings (Fernet, 2013), interpersonal relationships (La Guardia & Patrick, 2008), educational environments (Reeve & Lee, 2014), religious

engagement (Soenens et al., 2012), health behaviour change (Russell & Bray, 2010), and sports performance (Pelletier et al., 2001).

Central to SDT is the proposition that all individuals possess inherent psychological needs that must be satisfied to achieve optimal functioning. These basic psychological needs are:

- **Autonomy**: The need to experience one's actions as volitional, self-initiated, and aligned with one's values.
- **Competence**: The need to feel effective in interacting with the environment and capable of achieving desired outcomes.
- **Relatedness**: The need to feel connected to, cared for, and respected by others.

When these needs are supported, individuals are more likely to engage in activities with a sense of interest and commitment, leading to higher psychological resilience, motivation, and well-being.

Autonomous Motivation in Practice

Autonomous motivation is characterised by engaging in behaviour because it reflects one's personal values and authentic interests. Individuals who are autonomously motivated perceive their actions as freely chosen and aligned with their sense of self. This type of motivation contrasts with controlled motivation, which is driven by external demands or internal pressures such as guilt or obligation (Deci & Ryan, 2000; Ryan & Deci, 2017).

- The **need for autonomy** fosters a sense of ownership over one's behaviour, reinforcing a commitment to meaningful goals.
- The **need for competence** promotes self-efficacy, as individuals believe they can successfully meet challenges and perform effectively in their roles.
- The **need for relatedness** ensures individuals feel socially connected and emotionally supported, which is vital for engagement and resilience in high-stress environments.

Application to Intervention Design

Drawing on these SDT principles, the intervention applies theory-based methods to address the specific behavioural determinants identified in Step 2. Each theoretical method is operationalised through practical strategies designed to be implemented at the individual, interpersonal, organisational, and community levels. These strategies are tailored to the healthcare context and are intended to support nurses in cultivating resilience, enhancing well-being, and sustaining motivation in their professional practice.

The selected techniques include:

- **Autonomy-supportive feedback and reflection** to promote internalised values and meaningful goal setting.
- **Needs-supportive coping skills training** to build emotional regulation and stress management capacities.
- **Relatedness-enhancing group engagement methods** to foster social connection and collective efficacy.
- **Non-controlling recognition and inclusive leadership practices** to reinforce psychological safety and organisational support.
- **Patient-centred education and communication strategies** to strengthen patient involvement and appreciation for nursing care.

Each of these methods is detailed in subsequent matrices and programme components, where they are aligned with specific change objectives and target populations. The use of SDT as a guiding framework ensures that the intervention is both theoretically robust and practically grounded in strategies that enhance nurses' intrinsic motivation, resilience, and overall psychological well-being.

Table 7.6:

Theoretical Methods and Practical Applications

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
Self-Development			
Self-awareness and internalised values	Autonomy-Supportive Feedback and Reflection Facilitation Cognitive Evaluation Theory (Deci & Ryan, 1985).	**Avoid controlling language** • Do not use words like "must", "should", or "have to". Use supportive language such as "you might consider" or "what do you think?" **Emphasise choice and volition** Offer genuine options during discussions and	**Application:** • Create opportunities for individuals (e.g., patients, employees, learners) to explore their values and beliefs through guided reflection and receive **non-controlling, informational feedback**. *Examples:* • **Use open-ended reflective questions** such as: "What matters

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
		encourage self-direction in decision-making. **Provide competence-affirming feedback by** focusing on growth, effort, and understanding – not just outcomes. **Support inner exploration. by** avoiding the imposition of specific values or outcomes; instead, help the individual connect with their own beliefs. **Be empathetic and non-judgmental** Create a psychologically safe space for self-reflection. Use open-ended questions (e.g., "What matters most to you in life?").	most to you in your recovery/work/life right now?" and "How do your daily actions align with what you truly value?" **Provide feedback that supports competence**: • Acknowledge effort and insight: "It's clear you've put a lot of thought into what matters to you." • Highlight growth without judging: "You're starting to notice how your choices reflect your values – keep exploring that."
	Facilitate Meaning-Making (Organismic Integration Theory (OIT) (Deci & Ryan, 2000).	• Avoid imposing values; support autonomy in exploration. • Provide opportunities for choice and voice in treatment decisions.	**Values Clarification Exercises** **Application:** • Guide individuals to explore and reflect on what is personally important and how health behaviours align with those values.
Coping skills	Needs-Supportive Coping Skills Training	**Offer meaningful choice** • Let participants choose coping	**Application:** • Design a structured coping skills training intervention (individual or

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
	Basic Psychological Needs Theory (BPNT) (Deci & Ryan, 2000)	strategies that resonate with their values and context. **Provide positive, informational feedback** • Focus feedback on effort, skill development, and progress – not just results. **Use empathetic, validating communication** • Acknowledge emotional struggles and normalise the learning process. **Encourage collaborative learning** • Facilitate supportive group environments where shared learning is emphasised. **Structure tasks to allow early success** • Start with simple coping strategies to build early mastery and competence.	group-based) that integrates support for autonomy, competence, and relatedness at every step.
Goal Setting	**Intrinsic Goal Framing** (Framing or encouraging goal setting around **intrinsic goals** that align with	**Support autonomy** • Let individuals choose goals that reflect their personal values and interests.	**Activity Title:** *"Mapping My Meaningful Goals".* **Step 1 – Reflective Prompt (Autonomy support):** Ask participants to reflect:

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
	personal meaning, psychological growth, and connectedness to others).	Help individuals explore what goals are meaningful and internally motivating Avoid focus on external rewards. De-emphasise goals tied to approval, money, status, or pressure. • Highlight psychological needs. Link goals to autonomy (freedom), competence (growth), and relatedness (connection).	• *"What are the things you want to achieve in your life that bring you deep satisfaction or joy?"* • *"What would make you feel truly well or fulfilled – regardless of recognition or reward?"* **Step 2 – Goal Categorisation Exercise:** • Provide a list of potential goals (e.g., "maintain physical health", "be admired", "contribute to my community", "earn more money") and ask participants to sort them into **intrinsic** or **extrinsic** categor ies. **Step 3 – Personal Goal Selection and Framing:** • Each participant selects 1–3 **intrinsic goals** (e.g., "being physically healthy to play with my children", "growing emotionally to support others") and frames them in a positive, personally meaningful way. **Step 4 – Goal-Action Alignment (Competence support):** • Facilitate the creation of **SMART action steps** for each intrinsic goal.

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
			Step 5 – Peer Support Dialogue (Relatedness support): • In pairs or groups, participants share their intrinsic goals and action plans, offering encouragement and accountability.
Interpersonal Level			
Social networks or interconnectedness	Relatedness-Supportive Engagement (Basic Psychological Needs Theory (BPNT)	**Support autonomy in relationships** • Allow individuals to choose their connections and participation methods. Avoid forced interactions.. **Foster emotional safety and trust** • Create environments where individuals feel heard, respected, and free from judgment. **Encourage empathy and active listening** • Train facilitators or peers to validate others' experiences and respond with care. **Promote reciprocity and equal participation**	**Application:** 1. Peer Support Groups • **Description:** Facilitate regular peer discussion groups (in healthcare, workplace, or educational settings) where individuals can share experiences, offer support, and co-develop coping strategies. • **Goal:** Build trust, empathy, and social bonds. 2. Team-Based Activities and Group Goals • **Description:** Design group projects or wellness challenges that require collaboration and mutual support. • **Goal:** Promote cooperation and a shared sense of purpose. 3. Mentorship or Buddy Systems • **Description:** Pair participants with mentors or peers for regular check-ins, encouragement, and support.

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
		• Ensure mutual exchange and avoid hierarchies in peer support settings. **Link social connections to personal goals** • Assist participants in recognising how relationships support their growth, values, or recovery.	• **Goal:** Provide consistent social connection and guidance.
Collective efficacy	Needs-Supportive Group Facilitation Basic Psychological Needs Theory (BPNT)	**Autonomy-supportive group structure** Allow group members to make decisions together and voice opinions freely. Avoid top-down control. **Collective competence reinforcement** • Emphasise team strengths and progress. Celebrate group success rather than individual performance only.	**Application:** **1.** Co-created Group Goals and Planning • **Application:** Facilitate group goal-setting sessions where all members contribute ideas and agree on objectives. • **Purpose:** Fosters **autonomy** (ow nership) and **competence** (clarity and confidence in achieving goals).
		Strengthen social connection • Encourage trust, empathy, and informal bonding. Promote group cohesion through shared narratives.	**2. Collaborative Skill-Building Activities** • **Application:** Engage teams in challenges or simulations requiring joint problem-solving, decision-making, and support. • **Purpose:** Builds competence at the group level and reinforces the

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
			belief that "we can succeed together."
		Avoid extrinsic pressure • Do not rely on competition, external rewards, or fear-based motivation. Focus on meaning and shared purpose.	**3. Structured Peer Recognition** • **Application:** Create mechanisms for group members to recognise and affirm each other's contributions (e.g., shout-outs, feedback rounds). • **Purpose:** Reinforces **relatedness** and strengthens mutual respect and collective identity.
		Recognise and address group dynamics • Ensure equity in participation, manage conflict constructively, and support all voices.	**4. Inclusive Communication Practices** • **Application:** Train group leaders to use autonomy-supportive language and practices (e.g., active listening, offering meaningful choices, avoiding control). • **Purpose:** Ensures psychological safety and supports all three needs, especially **autonomy** and **related -ness**.
Organisational Level			
Expectations of emotionally intelligent management	Autonomy-Supportive and Emotionally Attuned Leadership	**Avoid controlling communication** • Managers should refrain from issuing demands, threats, or using guilt; instead,	**Application:** **1. EI-Based Leadership Training** • **Application:** Train managers in emotional intelligence competencies (self-awareness, empathy, emotional

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
	Basic Psychological Needs Theory (BPNT)	they should offer choices and rationale. **Support autonomy** • Allow employees to express their feelings and choose how to approach tasks or resolve conflicts. **Provide competence-affirming feedback** • Focus on growth, learning, and skill development – not only results. **Foster emotional validation** • Leaders must acknowledge emotions without judgment and respond with empathy.	regulation) **framed through the lens of autonomy-supportive practices**. • **Expected Result:** Employees begin to expect emotionally intelligent behaviour (e.g., active listening, compassion, validation) from leadership as a norm. **2. Emotionally Safe Feedback Culture** • **Application:** Managers practice giving feedback that is constructive, non-judgmental, and framed around effort and growth. • **Expected Result:** Builds competence and encourages open dialogue. Employees come to expect respectful, development-oriented interactions. **3. Empathetic Communication Protocols** • **Application:** Establish communication norms for leaders that include reflection, emotional validation, and support for employee autonomy in problem-solving. • **Expected Result:** Employees internalise a model of emotionally intelligent management and expect similar conduct from all supervisors.

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
		Ensure consistency and modelling • Managers must consistently model emotionally intelligent behaviours to reinforce employee expectations.	**4. Leader Self-Disclosure and Emotional Modelling** • **Application:** Leaders appropriately model emotional awareness by acknowledging challenges, showing vulnerability, and discussing coping strategies. • **Expected Result:** Employees come to expect authenticity, transparency, and emotional sensitivity from management.
Understanding the broader culture of the organisation regarding inclusion, openness to diversity, and responsiveness to staff needs	***Needs-Supportive Organisational Climate.*** **Basic Psychological Needs Theory (BPNT)**	**Psychological safety** • Create a non-judgmental environment where staff feel safe sharing diverse views and feedback. **Authentic participation** • Avoid tokenism – ensure staff input genuinely shapes inclusion practices and policy outcomes. **Avoid control and compliance pressure** • Do not force "diversity behaviours" through external rewards or threats; instead, connect them to shared values and personal meaning.	**Application:** **a) Autonomy-Supportive Practices** • Encourage employee participation in decision-making regarding inclusion and workplace policy. • Conduct diversity climate surveys and follow up with staff-driven action planning. • Offer flexible work options or spaces for self-expression (e.g., cultural days, staff storytelling). **b) Competence-Enhancing Structures** • Provide clear channels where staff can report concerns and see results (e.g., feedback → action loops). • Offer DEI training that is strengths-based and skill-building, rather than compliance-focused.

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
			• Acknowledge and celebrate culturally diverse contributions and achievements. **c) Relatedness-Building Initiatives** • Facilitate cross-cultural team-building events and inclusive rituals (e.g., shared meals, inclusive language policies). • Establish employee resource groups (ERGs) or peer mentoring circles that reflect staff identities. • Ensure leadership models respectful, empathetic engagement across differences.
		Support meaningful recognition • Acknowledge staff efforts to build inclusion not only through rewards but also through public appreciation and narrative sharing. **Consistency in leadership behaviour** • Leaders must consistently model openness, empathy, and responsiveness across all staff levels.	
Awareness of different forms of recognition (verbal, written, incentives) and when/how to use them effectively.	Informational Feedback and Non-Controlling Recognition. **Cognitive Evaluation Theory (CET)**	**Informational vs. controlling** • Recognition should inform individuals about their effectiveness, not attempt to control or manipulate their future behaviour. **Autonomy-supportive** • Offer recognition in a manner that respects the individual's choices and voice. Avoid conditional praise. **Competence-enhancing** Focus feedback on effort,	**Verbal praise** • Use specific, sincere, and effort-focused feedback (e.g., "I appreciate how thoughtfully you handled that situation."). Avoid generic praise (e.g., "Good job!") or praise tied to control (e.g., "You'd better keep it up!"). **Written recognition** • Acknowledge contributions in emails, newsletters, or public posts. Focus on impact and value to others. Allow for self-reflection or response (e.g., feedback letters with personal follow-up). **Incentives** Use sparingly and ensure they are symbolic (e.g., appreciation tokens or

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
		progress, and mastery – not solely on outcomes. Recognise specific strengths. **Private vs. public context** Tailor recognition to individual preferences – some may prefer private affirmation, while others may prefer public appreciation. **Consistency** • Recognition should be applied fairly and consistently to avoid perceptions of favouritism or inequality.	certificates). Always pair incentives with informational feedback. Avoid making rewards the sole reason people act (e.g., "Do this and get that").
A workplace environment that supports ongoing learning, career development, and open feedback	Needs-Supportive Professional Development. **Basic Psychological Needs Theory (BPNT)** **Developed by** Deci & Ryan (2000)	**Support autonomy** • Avoid imposing rigid training plans or career paths. Allow for self-directed learning and goal setting. **Enhance competence** • Feedback should be specific, actionable, and non-judgmental. • Provide resources and coaching to help facilitate improvement.	**Autonomy** • Offer choices in professional learning paths (e.g., self-selected courses, flexible learning formats). • Involve employees in setting career development goals. **Competence.** • Provide regular, constructive, and informative feedback. • Ensure access to skill-building opportunities (e.g., workshops, mentorship, stretch tasks). • Use feedback that emphasises progress and effort, not solely results.

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
		Foster relatedness • Use mentoring, buddy systems, and communities of practice to create safe spaces for development. **Avoid controlling language.** • Frame learning as an opportunity for growth, rather than as an obligation or performance test. **Encourage mastery orientation** • Emphasise learning and development over comparison or competition. **Consistency and fairness** • Ensure that opportunities for development and feedback are available equitably across roles and departments.	**Relatedness** • Encourage peer coaching, team learning, and collaborative knowledge-sharing. • Foster a culture where feedback is mutual and respectful, rather than top-down. • Recognise growth and development in group settings.
Understanding of roles, responsibilities, and crisis management processes.	Competence-Supportive Structuring and Autonomy-Supportive Communication	**Clarity with flexibility.** • Define roles clearly but allow individuals to incorporate their own experience or	**Autonomy** • Involve staff in co-creating crisis protocols where possible (e.g., tabletop exercises). • Offer rationales behind roles and responsibilities, not just task lists.

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
	Basic Psychological Needs Theory (BPNT)	style where appropriate. **Positive framing.** • Present crisis procedures as opportunities for mastery and growth – not as threats or rigid requirements. **Supportive feedback** • Deliver performance feedback that builds confidence, rather than criticism that induces fear or shame. **Avoid top-down control** Rather than employing command-and-control leadership, engage staff in understanding why ro les are defined and how they relate to outcomes. **Foster team identity** • Highlight the shared mission and how each individual contributes to the collective response.	• Allow flexibility in how some roles are executed, within guidelines. **Competence** • Provide hands-on training and • simulations to strengthen clarity and readiness. • Offer checklists, role cards, and visual aids that outline responsibilities clearly. • Use immediate, supportive feedback during crisis drills. **Relatedness** • Emphasise interdependence during crisis planning (e.g., how each role supports others). • Use team debriefings post-drill or post-crisis to reinforce shared purpose. • Encourage open dialogue about gaps in understanding without blame.
Managers' personal commitment to human dignity, equity, and ethical leadership.	**Intrinsic Goal Framing and Value Reflection**	**Focus on intrinsic values** • Emphasise leadership driven by meaning,	**Reflective values workshops** • Managers engage in structured sessions that explore their

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
	Goal Contents Theory (GCT) **Authors:** Edward L. Deci & Richard M. Ryan	justice, and connection – not image or control. **Avoid external pressure** • Do not frame equity or dignity as top-down mandates; instead, appeal to internal purpose and authentic identity. **Support identity integration** • Help managers see their ethical leadership role as part of who they are, not just what they do. **Encourage reflection and dialogue** • Use facilitated spaces that enable self-exploration, values alignment, and shared learning. **Modelling by senior leadership** • Senior leaders must embody intrinsic goal orientation to foster consistency and authenticity across the organisation.	personal leadership purpose, ethical commitments, and the role of dignity and equity in their day-to-day actions. **Ethical leadership development** • Programmes that focus not on compliance or image management, but on why ethical leadership matters, using case studies, storytelling, and inner reflections. **Organisational storytelling** • Sharing real-life examples of ethical leadership, dignity, and inclusion, showing intrinsic value alignment rather than external recognition. **Leadership journaling & mentoring** • Managers are encouraged to journal on their goals, monitor how their decisions reflect intrinsic values, and participate in peer coaching that reinforces ethical alignment.

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
Managerial values prioritising work-life balance and staff health.	Intrinsic Goal Activation and Integration. **Goal Contents Theory (GCT)**	**Emphasise intrinsic over extrinsic rewards** • Avoid rewarding wellness leadership with superficial perks – focus instead on how it enhances connection, trust, and meaning. **Support value alignment** Encourage managers to explore how work-life balance connects with their personal values, purpose, and leadership identity. **Avoid control or compliance framing** • Do not make well-being practices feel like mandates or image management; frame them as authentic, meaningful choices. **Model intrinsic values from the top** • Senior leaders should also demonstrate balanced, humane leadership to reinforce intrinsic culture. **Enable flexibility and personalisation**	**Values-based leadership training** • Develop workshops or coaching sessions where managers reflect on their leadership purpose, explore the importance of supporting work-life balance, and link staff health to organisational success. **Narrative-based learning** • Use storytelling (e.g., staff testimonials, case studies) to illustrate how managerial support for health and balance leads to engagement, retention, and well-being. **Goal-setting for well-being leadership** • Guide managers to set intrinsic, people-centred goals related to staff support (e.g., "I will model healthy boundaries and check in on my team's workload weekly."). **Recognition of well-being-oriented leadership** • Recognise and celebrate managers who implement meaningful work-life practices – not with status or competition, but through shared learning and affirmation.

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
		• Support autonomy by allowing managers to define well-being strategies that suit their context and team needs.	
Community Level			
Patients will increase their awareness of the value of nursing care and their willingness to express appreciation through respectful engagement and constructive feedback.	Value Clarification and Autonomy-Supportive Communication. **Organismic Integration Theory (OIT)** **Authors:** Edward L. Deci & Richard M. Ryan	**Provide a meaningful rationale** • Explain why appreciation and feedback are important to improving care and humanising the caregiving relationship. **Avoid pressure or obligation** • Patients should not feel coerced to give feedback or say thank you – keep participation voluntary. **Connect to patient values** • Use examples and language that align with what patients care about – healing, dignity, connection. **Support autonomy** • Use open, inviting language that respects	**Patient education on nursing roles and impact** • Provide patients with short, accessible materials (e.g., posters, videos) that explain how nursing care supports recovery and dignity. **Feedback tools that foster reflection** • Offer feedback forms or digital platforms that invite open, respectful input and include prompts like "What part of your care did you find most supportive?" **Storytelling and testimonials** • Share stories of patients who have benefited from nursing care and haven chosen to express their appreciation, reinforcing the social and emotional value of such actions. **Autonomy-supportive communication** • Invite patients to provide feedback by saying, "If you're willing, we would value hearing what worked

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
		patients' readiness and comfort levels. **Normalise and humanise appreciation** • Show that respectful engagement is a mutual, human act, not just a system requirement.	well for you", rather than "Please complete this form."
Patients develop the knowledge, confidence, and communication skills necessary to actively participate in discussions and decisions regarding their treatment options.	Competence-Building with Autonomy-Supportive Education and Relatedness-Sensitive Communication **Basic Psychological Needs Theory (BPNT)** **Authors:** Edward L. Deci & Richard M. Ryan	**Support autonomy** • Avoid pushing a single treatment choice; instead, affirm patient values and preferences. **Enhance competence** • Break down complex information into manageable, understandable parts. Provide feedback that affirms effort and encourages participation. **Promote relatedness** • Use a warm, respectful tone and create a safe environment where patients feel heard and valued. **Avoid controlling language** • Say: "You can choose what feels best for	**Autonomy** • Use decision aids that present options and pros/cons, allowing patients to make informed, personal choices. • Involve patients in goal-setting discussions about their treatment preferences. **Competence** • Offer simple, visual patient education tools to explain treatment options in lay language. • Use role-play, coaching, or guided questions to build communication skills and confidence in asking questions. **Relatedness** • Train nurses and clinicians to engage in empathetic, non-judgmental conversations. • Create structured dialogue formats (e.g., shared decision-making protocols) that foster respectful, two-way communication.

Determinants and Change Objectives	Theoretical Methods	Parameters for use	Practical Applications
		you", rather than "You should choose this treatment." **Encourage shared understanding** • Use teach-back methods to ensure the patient fully grasps options, rather than merely nodding along.	

Step 4: Programme Production

In this step, materials and activities supporting the programme, which allowed interaction between the programme and participants, were identified. The feasibility of the programme components and materials considered the time constraints that nurses may have due to the type of service they provide. The planning team needed to ensure that service quality is not compromised. Materials and/or activities are allocated per change objective. The planning team ensured that the final programme aligns with the target population and the context in which it will be delivered.

Table 7.7:

Theoretical Application

Determinants	Behaviour Change Methods	Programme Components: Selected Training, Tools, and Materials
Self-awareness and internalised values	Autonomy-Supportive Feedback and Reflection Facilitation	**1. Short Video Clips (3–5 mins)** **Testimonials or animated explainers on:** Why autonomy support and reflection matter How values-based reflection reduces burnout and fosters meaning. **2. Micro-Reflection Journal Cards** **Pocket-sized cards with prompts such as:** *"What value guided my action today?"*

		"When did I feel proud or frustrated, and why?" *"What strength did I use during a tough moment today?"* Designed to be completed in **60–90 seconds**. **Values & Strengths Word Cloud Poster or Card** A list of approximately30 values/strengths (e.g., compassion, courage, integrity, teamwork, perseverance) Nurses can quickly **circle 3 words** that felt most relevant to their day. **Peer Buddy Debrief (5–7 min)** Pair nurses and provide structured prompts to foster relatedness and support: "What was your high and low point today?" "What helped you keep going?" "How can I support you tomorrow?" This activity strengthens connections and normalises emotional expression.
Coping skills	Needs-Supportive Coping Skills Training	**Mini Coping Skills Workbook (8–10 Pages Max)** Self-guided resource organised in short sections (each <5 minutes to read/complete): Grounding & breathing techniques (competence) Decision-mapping for tough shifts (autonomy) How to ask for support or debrief (relatedness) Reflective journaling questions Include visual aids (like a stress curve or emotion thermometer). **Stress-Mapping Snapshot (2–5 min self-reflection)** Quick worksheet or visual chart with three questions: What triggered my stress today? How did I react (emotionally and behaviourally)? What supportive strategy could I try next time? Use as individual check-in or group icebreaker.

Goal Setting (physical well-being)	**Intrinsic Goal Framing** (Framing or encouraging goal setting around **intrinsic goals** that align with personal meaning, psychological growth, and connectedness to others).	**My Why for Well-Being Reflection Cards (Pocket or Poster Format)** Encourage reflection on *why* physical self-care matters, framed around intrinsic values: "I want to care for my body because it helps me." Be present with patients Have energy for what matters Feel calm and grounded Be strong for myself and others ***Cards can be printed, displayed, or shared via mobile apps/WhatsApp.***
Interpersonal Level		
Social Networks/interconnectedness	Relatedness-Supportive Engagement	**Peer Connection Cards** *(Print or Digital)* Short, value-based prompts that encourage authentic sharing and reflection: "What is one moment today when you felt supported?" "Can you share a time this week when a colleague helped you feel seen?" "What personal strength do you recognise in your teammate?" **Utilise these in pairs or during huddles to foster emotional presence and mutual affirmation.** **"You Matter" Buddy Notes** Each nurse is anonymously assigned a buddy. Each week, they leave one short affirmation note (physical or digital). For example, "I noticed how patient you were this week – you inspire me." This encourages mindful appreciation and connection. **Story Circle or Reflection Wall** Nurses post brief stories about meaningful patient or peer moments: "I felt connected to my purpose when …" "A colleague made a difference by …" This can be visual (sticky notes, postcards) or digital (email thread, WhatsApp group).
Collective efficacy	Needs-Supportive Group Facilitation	**Collective Strength Cards** Small, visual cards with affirming statements:

		"We adapt under pressure." "Our strength lies in how we support one another." "Together, we navigate through what we could not alone." **Use:** To open or close huddles; distribute weekly or display in staff areas. **Team Confidence Tracker Sheet (Weekly)** A simple group-based reflection with questions such as: "What challenges did we face as a team this week?" "What helped us overcome them?" "What does this say indicate our ability to handle adversity?" **Use:** As a poster, digital form, or verbal prompt in weekly debriefs. **Micro-Solution Circles (10 min)** The group selects one real, shared challenge. Utilises this needs-supportive structure: 1. Everyone shares how it affects them (validation). 2. Team brainstorms 1–2 realistic actions *we* can take together. 3. Close by affirming: *"We can try this together and adjust."* **Supports:** Autonomy (collaborative input), Competence (realistic action), Relatedness (shared voice).
Expectations of emotionally intelligent management	Autonomy-Supportive and Emotionally Attuned Leadership	**1. Emotionally Intelligent Leadership Cue Cards** Short, printable or digital cards with reminders for nurse managers: • "Before I respond: pause, listen, validate." • "Acknowledge stress before offering direction." • "Offer support, not just solutions." • "Recognise effort as well as outcomes." These can be posted at manager desks, integrated into huddle guides, or used during supervisory check-ins. 2. **Staff Expectation Feedback Poster or Survey**

			• Create a visual or digital tool asking nurses: • "What makes you feel supported by management?" • "What emotionally intelligent leadership behaviours do you value most?" • Utilise responses to shape team agreements or manager reflection prompts. **3. What I Need from Leadership" Prompt Cards** Nurses anonymously or openly complete cards with prompts: • "During challenging times, it helps when my manager …" • "I feel supported when ..." These can be collected monthly or quarterly and used in feedback loops.
Understanding the broader culture of the organisation regarding inclusion, openness to diversity, and responsiveness to staff needs	Needs-Supportive Climate	Organisational	**Feedback & Story Cards** • Anonymous cards or QR forms staff can complete: o "I feel included when …" o "A time I didn't feel heard was …" o "It would help me if managers …" Format: Printed cards, suggestion box, or Google Form. **Team Inclusion Agreement** • Small group activity: "What does inclusion mean to us?" • Collectively write three commitments for inclusive leadership, for example: o "We listen first." o "We challenge bias respectfully." o "We uphold each other's dignity."
Awareness of different forms of recognition (verbal, written, incentives) and when/how to use them effectively	Informational Feedback and Non-Controlling Recognition		**Quick Recognition Toolkit** • Templates for: o Thank-you notes

			○ Certificates of appreciation ○ Staff nomination forms **Recognition Planning Template (Excel or Google Sheets)** • Tracks: ○ Type of recognition ○ Recipient ○ Date ○ Outcome/response
A workplace environment that supports ongoing learning, career development, and open feedback	Needs-Supportive Development	Professional	**Peer Learning Circles** • Small groups meet monthly to: ○ Share clinical experiences ○ Teach one another new skills ○ Reflect on personal growth **Feedback Role-Playing Workshop** • Simulations: ○ Giving upward feedback to a supervisor ○ Receiving feedback without defensiveness • Utilise realistic clinical scenarios **Personal Development Plan (PDP) Exercise** • Each nurse drafts a 6- or 12-month PDP: ○ Learning goals ○ Skills to acquire ○ Resources needed ○ Support requested from management **Career Café Events** • Informal sessions where senior nurses or HR representatives: ○ Share stories of their career progression ○ Offer Q&A about job advancement or educational opportunities
Understanding of roles, responsibilities, and crisis management processes	Competence-Supportive Structuring and Autonomy-Supportive Communication		**Roles and Responsibility Chart Template** • Grid showing:

		○ Roles (across the top) ○ Tasks or responsibilities (down the side) ○ Who is Primary, Secondary, Backup, etc. • Colour-coded version for visual clarity **Crisis Response Flowcharts** • Visual tools for each common crisis: ○ "If X happens → Contact Y → Take Z steps" • Laminated posters or pocket-sized cards **Responsibility Clarification Workshop** • Participants write down: ○ Their understanding of their responsibilities ○ What they believe others are responsible for • Discuss gaps and overlaps; facilitator aligns understanding.
Managers' personal commitment to human dignity, equity, and ethical leadership	**Intrinsic Goal Framing and Value Reflection**	**Personal Ethics Development Plan (Template)** • A three- to six-month self-improvement tool: ○ Specific values to strengthen (e.g., fairness, humility) ○ Actions and behaviours to adopt ○ Mentors or feedback sources **Bias Awareness Checklist** • Prompts managers to examine: ○ Recruitment and promotion decisions ○ Recognition patterns ○ Team assignments ○ Disciplinary actions **Team Charter Co-Creation Toolkit** • A process to:

		○ Co-create shared values with the team ○ Set behavioural standards (e.g., how to treat each other) ○ Hold each other accountable respectfully **Monthly Reflection Prompt Journal** • Prompts such as: ○ "How did I show commitment to equity this week?" ○ "Did I speak up when I witnessed disrespect or exclusion?" ○ "Whose dignity might I have unintentionally undermined?" **360-Degree Ethical Leadership Feedback Survey** • Anonymous staff feedback on the manager's: ○ Fairness ○ Respectful communication ○ Responsiveness to ethical concerns
Managerial values prioritising work-life balance and staff health	Intrinsic Goal Activation and Integration	**Work-Life Balance Leadership Guide** • Topics include: ○ Definition and dimensions of work-life balance in nursing ○ Managerial responsibilities in creating supportive schedules ○ Signs of burnout and stress in teams ○ Impact of staff health on performance and retention **Occupational Health & Wellness Framework (Toolkit or Poster)** • Includes: ○ South African occupational health guidelines for Professional nurses

- Psychosocial risk factors in nursing
- Resources for mental health, counselling, and support services

Self-Care and Stress Management Handbook

- Offers strategies for both staff and managers:
  - Time management
  - Stress recovery techniques
  - Micro-breaks, mindfulness, and shift decompression

Manager-Led Staff Wellness Brainstorm

- Group activity:
  - Staff share simple, low-cost ideas to improve wellbeing
  - Manager commits to implementing one to two changes each month

Work-Life Balance Policy Checklist

- Quick guide to ensure:
  - Breaks are respected
  - Staff aren't pressured into constant overtime
  - Leave requests are handled fairly
  - Family emergencies are supported

Monthly "Wellbeing Leadership Pledge" Reflection

- Prompts for managers:
  - "Did I model healthy boundaries this week?"
  - "Did I check in with my team emotionally, not just task-wise?"
  - "What change did I support to protect work-life balance?"

Feedback Loop: Staff Wellness Pulse Survey

- Anonymous monthly survey with items such as:

		"My manager supports my mental health." o "I feel comfortable requesting schedule changes when needed." o "I am encouraged to prioritise self-care." **Recognition for Wellness Leadership** • Highlight managers who: o Introduce innovative wellness initiatives o Successfully support staff during life transitions (e.g., illness, grief, family care)
Patients will increase their awareness of the value of nursing care and their willingness to express appreciation through respectful engagement and constructive feedback	Value Clarification and Autonomy-Supportive Communication	**Patient Information Leaflet: "Understanding and Valuing Your Nursing Team"** • Brief, illustrated guide explaining: o What nurses do: clinical and emotional care, advocacy, coordination o The impact of kind, constructive communication o Examples of appreciation (words, gestures, feedback) **Poster Campaign: "Nurses Make a Difference"** • Displayed in waiting areas or wards • Features quotes and stories from patients and nurses • Promotes respectful engagement and recognition **Short Educational Video (3–5 min)** • Title: *"The Heart of Care: Why Nurses Matter"* • Content: o A day in the life of a nurse o Testimonials from patients o Prompts: "What will you say to your nurse today?"

Patients develop the knowledge, confidence, and communication skills necessary to actively participate in discussions and decisions about their treatment options	Competence-Building with Autonomy-Supportive Education and Relatedness-Sensitive Communication	**Patient Empowerment Booklet: "Your Health, Your Voice"** • Sections include: o Understanding your diagnosis and treatment options o Common questions to ask your care team o What shared decision-making entails o Rights and responsibilities in the treatment process • Utilises plain language and culturally sensitive examples **Interactive Activities for Learning and Skill Building** Role-Play Exercises: "Doctor, I Have a Question" • Patients engage in scenarios with a nurse facilitator: o Seeking clarification o Expressing preferences (e.g., "I would prefer not to take that medication.") o Confidently stating "I don't understand" confidently • Emphasis on body language, tone, and clarity **Communication Confidence Circle** • Group discussions where patients: o Share experiences of asking questions or voicing concerns o Support one another in building self-assurance o Practice stating "I would like to know more about my treatment options"

7.4 Relevance of intervention mapping to the overall study and its significance.

This chapter has demonstrated the value of Intervention Mapping (IM) as a systematic, theory-driven, and contextually responsive framework for addressing

the complex interplay between workplace spirituality, resilience, and mental health among nurses, particularly during times of crisis. In high-pressure healthcare environments, often intensified by pandemics, resource constraints, and emotional labour, nurses are exposed to sustained psychological strain, which necessitates interventions that are not only evidence-based but also holistic and contextually grounded.

The application of IM in this study provides a structured pathway for developing interventions that move beyond fragmented or reactive approaches to mental health support. By integrating behavioural theory, stakeholder engagement, and ecological perspectives, IM enables the identification of key determinants influencing nurses' well-being, including organisational culture, leadership practices, and individual coping mechanisms. Importantly, it facilitates the co-creation of interventions that are meaningful to nurses, thereby enhancing relevance, acceptability, and sustainability within real-world healthcare settings.

The chapter further underscores the critical role of workplace spirituality as a foundational resource that fosters meaning, connectedness, and compassion in nursing practice. When embedded in intervention design, spirituality contributes to a sense of purpose and alignment with professional values, which, in turn, strengthens psychological resilience. Resilience, conceptualised not merely as an individual trait but as a dynamic and relational process, is reinforced through supportive organisational systems, reflective practices, and opportunities for emotional expression.

Moreover, the integration of IM highlights the importance of addressing mental health proactively rather than reactively, particularly during crises where the risk of burnout, compassion fatigue, and psychological distress is heightened. Interventions informed by IM are better positioned to incorporate multi-level strategies spanning individual, team, and organisational domains that promote sustained well-being and adaptive functioning among nurses.

In conclusion, this chapter positions Intervention Mapping as a critical methodological and practical tool for advancing nurse well-being in crisis contexts.

Its emphasis on theory integration, stakeholder participation, and contextual sensitivity makes it particularly suited for designing interventions that harness workplace spirituality and resilience as protective factors for mental health. Future research and practice should continue to refine and implement IM-informed interventions, with a focus on scalability, cultural relevance, and long-term impact within diverse healthcare systems, particularly in resource-constrained settings such as South Africa.

CHAPTER 8:

INTEGRATIVE CHAPTER, RECOMMENDATIONS AND CONCLUSION

8.1 Introduction

Workplace spirituality is a multifaceted concept influenced by philosophical traditions, historical developments, cultural contexts, and leadership styles. Despite the diversity of perspectives in the literature, several common themes consistently emerge. These include the recognition and cultivation of an individual's inner life, the pursuit of meaning and purpose through work, a sense of connectedness with others and the broader environment, and the experience of transcendence within the workplace context (Pandey, 2017).

Empirical research supports the relevance of workplace spirituality in professional settings, particularly in high-stress environments such as healthcare. For example, Norouzi et al. (2017) found a significant positive relationship between workplace spirituality and occupational ethics among nurses in Zahedan, Iran. Nurses with higher levels of workplace spirituality engaged more positively with their colleagues, reported greater job satisfaction, and better aligned their personal potential with organisational goals and values.

The growing body of literature highlights the dual benefits of workplace spirituality for both organisations and individuals. From an organisational perspective, workplace spirituality has been associated with enhanced work engagement, increased productivity, and improved overall performance. At the individual level, it contributes to psychological well-being, greater resilience, and reduced levels of stress. These findings underscore the importance of fostering spiritually enriching work environments, particularly in professions with high emotional and ethical demands, such as nursing.

This doctoral thesis first conducted a scoping review on the benefits of workplace spirituality among registered nurses in Sub-Saharan Africa. Subsequently, a qualitative research study explored workplace spirituality, resilience, and mental health among nurses during times of crisis. The aim of the study was to understand nurses' perceptions and experiences of workplace spirituality, how it influences their resilience and mental health during a crisis, and what recommendations they would offer management to support them during such times. This chapter provides an integrative discussion of the findings from these discrete studies to address the overall aim of the thesis. Limitations of the overall thesis are also outlined in this chapter. This chapter concludes with recommendations for interventions

as well as suggestions for future research. A table depicting the overall synthesis of the study findings is presented in Table 8.1.

Table 8.1:

Synthesis of Research Conclusions and Recommendations

Objectives	Data utilised	Conclusion	Recommendations
1. Scoping Review Objectives Mapping evidence on the benefits of workplace spirituality among registered nurses in healthcare facilities in Sub-Saharan Africa	Scoping review presented in Chapter 4.	• The findings of this study reaffirm the significance of workplace spirituality as a critical component in supporting nurses' psychological resilience and mental health. Nurses consistently perceive spirituality as an integral aspect of their professional identity, contributing to a deeper sense of meaning, inner peace, and satisfaction in their daily work (Nkomo, 2016). This spiritual orientation not only nurtures personal well-being but also enhances professional commitment and emotional endurance in demanding healthcare environments. •	• Further research is warranted to explore the benefits of workplace spirituality within healthcare settings. A review of the existing literature indicates that while workplace spirituality has been widely studied in the educational and corporate sectors, there remains a noticeable gap in empirical research focusing on its application and impact in healthcare environments. Addressing this gap is essential to better understand how spiritual dimensions of work may influence the well-being and resilience of healthcare professionals. • Based on the evidence presented in this study, it is recommended that workplace spirituality be integrated into the organisational culture, given its demonstrated positive impact on both individual well-being and overall organisational outcomes. Cultivating a spiritually supportive work environment may enhance nurses' resilience, job satisfaction, and mental health, thereby contributing to a more sustainable and compassionate healthcare system.
2. Qualitative Objectives **2.1** To explore professional nurses' perceptions of workplace spirituality,	• Qualitative data results for professional nurses are	• This study has illuminated the profound role that workplace spirituality plays in the lived experiences of professional nurses during times of crisis. The findings reveal that nurses primarily expressed spirituality through strong peer relationships characterised by compassion,	• Healthcare institutions should **intentionally recognise and support the spiritual dimension of workplace relationships** by fostering a culture that values **spiritual expression, empathy,**

Objectives	Data utilised	Conclusion	Recommendations
resilience, and mental health during a crisis. **2.2** To ascertain nurses' recommended actions that PHC management may consider towards improving frontline workers' preparedness during times of crisis.	presented in Chapter 6	mutual support, and a deep sense of interconnectedness. During the COVID-19 pandemic, participants reported caring for one another not only professionally but also emotionally and spiritually, checking in on sick colleagues, sharing workloads, and offering practical support. These acts were perceived as genuine expressions of spirituality, underpinned by an inner sense of connectedness that sustained them during periods of great uncertainty and emotional strain. Such experiences resonate with the African philosophy of *Ubuntu*, which emphasises communal harmony, interdependence, and the intrinsic value of every individual within the collective (Ohajunwa & Mji, 2018; Magezi, 2020). Similarly, parallels can be drawn with Eastern spiritual traditions that stress compassion, selflessness, and the interconnectedness of all beings (Nandram et al., 2019; Kjonstad, 2020; Akmal, 2024). These philosophical foundations enrich our understanding of how workplace spirituality is experienced in a healthcare context and highlight its universal relevance across cultures and belief systems. Importantly, the study revealed that this dimension of spirituality was more evident among peers than between nurses and management, suggesting that while spiritual expression is present and impactful, it may be insufficiently recognised or supported at the institutional level. Nevertheless, the strong sense of community and shared purpose reported by participants aligns with key dimensions of workplace spirituality such as compassion, meaningful work, and a sense of belonging as outlined in the literature (Mahoney & Graci, 1999; Shrestha et al., 2023). Ultimately, this research affirms that workplace spirituality is not only a personal or philosophical construct but also a practical and relational resource that can enhance nurses' resilience, mental health, and professional fulfilment. These findings point to the importance of cultivating a spiritually supportive work environment – one that values human connection,	**and emotional connection** not only among peers but also between staff and management. This can be achieved through **leadership training in compassionate engagement,** incorporating **spiritual well-being into organisational wellness programmes,** and creating **safe, inclusive spaces** for reflection, prayer, or mindfulness, thereby promoting a more holistic and supportive work environment. • The Department of Health and healthcare facility leadership should **embed humanistic values such as respect, inclusion, and emotional support into all levels of organisational practice and leadership development**. This can be operationalised by implementing **structured leadership training in humanistic and compassionate management,** establishing **formal recognition systems,** and promoting an **inclusive organisational culture** that respects diverse spiritual beliefs. Furthermore, policies should be revised to allow **flexibility for spiritual expression,** and **regular staff engagement forums** should be introduced to ensure that nurses feel heard, valued, and supported, particularly during times of crisis. These measures will strengthen alignment between institutional values and daily practices, thereby enhancing resilience, motivation, and spiritual connectedness among nurses. Healthcare management should develop a **comprehensive crisis preparedness and staff**

promotes holistic well-being, and recognises the integral role of spiritual care in sustaining the healthcare workforce.

- The findings of this study highlight the critical role of self-transcendence as a dimension of workplace spirituality, particularly during times of crisis. Nurses demonstrated a profound capacity to move beyond personal interests, finding meaning and strength in their connection to a higher purpose. For some, this was reflected in perceiving their profession as a calling – bestowed through spiritual lineage or prophecy – while others derived fulfilment from their service to patients and the broader community. These expressions align with Maslow's conceptualisation of self-transcendence as the highest human need, characterised by connection to the divine, altruism, and a pursuit of meaning beyond the self (Venter, 2016; Oliver et al., 2018).
- Belief in God, ancestors, and spiritual practices such as prayer emerged as essential sources of strength and resilience during the COVID-19 pandemic. Participants relied on these spiritual anchors to navigate uncertainty, fear, and emotional exhaustion, reaffirming the integral role of faith in their professional endurance. The call for dedicated prayer spaces within healthcare facilities underscores the centrality of spirituality – both religious and non-religious – in sustaining the well-being of nurses. These findings mirror perspectives from African and Eastern spiritual traditions, where interconnectedness with divine forces, meditation, ritual practices, and the presence of ancestral spirits are viewed as foundational to inner peace and collective well-being (Ohajunwa & Mji, 2018; Singh & Bhagwan, 2020; Akmal, 2024). In essence, transcendence in this study was not merely a personal spiritual experience but a deeply embedded cultural and relational phenomenon. It provided nurses with a sense of

support strategy that incorporates the key recommendations provided by nurses. This strategy should include:

- **Provision of accessible emotional support services**, such as hiring or partnering with an in-house psychologist.
- **Regular, transparent communication** from leadership to ensure timely updates and role clarity during crises.
- **Strengthening human and financial resourcing,** including contingency staffing plans and budget allocations for essential equipment.
- **Implementation of a dedicated mental health leave policy** and the strengthening of Employee Assistance Programmes (EAPs) or wellness services.
- **Regular team-building and debriefing activities** to foster cohesion, emotional release, and collective resilience.
- **Inclusion of frontline nurses in crisis planning and decision-making processes** to enhance relevance, trust, and shared responsibility.
- **Institutional recognition and accommodation of spiritual needs**, such as creating inclusive spaces and policies that allow staff to practice spirituality in diverse forms.

By addressing these areas, healthcare organisations can significantly improve their **crisis readiness,**

Objectives	Data utilised	Conclusion	Recommendations
		purpose, direction, and spiritual endurance that enabled them to serve others amid adversity – demonstrating that workplace spirituality, when inclusive of transcendent and culturally relevant elements, can be a powerful force for resilience and holistic health in the nursing profession. • Although initially mentioned by only a few participants, the concept of the **inner being** emerged as a significant dimension of workplace spirituality, resonating with many others upon reflection. The study highlights that **connecting with the inner self** – through practices such as prayer, mindfulness, self-awareness, and moments of silence – provides emotional strength, inner peace, and resilience during times of crisis (Weathers, 2018). These findings align with broader theoretical perspectives that associate spirituality with **inner guidance, emotional regulation, and harmony** (Miller & Ewest, 2024; Akmal, 2024). Therefore, nurturing the inner being plays a vital role in supporting psychological recovery and promoting well-being in the workplace, particularly during challenging periods. • The findings of this study underscore the central role of **feeling valued** and experiencing **meaningful work** in promoting **psychological resilience and workplace spirituality** among nurses. Participants indicated that appreciation from patients, peers, and managers affirmed the significance of their role and contributed to a sense of purpose and personal growth. This sense of **meaning** was especially vital during crises like COVID-19, where nurses drew strength and fulfilment from witnessing patient recovery and fulfilling their caregiving responsibilities. The data further suggest that when nurses perceive their work as meaningful – through acknowledgment, contribution to patient well-being, and alignment with organisational goals – they are more likely to remain resilient, motivated, and emotionally connected to their duties. These insights affirm that **workplace**	**staff well-being, and workplace spirituality**, ultimately leading to better patient care and more resilient nursing teams.

Objectives	Data utilised	Conclusion	Recommendations

spirituality, expressed through meaningful work and recognition, plays a pivotal role in fostering well-being, performance, and a culture of learning and care in healthcare settings.

- The findings of this study reveal a deep disconnection between nurses and organisational leadership during the COVID-19 crisis, with management perceived as failing to embody the core values of respect, inclusion, and care central to workplace spirituality and humanistic leadership. Nurses viewed managers as representatives of the health department, and their lack of support – both emotional and material – was interpreted as a misalignment between the organisation's stated values and lived experience. This perceived absence of appreciation, recognition, and psychological support led to feelings of demotivation, isolation, and spiritual disconnection, particularly during a time of crisis when support was most needed. Despite this, nurses remained committed to their professional oath, deriving meaning and motivation from patient recovery and the fulfilment of their caregiving roles. The study also identified **three emergent themes** essential to fostering workplace spirituality: **respectful engagement, inclusive organisational culture**, and **flexible policies** that acknowledge diverse spiritual practices. These findings suggest that aligning organisational practices with humanistic values – such as respect, inclusion, and emotional support – not only enhances psychological well-being but also promotes spiritual connectedness, resilience, and meaningful engagement in nursing practice.
- This study underscores the pivotal role of **social connectedness and support networks** in fostering nurses' **resilience** during the COVID-19 pandemic. While organisational leadership was largely absent in providing emotional support, **collegial solidarity and familial**

Objectives	Data utilised	Conclusion	Recommendations
		encouragement emerged as key sources of strength. Acts of empathy, shared struggles, and collaborative efforts toward patient care created a sense of belonging and mutual reliance, reinforcing the spiritual dimension of connection at work. These findings affirm that **interpersonal support and emotional validation** – more than formal structures – can significantly bolster resilience in times of crisis, highlighting the critical need to cultivate a **culture of care, unity, and recognition** within healthcare environments. • The findings highlight the critical need for **proactive organisational strategies** to support nurses' resilience during crises. Participants emphasised that **team-building activities,** particularly as a form of debriefing, can strengthen solidarity and emotional recovery. Additionally, **adequate staffing, sufficient funding, and timely communication** were identified as essential structural supports. The lack of basic resources, such as protective equipment, during the COVID-19 pandemic not only endangered nurses but also undermined their sense of safety and value. Ensuring **preparedness through contingency planning, resource allocation, and clear information sharing** can significantly reduce stress, prevent burnout, and empower nurses to remain resilient in high-pressure situations. • The findings of this study challenge the assumption that previous trauma inherently increases psychological vulnerability during crises. Instead, **life experience, age, cultural beliefs, and learned coping mechanisms** were found to enhance nurses' **resilience.** Participants described drawing strength from past adversities, viewing them as life lessons that cultivated emotional endurance and a proactive mindset. This perspective aligns with Antonovsky's theory of **Generalised Resistance Resources (GRRs),** suggesting that resilience is shaped	

Objectives	Data utilised	Conclusion	Recommendations
		over time through consistency, balance, and participation in shaping outcomes. **Social support** from family, friends, colleagues, and community emerged as a crucial protective factor for **mental health**, while its absence contributed to feelings of loneliness, hopelessness, and emotional exhaustion. The study further confirmed the critical role of **spirituality** as a coping mechanism, with nurses relying on prayer and cultural beliefs to maintain hope and inner strength, especially during the COVID-19 crisis. **Male nurses**, in particular, emphasised culturally grounded beliefs in self-reliance and perseverance, demonstrating how **cultural identity can shape resilience strategies**. • Additionally, participants emphasised the importance of healthy coping practices, including physical exercise, music, rest, and self-care. However, the lack of institutional support, especially the denial of rest and being forced to work while unwell, was reported to **negatively impact mental well-being**, undermining their ability to recover. Overall, the study illustrates that **resilience is a dynamic, multifaceted construct** influenced by personal experience, culture, spirituality, social connectedness, and supportive work environments.	

Objective	Data Utilised	Conclusion	Recommendations
Objective 3: Intervention Mapping To develop a guideline on the design and implementation of a theory-driven intervention that enhances workplace spirituality, resilience, and mental health among nurses during crises.	Literature Review (Chapter 2), Scoping Review (Chapter 4). Empirical evidence (Chapter 6) findings.	• Intervention Mapping provides a structured, evidence-based approach to translate complex psychosocial and spiritual needs into practical interventions, ensuring contextual relevance and sustainability. • Workplace spirituality strengthens purpose, alignment, and emotional grounding, which are critical for sustaining nurses during crises.	• Adopt Intervention Mapping as a standard framework for designing nurse wellness programmes, particularly in crisis-prone healthcare settings. • Integrate structured reflection practices, journaling tools, and value clarification exercises into daily nursing routines.

Objective	Data Utilised	Conclusion	Recommendations
		• Resilience is enhanced when coping strategies are both psychologically and culturally relevant, combining clinical and psychological health-promoting approaches. • Social support systems are critical in mitigating emotional strain and promoting collective resilience and teamwork. • Leadership plays a central role in shaping psychological safety, trust, and staff well-being. • A needs-supportive organisational climate enhances engagement, belonging, and well-being. • Sustainable well-being requires system-level changes, not just individual-level interventions. • Mental health and resilience are multi-dimensional and co-constructed, requiring integrated interventions across levels.	• Implement coping skills programmes that include mindfulness, breathing techniques, and culturally appropriate practices. • Establish peer support groups, buddy systems, and team reflection spaces to strengthen relational support. • Implement emotional intelligence training, feedback systems, and leadership development programmes for nurse managers. • Promote inclusive policies, staff engagement platforms, and recognition systems aligned with diverse staff values. • Review and implement flexible work policies, special leave provisions, and wellness-focused HR strategies. • Design holistic, multi-level interventions and conduct longitudinal evaluations to assess impact and scalability.

8.2 Finding Per Objectives

Objective 1: Mapping evidence on the benefits of workplace spirituality among registered nurses in healthcare facilities in sub-Saharan Africa.

Q.1 The perceptions of nurses working in sub-Saharan Africa on workplace spirituality.

The scoping review identified a range of benefits associated with workplace spirituality, particularly its positive impact on nurses' well-being. These benefits were observed at both the individual and organisational levels. Workplace spirituality was found to have a significant influence on professional practice, attitudes, and the quality of patient care. Nurses reported that fostering spirituality in the workplace strengthened interpersonal relationships, leading to greater compassion, improved holistic care, and a deeper commitment to patient-centred care. Furthermore, workplace spirituality was perceived to strengthen collegial relationships through the expression of genuine care and concern. These meaningful interactions not only nurtured mutual support among nursing staff but also created opportunities to engage with diverse spiritual perspectives, thereby enriching nurses' understanding and improving their interactions with patients. This is consistent with the workplace spirituality review (Chapter 2) and findings from qualitative studies (Chapter 6).

The integration of psychological and emotional support through spiritually informed interventions has emerged as a significant trend in contemporary nursing practice. Healthcare organisations are increasingly called upon to acknowledge and address the spiritual needs of both patients and staff (Nkomo, 2016). This aligns with findings by Chandramohan et al. (2016), who advocate for a holistic approach to nursing that explicitly includes spirituality as a core dimension of care. Furthermore, nurses perceive the organisational context and culture as critical in shaping how workplace spirituality is understood and enacted. The heightened stress and emotional burden experienced during the COVID-19 pandemic further accentuated the importance of workplace spirituality, which has been increasingly recognised as a vital coping mechanism for nurses. Consequently, there is a growing institutional awareness of the need to support nursing professionals through spiritually attuned practices that foster both individual and collective well-being.

Objective 2:

2.1 To explore professional nurses' perceptions of workplace spirituality, resilience, and mental health during a crisis.

Workplace Spirituality

The findings of this study revealed interconnectedness as one of the strongest indicators of spirituality experienced by nurses during times of crisis. Nurses reported that mutual availability, messages of support received from colleagues (especially following a COVID-19 diagnosis), and covering for sick colleagues to prevent work overload played crucial roles in overcoming the adversity of the COVID-19 pandemic. This interconnectedness also extended to nurses' interactions with their patients; they indicated that going to work and engaging with patients during difficult times provided them with a sense of purpose and something to look forward to.

These findings reinforce the existing evidence from Eastern, Western, and African perspectives on workplace spirituality, where interconnectedness is recognised as an important component. Eastern spiritual traditions place significant emphasis on the interconnectedness of all forms of life (Shrestha et al., 2023; Markani et al., 2013; Kernochan et al., 2007). For example, in Hinduism, the concept of *Brahman* underscores the intrinsic unity and interrelatedness of all existence. Similarly, Buddhism's doctrine of *dependent origination* highlights the mutual dependence of all phenomena. Taoism, through the concept of the *Tao*, reflects a profound recognition of the harmonious interconnection between all elements of the natural world (Akmal, 2024). These insights support the work of Shrestha et al. (2023), who observed that employees engaging in collaboration with their coworkers exhibit self-restraint and a sense of concern that extends beyond their immediate colleagues to encompass all of humanity. Moreover, such individuals tend to demonstrate a heightened sense of higher consciousness. Similar findings were reported by Olupona (2020), who asserted that African spirituality transcends formal religious beliefs and practices, encompassing a broader consciousness of the self and the interconnectedness of humanity and the natural environment. He further contended that spirituality entails inner strength, emotional regulation, and a positive mindset, all of which shape an individual's behaviour toward others and the natural world.

The theme of interconnectedness also emerged through expressions of collective spirituality, grounded in the belief that individuals are intrinsically connected to one another, to nature, and to a higher power. This perspective strongly emphasises well-being and shared responsibility (Ohajunwa & Mji, 2018; Amanze, 2011; Mji, 2012). The support and care nurses extended to one another during the COVID-19 pandemic, which served as a crucial source of resilience, aligns with the observations of Ohajunwa and Mji (2018). These authors conceptualise African spirituality through the lens of the philosophy of *Ubuntu*, which

emphasises the interconnectedness of humanity. They argue that *Ubuntu* embodies the notion that individuals exist in relation to and through others, underscoring the significance of community, kinship networks, and extended family in offering spiritual and emotional support (Magezi, 2017).

Dladla (2017) posits that *Ubuntu* promotes communal harmony and collective well-being, principles central to many spiritual traditions that underscore values such as interconnectedness, compassion, and shared responsibility. Similarly, Kobe (2021) highlights these elements as integral to spiritual practice. The findings of the present study affirm these perspectives. This dimension of workplace spirituality was found to exert a significant positive influence on nurses' resilience and mental health. These findings highlight the crucial role of interpersonal interconnectedness in promoting resilience and enhancing mental health among nurses, particularly during times of crisis.

Humanistic Organisational Theory, Resilience, and Mental Health

The exploration of workplace spirituality in this study is underpinned by humanistic organisational theory, drawing from the foundational work of scholars such as Maslow (1943) and Rogers (1951). This theory emphasises the recognition of human needs, intrinsic motivation, and the prioritisation of well-being within the workplace. This theoretical perspective aligns with the experiences shared by nurses in the current study, who reported that a sense of interconnectedness played a crucial role in sustaining their resilience and improving their mental health during times of crisis.

When nurses were asked to identify factors contributing to their resilience, social connectedness and support networks emerged as prominent themes. Participants highlighted peer support, leadership support – particularly in the form of mentoring – and collective efficacy as key contributors. The interconnectedness dimension of workplace spirituality is further supported by the work of Ungar (2003), who emphasises the critical role of community in promoting mental health and emotional restoration. He advocates for a shift away from the individualistic orientation characteristic of many Western societies toward a macro-ecological perspective that recognises the value of collective identity. This perspective replaces the notion of the autonomous "I" with a communal "we", highlighting the significance of relational and cultural contexts in shaping psychological well-being. Similarly, Wang et al. (2014), Kulig et al. (2013), and Ungar (2003) argue that a more contextualised and inclusive understanding of human resilience requires moving beyond reductionist models of the mind toward an appreciation of the psychosocial, tribal, and intercultural dimensions of human experience.

Within this framework, strong cultural ecologies and supportive communal structures are viewed as foundational to healthy coping, adaptability, and emotional resilience – all of which are essential to the development of resilience. The findings of this study resonate with this view, as nurses described how experiences of connectedness within their professional and personal communities significantly enhanced their ability to cope with crises and maintain mental well-being. In their study, McDonald et al. (2016) similarly reported that nursing professionals often draw upon their support networks, including partners, family members, friends, and workplace colleagues, for emotional support and stress management. A sense of belonging and connectedness to both the nursing profession and the organisational environment fosters a grounded professional identity and provides a critical source of support, thereby contributing meaningfully to the development of resilience.

The second dimension of spirituality, identified as having a positive influence on nurses' resilience and mental well-being, was their system of belief, a sub-theme of transcendence. Participants described this belief as rooted in trust in a higher power, commonly expressed as faith in God, while others referred to spiritual convictions grounded in ancestral beliefs. These expressions of faith served as vital sources of strength, meaning, and emotional stability during times of crisis. This study did not include a religious perspective as part of spirituality at work; however, the majority of nurses could not divorce spirituality from their religious beliefs. It is not unexpected that many nurses in this study perceived spirituality through a religious lens. Similar observations were made in studies by Mahlaba (2015) and Gupta (2016), where participants equated spirituality with religious beliefs and practices, reflecting a tendency to conflate the two concepts within certain cultural and professional contexts.

Service orientation also emerged as a prominent theme in this study, reflecting nurses' profound commitment to patient care, their passion for the profession, and the deep sense of fulfilment derived from witnessing patient recovery. This intrinsic motivation served as a sustaining force, enabling them to persevere through adversity. These expressions of purpose and dedication align with Maslow's (1943) theory of self-actualisation, which posits that individuals strive to fulfil their highest potential through meaningful engagement and personal growth. For these nurses, serving others was not merely a professional obligation but a pathway to achieving a deeper sense of purpose, identity, and self-worth, which are hallmarks of self-actualisation.

The findings of this study are consistent with the perspective offered by Oliver et al. (2018), who define transcendence as the pursuit of concepts that extend beyond self-interest, such as the search for a higher purpose, connection with a divine presence, or the commitment to

serving others. This alignment suggests that nurses' experiences of purpose, spiritual connection, and service reflect a transcendent orientation that contributes to resilience and psychological well-being by facilitating identification with something greater than the self. Transcendence, as a dimension of workplace spirituality, aligns closely with the concepts of moral purpose and duty, which have been identified as antecedents of resilience. Fortune (2022) argues that resilience among healthcare professionals is often underpinned by a shared moral commitment to patient care. His research highlights a strong sense of identification with the caregiving role, accompanied by feelings of accountability and dedication – not only to the work itself but also to the well-being of the patients. This moral orientation reinforces the transcendent dimension of spirituality, wherein individuals find strength and meaning by aligning their professional responsibilities with a higher ethical or spiritual calling. The findings of this study confirm the positive contribution of this dimension of workplace spirituality to nurses' resilience and mental well-being, a finding that is consistent with previous research on workplace spirituality.

Transcendence, as a dimension of spirituality, is closely aligned with a key perspective within humanistic organisational theory, which recognises the human capacity for spiritual fulfilment and transcendence. According to Mele (2016), this perspective encourages the cultivation of deeper purpose, meaning, and connectedness within the context of work and organisational life, highlighting the role of spirituality in enhancing both individual well-being and organisational culture.

The Salutogenic Model and Its Application

The Salutogenic model, developed by Antonovsky (1979), emphasises an individual's capacity to manage persistent stressors by effectively utilising *General Resistance Resources* (GRRs). These resources encompass a wide range of internal and external factors, including physical, biochemical, artefactual-material, cognitive, emotional, valuative-attitudinal, interpersonal-relational, and macrosocial-cultural characteristics operating at the individual, group, subcultural, and societal levels. Antonovsky (1979) further posits that while GRRs serve as protective factors, they may paradoxically also act as sources of stress. Central to the Salutogenic framework is the notion that GRRs are instrumental in fostering a *sense of coherence*, a crucial determinant of resilience and well-being.

Lindström and Eriksson (2005) expand on this by noting that GRRs may take diverse forms, including genetic, institutional, psychosocial, cultural, and spiritual dimensions, as well as a preventive health orientation. Within this broader conceptualisation, spirituality, particularly

the dimensions of interconnectedness and transcendence, emerges as a vital psychosocial resource. Interconnectedness fosters a sense of belonging and mutual support across personal, professional, and societal relationships, while transcendence provides individuals with a deeper sense of purpose and connection to something greater than the self. Both dimensions contribute meaningfully to an individual's ability to derive coherence and meaning in the face of adversity, thereby enhancing resilience and mental well-being.

Meaningful Work

The findings of this study identified task significance and personal growth as key indicators of meaningful work among nurses. Participants expressed that engaging with supportive colleagues who contribute to their spiritual growth fostered a sense of value and purpose in the workplace. Feeling appreciated and being involved in diverse work activities further enhanced their sense of meaning. Additionally, a clear understanding of one's role and its contribution to the broader goals of the organisation was reported as a source of meaningful engagement. Nurses also highlighted that bringing hope to patients and recognising the profound responsibility embedded in their professional roles significantly contributed to their experience of work as meaningful and fulfilling.

These findings align with the conceptualisation offered by Widodo and Suryosukmono (2021), who describe meaningful work not as a mechanism for achieving work-life balance, but as a path that brings harmony to the demands of professional life, allowing employees to feel at ease and perform optimally. Steger (2016) provides a complementary perspective through his three-tiered framework for understanding meaningful work: first, the perception that one's work is significant; second, that the work contributes to a deeper sense of meaning or life purpose; and third, the belief that one's job benefits humanity or others. The nurses in this study demonstrated experiences across all three tiers, illustrating how meaningful work rooted in task significance, spiritual growth, and a service-oriented mindset enhances resilience and overall well-being in high-demand healthcare environments. Additionally, the potential for personal and professional growth, particularly during challenging times, emerged as a critical factor in reinforcing both meaningful work and resilience. Curtin et al. (2022) argue that such growth opportunities are vital antecedents of resilience, enabling professional nurses to adapt, develop, and sustain their well-being in the face of adversity. This was evident in the narratives of nurses who perceived periods of crisis not only as sources of stress but also as moments of transformation and professional affirmation. In this context, meaningful work served as both a

protective factor and a motivating force, contributing to psychological resilience and long-term occupational commitment.

Organisational Values, Rewards, and Recognition

Regarding the alignment between nurses' personal values and the organisation's values, the study revealed that nurses demonstrated a strong commitment to the ethical principles and responsibilities inherent to the profession. Participants expressed deep respect for the professional pledge taken upon entering nursing, which they viewed as a guiding framework for their practice. They acknowledged the importance of honouring patients' values, even when these did not fully align with their own personal beliefs, reflecting a professional ethic of respect and compassion. Organisational values, however, were predominantly perceived by nurses as being communicated and embodied by management rather than as collectively shared or co-constructed by all staff. This distinction highlights the perceived gap between institutional messaging and personal-professional identity, which may influence nurses' sense of value alignment and workplace cohesion.

Rewards and recognition, along with **inclusion**, emerged as noteworthy sub-themes under the broader category of organisational values. These themes were particularly salient considering the enduring psychological impact of the COVID-19 pandemic, which remained a vivid reference point for many participants. Nurses expressed a strong sense of disappointment and emotional distress stemming from what they perceived as a lack of acknowledgment and recognition from management for their exceptional dedication and hard work during the crisis. This absence of formal appreciation or tangible reward was described as a demotivating factor, contributing not only to diminished morale but also to heightened stress levels. The perceived exclusion from decision-making processes and insufficient validation of their efforts during a period of unprecedented professional strain underscored the critical importance of inclusive leadership and recognition practices in promoting psychological well-being and organisational commitment.

Management Support and Humanistic Principles

The study's findings revealed a perceived lack of support from management during the COVID-19 crisis. Participants interpreted this absence of support as reflecting a lack of care and concern from leadership. While some nurses acknowledged that the crisis placed immense pressure on all stakeholders, including management, the majority expressed feelings of neglect

and described the treatment they received as inhumane. This perceived indifference had a demoralising effect and contributed negatively to their mental well-being. Participants reported being expected to report for duty despite being ill themselves, which reinforced their belief that their well-being was not a priority for management and that even if they died, it would not have elicited concern from leadership. Such experiences stand in stark contrast to the principles of Humanistic Theory, as advanced by Maslow and Herzberg (1968), which emphasise the inherent dignity of individuals, the fulfilment of human needs, and the role of intrinsic motivation. Rather than treating employees through a mechanistic or purely operational lens, the humanistic approach promotes people-centric management practices that recognise individuals' value, contributions, and well-being. The lack of empathetic and supportive leadership reported by nurses during the pandemic contradicts these foundational humanistic values and highlights a critical gap in management's alignment with holistic, person-centred care principles.

Furthermore, Hisam and Sanyal (2021) assert that employees who identify with and share their organisation's values are more likely to experience loyalty, happiness, and a sense of purpose in their work. This alignment of personal and organisational values serves as a powerful intrinsic motivator. In the context of this study, the reported lack of support and perceived misalignment between nurses' values and organisational actions likely contributed to demotivation, emotional distress, and a weakened sense of professional purpose during a time of profound crisis.

2.2 To ascertain nurses' recommended actions that PHC management may consider towards improving frontline workers' preparedness during times of crisis.

As reported in Chapters 2 and 6, interconnectedness and the alignment of individual values with organisational values significantly contribute to employee resilience and promote mental well-being by fostering a sense of purpose, belonging, and psychological safety. However, this study found that nurses experienced a lack of managerial support and a perceived misalignment between their personal values and those upheld by the organisation during the COVID-19 crisis.

Despite these challenges, many nurses emphasised their ongoing commitment to the professional values enshrined in their nursing pledge. This commitment underpinned their continued respect for patient values, even in the face of organisational challenges. Furthermore, participants emphasised the importance of inclusivity and respect for diverse belief systems, stressing that no single belief should be regarded as superior to any other. This emphasis on

mutual respect and equality reflects a core aspect of workplace spirituality and underscores the ethical foundation of nursing practice, even when organisational support structures are perceived as lacking. Given the evidence that workplace spirituality contributes positively to nurses' resilience and mental well-being, participants in this study offered several recommendations aimed at guiding managers in better supporting nursing staff and enhancing their preparedness for adversity. These recommendations collectively reflect the need for a more compassionate, inclusive, and values-driven organisational approach that aligns with the core principles of workplace spirituality.

Implications for Human Resources for Health

Participants highlighted the critical impact of staffing shortages during times of crisis, noting that an insufficient number of nurses resulted in increased workloads, excessive stress, and emotional exhaustion. This imbalance not only compromised the quality of patient care but also undermined nurses' resilience and mental well-being. Consequently, it is recommended that healthcare managers prioritise proactive human resource planning, including adequate nurse staffing, flexible deployment strategies, and contingency workforce measures to reduce work overload during periods of heightened demand. Strengthening human resource capacity is crucial for cultivating a supportive work environment that fosters psychological resilience and upholds the principles of workplace spirituality.

Financial Resources

A recurring concern among participants was the lack of essential protective equipment, particularly during the COVID-19 crisis. Nurses reported experiencing significant anxiety and fear due to inadequate access to personal protective equipment (PPE), such as masks, which they perceived as a fundamental safety measure. The absence of such resources was interpreted as a lack of organisational commitment to their health and safety. This not only heightened their vulnerability to infection but also negatively impacted their mental well-being. Therefore, it is recommended that healthcare institutions allocate sufficient financial resources to ensure the consistent availability of critical protective equipment. Investing in basic safety provisions is not only a practical necessity but also a reflection of organisational values that prioritise the well-being, dignity, and psychological security of professional nurses.

Psychological Support and Special Leave

Participants expressed the need for more robust emotional and psychological support systems within the workplace, particularly during times of crisis. Many nurses reported experiencing overwhelming stress and emotional strain, with minimal acknowledgement or intervention from management. As a result, they recommended the introduction of special leave provisions specifically designed to accommodate employees struggling with mental health challenges. Such leave would serve as a formal recognition of the psychological toll associated with high-pressure healthcare environments, particularly during crises such as the COVID-19 pandemic and natural disasters. Implementing this measure could provide nurses with the necessary space to recover and cope more effectively with adversity, while simultaneously fostering a culture of care, compassion, and psychological safety aligned with the principles of workplace spirituality.

Spiritual Spaces for Reflection and Renewal

Participants recommended the establishment of dedicated spaces within the healthcare environment for spiritual and emotional restoration. These spaces would be accessible for activities such as prayer, meditation, scripture reading, and moments of silence. Nurses indicated that, following exposure to stressful or traumatic events, having a quiet, sacred space would allow them to reconnect with their inner selves, process their experiences, and regain emotional and spiritual strength. Such spaces are considered essential in supporting workplace spirituality, promoting resilience, and fostering overall mental well-being. Providing accessible and inclusive spiritual spaces reflects an organisational commitment to holistic care, not only for patients but also for staff, and reinforces a culture that honours diverse belief systems and the need for inner renewal in high-stress professions.

Access to On-site Psychological Support

Participants strongly recommended the appointment of in-house psychologists to provide immediate and professional mental health support, particularly during times of crisis. Nurses highlighted the need for structured psychological services, including regular debriefing sessions, to help process traumatic experiences, manage stress, and maintain emotional resilience. The availability of an on-site psychologist was viewed not only as a practical intervention to support mental well-being but also as a symbolic gesture of management's genuine care and concern. Such support would contribute to a psychologically safe work environment, reinforce organisational commitment to employee welfare, and align with the

core tenets of workplace spirituality by addressing the holistic needs – emotional, psychological, and spiritual – of healthcare professionals.

Objective 3: The development of a theory and evidence-based intervention aimed at improving the mental health and resilience of professional nurses.

Firstly, the objective was met through the integration of synthesis evidence (Chapter 4) and empirical evidence derived from the study findings (Chapter 6), which identified key psychosocial and organisational challenges affecting nurses. These included emotional distress, lack of support, reliance on spiritual coping mechanisms, and the need for inclusive and responsive organisational practices. By grounding the intervention in these context-specific findings, the study ensured that the proposed strategies directly addressed nurses' real and expressed needs, thereby enhancing relevance and applicability.

Secondly, the intervention was firmly anchored in established behavioural and psychological theories, mainly the Self-Determination Theory. This theory informed the identification of key determinants, including autonomy, competence, relatedness, meaning-making, and intrinsic motivation. Through this theoretical grounding, the intervention moved beyond descriptive insights to provide a mechanistically informed framework for behaviour change and well-being enhancement.

Thirdly, the IM process enabled the systematic translation of evidence and theory into clearly defined performance and change objectives across multiple levels. At the individual level, the intervention targeted self-awareness, coping skills, and goal setting; at the interpersonal level, it focused on peer support and collective efficacy; and at the organisational level, it addressed leadership practices, inclusion, and work-life balance. This multi-level structuring ensured that mental health and resilience were approached as complex, system-driven outcomes, rather than isolated individual responsibilities.

Furthermore, the objective was operationalised through the development of practical, implementable intervention components. These included value-based reflection activities, coping skills training, peer support mechanisms, emotionally intelligent leadership tools, and organisational policy recommendations. The inclusion of specific tools (e.g., reflection guides, coping workbooks, leadership cue cards, and feedback systems) demonstrates that the intervention is not only conceptual but also actionable and scalable within healthcare settings.

Importantly, the framework incorporated stakeholder engagement and contextual adaptation, ensuring that both nurses and managers contributed to the design and refinement of the intervention. This participatory approach strengthened the feasibility, acceptability, and sustainability of the intervention, aligning with best practices in intervention development.

Finally, the IM framework facilitated alignment between short-term outputs and medium- and long-term outcomes, including increased self-awareness, improved coping capacity, enhanced teamwork, strengthened leadership support, and, ultimately, reduced burnout and improved psychological well-being. This clear linkage between intervention activities and expected outcomes demonstrates that the study achieved its objective in a structured, measurable, and theoretically coherent manner. By systematically developing an intervention that is empirically grounded, theoretically informed, multi-level in design, and practically implementable. The use of Intervention Mapping ensured that the intervention is not only responsive to the challenges faced by professional nurses but also positioned for sustainable impact on mental health and resilience in crisis contexts.

8.3 Recommendations for Objective 1

Based on the findings of this study, the following recommendations are proposed to enhance psychological resilience, mental well-being, and the experience of workplace spirituality among nurses:

- **Provision of Emotional Support and Recognition:** Management should provide consistent emotional support to nursing staff, particularly during and after crises. A structured reward and recognition system should be developed to acknowledge nurses' dedication and efforts, thereby fostering motivation, a sense of appreciation, and professional fulfilment.
- **Enhanced Access to Health and Wellness Services:** Organisations should invest in comprehensive wellness programmes that include access to psychologists or mental health professionals. Regular debriefing sessions should be offered to help nurses process work-related stress and trauma, contributing to improved resilience and emotional stability.
- **Implementation of Team Building and Resilience Training:** Quarterly team-building initiatives and coping-skills workshops should be

implemented to foster camaraderie, improve communication, and equip nurses with practical strategies for managing adversity in high-stress environments.

- **Integration of Spiritual Values into Organisational Culture:** Spiritual values should be intentionally embedded into the organisational culture to promote workplace spirituality. This may involve fostering a culture of compassion, purpose, interconnectedness, and respect for diverse spiritual beliefs.
- **Designated Space for Spiritual Practices:** Management should allocate a quiet, dedicated space within the healthcare facility for prayer, meditation, or silent reflection. Such a space would support nurses in reconnecting with their inner selves, thus enhancing their spiritual well-being and capacity to cope with ongoing challenges.
- **Inclusive Decision-Making and Acknowledgement of Contributions:** Nurses should be actively involved in organisational decision-making processes, as acknowledging their contributions and respecting their professional judgement enhances their sense of value, meaning, and purpose within the workplace. Furthermore, when incorporating spirituality into the workplace, particularly in multicultural environments, it is recommended that it be approached from a values-based perspective. The study indicates that interpretations of workplace spirituality differ across cultural contexts: Eastern perspectives tend to associate spirituality primarily with religion; African perspectives often integrate both religious and ancestral dimensions; while Western perspectives frequently frame spirituality in intrinsic and existential terms. Despite these differing viewpoints, all perspectives share common underlying values, including empathy, mutual trust, care and concern for others, and honesty. Therefore, to promote inclusivity and respect for diverse cultural understandings, workplace spirituality should be conceptualised and implemented through a shared values-based framework.

- **Promotion of Physical Activity as a Coping Strategy:** Physical exercise should be encouraged as a healthy mechanism for managing stress. Management can support this initiative by offering wellness challenges, fitness resources, or designated time for physical activities during shifts.

8.4 Recommendations for Objective 2

In relation to Objective 2, nurses were given the opportunity to propose recommendations they believed would support them during times of crisis. These suggestions have been outlined in the preceding section. It is therefore recommended that management seriously consider nurses' input, as they are the frontline workers most directly affected during such periods. When management acknowledges and integrates nurses' perspectives on effective coping mechanisms, it fosters a sense of ownership and inclusion. This participatory approach is likely to reduce resistance to organisational interventions and enhance nurses' perception of being valued and heard, thereby contributing to improved morale, engagement, and resilience.

8.5 Recommendations for Objective 3

I. It is recommended that future research prioritise implementing the developed intervention through pilot studies in selected healthcare settings, such as primary healthcare clinics and hospitals in KwaZulu-Natal. This should include conducting feasibility studies to assess the practicality, acceptability, and resource requirements of the intervention, as well as engaging key stakeholders such as nurse managers, human resource departments, and policy-makers to support programme adoption. A clear implementation protocol should be developed, outlining facilitator training, timelines, and delivery methods, including workshops, peer support sessions, and digital platforms.

II. It is further recommended that rigorous evaluation studies be conducted to determine the effectiveness of the intervention. Future research should employ mixed-methods designs to assess both outcomes and processes, measuring variables such as mental health outcomes, resilience, job satisfaction, and workplace spirituality. Pre- and post-intervention assessments, including follow-up evaluations, should be conducted to determine sustainability, while process evaluations should explore implementation fidelity, participant engagement, and contextual barriers.

III. There is a need for longitudinal research to assess the long-term impact of the intervention. Future studies should examine whether improvements in resilience and mental health are sustained over time and investigate broader organisational outcomes such as staff retention, absenteeism, and performance. This will strengthen the evidence base and provide insights into the enduring value of the intervention within healthcare systems.

IV. It is recommended that the intervention be adapted and tested across diverse healthcare contexts to enhance its applicability and scalability. This includes implementation in both rural and urban settings, across different levels of care, and within varying cultural contexts to ensure relevance to diverse belief systems and spiritual practices. Consideration should also be given to the feasibility of scaling the intervention within resource-constrained environments, particularly in the South African public healthcare sector.

V. The intervention should be integrated into organisational policy and practice to ensure sustainability. It is recommended that components of the intervention be embedded within Employee Wellness Programmes and occupational health strategies, aligned with human resource policies on work-life balance, mental health support, and staff recognition, and incorporated into leadership development programmes that emphasise emotional intelligence and supportive management practices.

VI. Capacity building is essential for effective implementation, and it is recommended that nurse managers and facilitators be trained in Intervention Mapping principles, emotional intelligence, and supportive leadership practices. In addition, healthcare staff should be equipped with the necessary skills to facilitate peer support groups and reflective practices, thereby promoting ownership and sustainability of the intervention.

VII. It is recommended that future implementation efforts strengthen the community-level component of the intervention by promoting patient awareness and appreciation of the nursing role and encouraging patient participation in care decisions. This may contribute to a more respectful and supportive healthcare environment, which in turn supports nurse well-being.

VIII. Further research is recommended to advance theoretical contributions by exploring workplace spirituality within healthcare settings, particularly in African contexts, and examining the interaction between spirituality, resilience, and organisational systems. This will contribute to the broader body of knowledge on Intervention Mapping and mental health interventions in organisational contexts.

IX. Finally, it is recommended that future studies complete all six steps of the Intervention Mapping framework by extending the current work to include implementation and evaluation phases. This will enhance methodological rigour and contribute to best practices in applying Intervention Mapping within healthcare and organisational research contexts.

8.6 Contributions of this Study

8.6.1 Contribution to Existing Literature

This study makes a significant contribution to the growing but still limited body of literature on workplace spirituality, resilience, and mental health, particularly within primary healthcare settings and during times of crisis. While previous research has established links between workplace spirituality and outcomes such as job satisfaction, engagement, and organisational commitment, fewer studies have explicitly examined its relationship with psychological resilience and mental well-being among professional nurses in resource-constrained environments. By empirically demonstrating that workplace spirituality enhances resilience and supports mental health during crisis conditions, this study extends existing theoretical understandings of the construct.

Importantly, the study reinforces the multidimensional nature of workplace spirituality by confirming the relevance of meaningful work, interconnectedness (sense of community), transcendence, and alignment with organisational values. Furthermore, the emergence of communication and inclusivity of diverse spiritual beliefs as additional sub-dimensions broadens the conceptualisation of workplace spirituality. These findings contribute new empirical evidence suggesting that workplace spirituality is not limited to individual meaning-making, but also encompasses relational dynamics, open dialogue, and inclusive organisational culture. In doing so, the study addresses a gap in the literature and provides context-specific evidence from primary healthcare nurses, particularly within a crisis context.

Additionally, by integrating Humanistic Organisational Theory and the Salutogenesis Model, the study strengthens theoretical linkages between spirituality, resilience (Generalised Resistance Resources), and mental health (Sense of Coherence). This integration contributes to a more holistic understanding of how supportive organisational environments foster psychological well-being.

8.6.2. Contribution to the Field of Organisational Psychology and Human Resources for Health

From an organisational psychology perspective, this study contributes to the understanding of how workplace spirituality functions as a protective and promotive factor in enhancing

psychological resilience and mental health. It provides empirical support for the view that organisations can serve as environments that either strengthen or undermine employees' psychological resources. By demonstrating that workplace spirituality supports coping, emotional stability, and sustained engagement during crises, the study adds to resilience-based organisational research and positive organisational scholarship.

In the context of healthcare management, the study offers practical insights for leadership, human resource development, and policy formulation. The findings highlight the importance of cultivating supportive, inclusive, communicative, and value-driven organisational cultures that prioritise employee well-being alongside clinical performance. This aligns with global workforce priorities, including strategies aimed at developing an enabled, productive, and empowered health workforce. By demonstrating that spiritual dimensions in the workplace contribute to resilience and mental well-being, the study provides evidence to inform human resource policies, leadership development programmes, staff wellness initiatives, and organisational culture reforms.

The identification of communication and inclusivity as key subthemes further informs management practice by emphasising the need for open dialogue, respect for diverse beliefs, psychological safety, and inclusive leadership approaches. These elements are particularly critical in multicultural healthcare environments. Ultimately, the study supports the argument that investing in workplace spirituality is not only ethically and socially responsible but also strategically beneficial for reducing burnout, enhancing engagement, improving staff retention, and promoting better patient care outcomes.

8.6.3 Methodological contribution of the study

The study contributes to mixed methods approaches in research. The author utilised an evidence-based evidence synthesis of a scoping review (Chapters 3 and 4). This method of investigating gaps in the literature is comprehensive and necessary for a PhD-level study. The registered scoping review identified gaps in the literature regarding evidence on workplace spirituality among nurses in primary health care in sub-Saharan Africa.

Secondly, the study utilises an intervention mapping framework to develop guidelines for an intervention for nurses focused on promoting workplace spirituality and resilience, and on improving mental health for frontline nurses during times of crisis. This is a first-of-its-kind and cements the study's value in practice in the field of Industrial-Organisational Psychology

and Human Resources for Health (HRH). The proposed intervention map is outlined in detail in Chapter 7. The combination of a scoping review, a qualitative research approach, and intervention mapping was intentional to provide a solid, theory-grounded solution to help prevent distress and strengthen resilience and mental health for professional nurses during a time of crisis and a need for psychosocial support.

8.6. Limitations of the study

This study, employing a qualitative research design, primarily aimed to gain rich, in-depth insights into nurses' lived experiences and perceptions of workplace spirituality, resilience, and mental health during a crisis. Consequently, the limited sample size inherent to qualitative inquiry restricts the direct statistical generalisability of these findings to the broader population of nurses globally. While the findings offer valuable thematic understanding and theoretical implications, they are more applicable to contexts similar to where the data was collected, warranting caution when extrapolating to other Sub-Saharan African countries or regions with different healthcare infrastructures and cultural contexts.

Another limitation was the exclusion of healthcare management's perspectives. Although the study illuminated nurses' experiences of managerial support and organisational values, a comprehensive understanding of the organisational context and the support mechanisms available to frontline professional nurses would have been significantly enriched by including management's views and lived experiences during the crisis. This omission means the study presents a primarily unilateral view of organisational dynamics during a high-stress period.

Finally, given the study's cross-sectional nature, data were collected at a specific point in time following the COVID-19 crisis. This provides a snapshot of nurses' experiences but does not capture the dynamic evolution of their perceptions, resilience, or mental health over the entire duration of the pandemic or during different phases of crisis. Longitudinal research would offer insights into how these factors change and adapt over time.

The last key limitation of this study is that, although it successfully developed a theory- and evidence-based intervention using the first four steps of the Intervention Mapping framework, it did not extend to the implementation and evaluation phases (Steps 5 and 6). As a result, the intervention remains conceptual and has not yet been empirically tested in real-world healthcare settings. This limits the ability to draw conclusions about its feasibility,

effectiveness, and sustainability in improving the mental health and resilience of professional nurses. Furthermore, the absence of pilot testing and outcome evaluation means that potential contextual challenges, implementation barriers, and unintended effects could not be identified or addressed. Consequently, while the intervention is theoretically robust and contextually grounded, its practical impact and scalability remain to be established through future research.

8.7. Recommendations for future studies

Firstly, it is recommended that a similar study be conducted with a larger, more diverse sample to capture a broader range of nurses' perceptions and experiences regarding workplace spirituality, resilience, and mental health during times of crisis. A larger sample would enhance the transferability and depth of the findings.

Secondly, considering that spirituality is a deeply subjective and culturally influenced concept, particularly within the South African context, it is recommended that future research explore how workplace spirituality is understood and experienced by South African nurses. Such studies should aim to develop contextually relevant insights rather than relying solely on Western definitions and frameworks of workplace spirituality.

Thirdly, the current study had limited representation among males. Future research should aim to include more male participants to gain a more comprehensive understanding of how male nurses perceive the role of workplace spirituality in fostering resilience and supporting mental health during crises.

Future research should prioritise the implementation and empirical testing of the developed intervention to establish its effectiveness in improving the mental health and resilience of professional nurses. This includes conducting pilot studies within diverse healthcare settings, followed by larger-scale trials to assess feasibility, acceptability, and impact. Rigorous evaluation designs, particularly mixed-methods and quasi-experimental or experimental approaches, are recommended to capture both the effectiveness of outcomes and the implementation processes.

In addition, longitudinal studies are needed to examine the sustainability of intervention outcomes over time. Future research should investigate whether improvements in resilience, workplace spirituality, and mental health are sustained beyond the intervention period, and how these outcomes influence broader organisational indicators, such as staff retention, absenteeism, and the quality of patient care.

Further research should also examine the intervention's adaptability and scalability across different contexts. This includes testing the intervention in rural and urban healthcare facilities, across various levels of care, and within diverse cultural and socio-economic environments. Such studies would provide insight into the contextual factors that influence intervention success and inform strategies for broader implementation within the South African healthcare system and other similar settings.

There is also a need to deepen the theoretical understanding of workplace spirituality within healthcare contexts, particularly in African settings. Future studies should examine how spirituality interacts with resilience, coping mechanisms, and organisational systems, and whether it functions as a mediator or moderator in mental health outcomes among nurses.

Moreover, future research should investigate the role of leadership and organisational systems in sustaining mental health interventions. This includes exploring how emotionally intelligent leadership, organisational culture, and policy frameworks contribute to or hinder the effectiveness of well-being interventions in healthcare environments.

Finally, it is recommended that future studies fully apply all six steps of the Intervention Mapping framework, including implementation planning and evaluation, to enhance methodological rigour. By doing so, researchers can contribute to the development of best practices in designing, implementing, and sustaining complex interventions aimed at improving healthcare worker well-being.

8.8. Conclusion

The findings of this study highlight the importance of workplace spirituality as a crucial factor in enhancing psychological resilience and promoting nurses' mental well-being during times of crisis. In alignment with Goal 5 of the 2030 Human Resources for Health Strategy, which emphasises the creation of an enabled, productive, and empowered health workforce, this research underscores the relevance of cultivating a workplace culture grounded in care, compassion, and support for healthcare professionals.

The study explored four key dimensions of workplace spirituality: meaningful work, interconnectedness/sense of community, transcendence, and alignment with organisational values. Among these, meaningful work, interconnectedness, and transcendence emerged as particularly influential in sustaining nurses' resilience and mental health amid crisis conditions. Although some misalignment between personal and organisational values was observed, this did not significantly compromise nurses' well-being or commitment, largely due to their

adherence to the professional pledge and ethical duty to prioritise patient care above personal beliefs.

Notably, the study revealed the emergence of two additional sub-dimensions: communication and inclusivity of diverse spiritual beliefs, both of which were perceived as vital to enhancing workplace spirituality and fostering a sense of belonging. These findings corroborate prior research indicating that the psychological needs of nurses are often overlooked during crises, as institutional focus tends to centre on clinical outcomes and physiological concerns, particularly in patients.

By fostering a culture of workplace spirituality, healthcare institutions can cultivate supportive environments that not only safeguard the mental well-being of their staff but also contribute to enhanced performance, increased engagement, and improved patient satisfaction. Ultimately, this approach advances Goal 5 by supporting strategies to reduce burnout and enhance professional nurses' overall well-being.

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Appendix A: Ethical Clearance by Research Institutions, University of KwaZulu-Natal

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

22 May 2024

Nompumelelo Penny Dittrich (222130715)
School of Applied Human Sc
Howard College Campus

Dear NP Dittrich,

Protocol reference number: HSSREC/00006842/2024
Project title: To explore workplace spirituality, resilience and mental health of professional nurses during time of crisis in UMgungundlovu Health District
Degree: PhD

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 02 April 2024 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

Incidents of adverse events and serious adverse events (AEs and SAEs) should be reported in writing to HSSREC, the study sponsors, and any regulatory authority (where appropriate), within 7 working days of the occurrence for local sites and 14 days for all other South African sites.

This approval is valid until 22 May 2025.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

HSSREC is registered with the South African National Health Research Ethics Council (REC-040414-040).

Yours sincerely,

Professor Dipane Hlalele (Chair)
/dd

Humanities and Social Sciences Research Ethics Committee
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: +27 (0)31 260 8350/4557/3587 **Email:** hssrec@ukzn.ac.za **Website:** http://research.ukzn.ac.za/Research-Ethics
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

INSPIRING GREATNESS

Appendix B: Ethical Approval by KwaZulu-Natal Provincial Department of Health

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email:

Health Research & Knowledge Management

NHRD Ref: KZ_202406_002

Dear Ms N P Dittrich
(UKZN)

Approval of research

1. The research proposal titled **'Exploring workplace spirituality, resilience, and mental health during a time of crisis amongst professional nurses in KwaZulu-Natal.'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at Bruntville, East Boom, Harry Gwala Gateway & Imbalenhle clinics

2. You are requested to take note of the following:
   a. ***Kindly liaise with the facility manager BEFORE your research begins.***
      This is to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.
   b. *All research conducted in KwaZulu-Natal must comply with government regulations relating to Covid-19. These include but are not limited to: regulations concerning social distancing, the wearing of personal protective equipment, and limitations on meetings and social gatherings.*
   c. *Please ensure that you provide your letter of ethics re-certification to this unit when the current approval expires.*
   d. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za*
   e. *Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.*

For any additional information please contact Dr. G Shezi on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Provincial Health Research Committee
Date: 24/06/2024

GROWING KWAZULU-NATAL TOGETHER

Appendix C: KwaZulu-Natal Provincial Health Permission Letter

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:
DISTRICT DIRECTOR

Private Bag X9124, PIETERMARITZBURG, 3200
Physical Address :171Hoosan Haffejee, Pietermaritzburg 3210
Tel: 033 8971002 Fax: 033 8971078 E-mail: Thule.kunene@kznhealth.gov.za

Enquiries: Nokuthula Nzimande
20 JUNE 2024

TO: PENNY DITTRICH
pennyd@raf.co.za>

Dear, PENNY DITTRICH

RE: *Industrial Psychology study within the community Healthcare Clinics*

I have pleasure in informing you that permission has been granted to you by UMgungundlovu Health District to conduct research on "***Industrial Psychology within the community Healthcare Clinics.***"

PLEASE NOTE THE FOLLOWING

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received the full ethics approval has been received and the confirmation from the Provincial Health Research Committee in the KZN Department.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thank you,

DR M.T ZULU
DISTRICT DIRECTOR:
UMGUNGUNDLOVU HEALTH DISTRICT

GROWING KWAZULU-NATAL TOGETHER

Appendix D: Gatekeeper's Permission Letter

Health Research and knowledge Management
Secretariat
Private Bag X 9051
Pietermaritzburg
3201

Email address: Elizabeth.lutge@kznhealth.gov.za

Dear Dr. Elizabeth Lutge

Re: Permission to conduct research at Primary Health Care in KwaZulu-Natal.

I am Nompumelelo Penny Mahlaba PhD candidate in the Discipline of Industrial Psychology studying toward a PHD at the University of KwaZulu-Natal under the supervision of Dr. Zandile Madlabana.

The purpose of the study is to explore workplace spirituality, resilience, and mental health during times of crises like (COVID-19, floods) of professional nurses in Primary Health Care in the KwaZulu-Natal Province and get nurses' perceptions on the topic.

The research will entail collecting data from professional nurses who has been exposed to any health-related crises or any natural crises. They will be invited to participate in this study, and if they consent, they will be interviewed on face-to-face basis. They will first be three focus groups which will be followed by an interview of six individuals. The anticipated time for the focus group will be 45 minutes to an hour and this will be conducted over 5 days including the individual interviews. Participants' responses will be audio recorded for data analysis at a later stage.

Only participants who provide written consent will participate. All ethical requirements to conduct the research study as per the guidelines from the University of KZN Humanities & Social Sciences Research Ethics Committee (HSSREC) will be adhered to.

Their participation will be voluntary. They will be guaranteed that they can withdraw their permission at any time during this project. The identity of the participants will be kept anonymous. The results will be communicated in the final copy of the thesis, and in academic journals.

All research data will be kept and destroyed after 5 years as per the UKZN research guidelines.

Kindly let me know if you require any further information or clarification of the processes.

Yours sincerely,

Nompumelelo Mahlaba
dittrichpenny@gmail.com

Supervisor's Details

Dr Zandile Madlabana

Lecturer | Registered Industrial Psychologist
Academic Coordinator: Psychology Honours Programme

School of Applied Human Sciences I College of Humanities
Tel:031 260 8389
madlabana@ukzn.ac.za

Appendix E: Participant Information Sheet

Dear Sir/Madam,

My name is Nompumelelo Mahlaba, and I am currently completing my Doctor of Philosophy (Psychology), degree at the University of KwaZulu-Natal. As part of the requirements for my degree, my area of research is to explore professional nurses' perceptions and experiences of workplace spirituality, resilience, and mental health during time of crisis at the district department of health in KwaZulu-Natal. The study will further explore the recommended actions that managers need to consider in ensuring preparedness of professional nurses during crisis.

To determine eligibility to participate in this study, please answer the following questions:

1) Are you an employee or manager within the district of department of health? _____

2) Are you between the ages of 18-65 years? _____

3) Have you ever worked during a time of crisis in your professional capacity?

_____

4) Do you understand what is spirituality at work or workplace spirituality?

_____

5) Are you willing to describe your lived experiences / perceptions and/or observations of workplace spirituality in relation to resilience and mental health during crisis?

_____

You have been invited to participate in this study after having obtained ethical clearance for this study from the Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal as well as authorisation in terms of the gatekeeper's permission letter to conduct the study within uMgungundlovu District. Thus, if you are an employee or are employed at any level of management within this District, I would like to invite you to participate in my research.

This research is a qualitative study, which is interested in obtaining a description of your understanding, lived experiences and perceptions of the research phenomenon, which in this study are workplace spirituality, resilience, and mental health. Accordingly, participation is undertaken through the completion of a biographical questionnaire that will be emailed to you and returned to the researcher electronically, as well as the face-to face interview with the researcher which will take place in one of the boardrooms at your offices.

The interview will take approximately one hour to an hour thirty minutes to complete. Please note that participation in the interview process is completely voluntary and you will not be disadvantaged in any way should you decide not to participate.

Anonymity and confidentiality will be ensured throughout the study, by using codes during the transcripts, written reports, and any journal article or conference presentation that may follow. Additionally, all recordings and transcribed data will be securely stored on a password protected computer with access control limited to the research team (researcher and research supervisor). All hard copies of the interview data will be stored in a cabinet under lock and key with access strictly limited to the researcher. Similarly, all recordings, and written interview transcripts will be removed from all storage devices and cabinets and will be destroyed after five years.

Your informed consent to participate in the study will be provided through the signing an informed consent form that will be provided to you electronically by the researcher. This signed informed consent form must be returned to the researcher electronically. You have the right to voluntary withdrawal from the study at any point without any undue consequence to you and you are not obliged to answer any question.

Your well-being is of paramount importance in this study. Whilst minimal risk may be experienced, should you feel the need for counselling after the study, you may contact the researcher or supervisors vide the contact details listed below who will initiate a referral process to the relevant help line for counselling.

The benefits of participating in this research include the opportunity to anonymously and confidentially give voice to share your experiences and perceptions of workplace spirituality, resilience, and mental health during crisis.

If you have any concerns over the way the study is being conducted, please contact the UKZN Humanities and Social Sciences Research Ethics Committee, contact details as stated at the end of this form.

Please note that your interview responses will only be used for academic research purposes.

This is an independent study conducted under strict supervision of Industrial Psychologists at the University of KwaZulu-Natal.

If you are interested in participating in this study and would like to be interviewed, please complete, and send this form to the researcher's e-mail address and indicated below. The researcher will share the dates for the interview with the interested employees upon receiving this form.

Best regards,

Nompumelelo Mahlaba

Nompumelelo Mahlaba

Researcher: PhD Student (222130715)

Email: dittrichpenny@gmail.com

Cell Phone: +27 65 698 3080

Appendix F: Informed Consent Form

UNIVERSITY OF KWAZULU-NATAL: SCHOOL OF APPLIED HUMAN SCIENCES
Doctor of Philosophy (Psychology) Research Project; Student Researcher: Mrs. Nompumelelo Mahlaba (065 698 3080)
Supervisor: Dr. C.Z. Madlabana (+271 995 2816)

Date: 14 Feb. 24

Dear Research Participants

Greeting: A warm greeting to everyone.

My name is Nompumelelo Mahlaba, and I am currently registered as a student for the Doctor of Philosophy (Psychology) degree at the University of KwaZulu-Natal. The title of my research project is: Exploring workplace spirituality, resilience, and mental health during a time of crisis amongst professional nurses in KwaZulu-Natal, South Africa.

You are identified and invited to participate in this study after having obtained ethical clearance for this study from the Humanities and Social Sciences Research Ethic Committee of the University of KwaZulu-Natal, as well as authorisation in terms of the gatekeeper's permission letter to conduct the study at uMgungundlovu Health District.

The aim and purpose of this research is to understand professional nurses' experience and perception on workplace spirituality, resilience, and mental health during times of crises, also to ascertain what managers need to consider when preparing nurses for crisis. Through your participation, I hope to understand the effect of workplace spirituality has on individual resilience and mental health as well as proposed guidelines towards development of an intervention programme to enhance, resilience and prevent mental illness as well as ensure that employees are ready to face crisis. Your participation is this project is voluntary and you may withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this study. This is confidential and the records of this study will be kept private.

This study will be conducted on a face-to-face basis, and it will take approximately an hour to an hour thirty minutes depending on the follow up questions. The risks associated with this study are very minimal, however questions could possibly induce feeling of discomfort or negative memories. In an event an where someone feels emotional distress as a result of the questions asked, the researcher will take necessary steps to refer the individual for counselling.

Should you agree to participate, you are free not to answer any questions that could make you feel uncomfortable. The benefits of participating in this research include the opportunity to share your experiences and perceptions and contribute meaningfully to assist in putting forward ideas on how workplace spirituality can or cannot improve employee's resilience and support mental health of nurses during crisis. The researcher will then initiate a follow up individual interview with six individuals to further explore what would have been discussed during the focus group discussion. Furthermore, the researcher will arrange a brief follow up session with you to ensure accuracy in the capturing of your responses on workplace spirituality, resilience, and mental health during crisis.

Confidentiality and anonymity of information identifying you as a participant will be maintained by the researcher using codes and neutral referents of the organisation in which the workplace spirituality will be investigated. Limits to confidentiality are that the overall key research findings will be reported at human resources and management fora in the form of reports and presentations. It must be noted that the researcher will consult with each participant prior to reporting findings on these platforms. Electronic devices, written interview transcripts, emails and biographical questionnaires will be kept in a cabinet under lock and key, and online meeting recordings on password protected computers with access control. Privacy and security of the data will be ensured as it will not be shared with anyone outside of the research team other than the research supervisor. After five years, these materials will be destroyed.

Information received during the project will be utilised solely for research purposes and will not be released nor have any influence on any performance evaluation, selection, or promotion decision, and/or disciplinary measures. The researcher will provide each individual participant with feedback on the research findings on Microsoft Teams or Zoom online platforms. The findings of this research may be used in academic publications and conference proceedings but that your identity as a research participant will be kept strictly anonymous.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (Approval Number_____).

In the event of any problems or concerns / questions you may contact the researcher at dittrichpenny@gmail.com or on 065 698 3080. Alternatively you can contact the UKZN Humanities and Social Sciences Research Ethics Committee, contact details as follows:

Humanities and Social Sciences Research Ethics Administration
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 260 4557 – Fax: 27 31 260 4609
Email: HSSREC@ukzn.ac.za

Sincerely
Nompumelelo Mahlaba

Researcher's signature: _____ Date:_____

Nompumelelo Mahlaba

Researcher: PhD Student (222130715)

Email: dittrichpenny@gmail.com

Cell Phone: +27 65 698 3080

Dr. Cynthia Zandile Madlabana

Research -Supervisor

Email: Madlabana@ukzn.ac.za

Office Phone: +27 71 995 2816)

Date: 14 February 2024

Appendix G: Semi-Structured Interview Guide

Proposed topics	Open-ended questions	Potential follow up probes
1. Understanding how participants define workplace spirituality.	1.1. What is your understanding of workplace spirituality? 1.2 How would you define workplace spirituality from an individual perspective? 1.3 How would you define workplace spirituality from a group perspective? 1.4 How would you define workplace spiritualty from an organisational perspective.	1.1. What does your day-to-day work entail? 1.2. What motivates you to wake up and come to work every day? 1.3. What demotivates you when you think of coming to work? 1.4. What energises you in the work you do? 1.5. What is most fulfilling with the work you do? 1.6. What actions and behaviours do you regard from your peers to represent workplace spirituality? 1.7. What actions or behaviours would you regard from your manager to represent workplace spirituality 1.8. How would you feel if your values and beliefs were aligned with the department of health's mission, vision and values? 1.9. How would you feel if your values and beliefs were misaligned with the department of health's mission, vision and values?
2. Exploring the perceptions of professional nurses regarding workplace spirituality during time of crisis.	2.1. What is your perception of spirituality in the work? 2.2 What do you think would be the benefits of encouraging workplace spirituality during a crisis?	2.1. Can you please tell me why you perceive this to be so? 2.2 why do you think this will benefit nurses during a times of crisis?

3. Exploring professional nurses' experiences of workplace spirituality.	3.1 Explain your personal experience of workplace spirituality in your work environment. 3.2 How can spirituality at work assist in coping with crises? 3.3 Would you encourage the incorporation of spirituality at work and WHY	3.1 Can you provide examples of the types of workplace spirituality actions and behaviours you have observed or experienced within your workplace and organisation?
Resilience		
4. Exploring professional nurses' perceptions of resilience during a crisis?	4.1 What is your perception of resilience during crisis? 4.2 How have you coped, or what are the coping mechanisms that assisted your during times of crises?	4.1 What do you think are the contributing factors to nurses' resilience during a crisis? 4.2 Can you please discuss the coping mechanisms you have employed to deal with a crisis? 4.3 How have your peers contributed to your resilience during this time of crisis? 4.4 How has your manger contributed to your resilience during crisis? 4.5 How has the department of health contributed to your resilience during time of crisis? 4.6 What other factors that you can think of which contributed to enhancement of your resilience.
Mental Health		
5. Exploring nurses' perceptions on mental health/wellbeing during crisis?	5.1 What is your perception of mental health during crisis?	5.1 How would you say crises affected your mental well-being? 5.2 Would you say your cultural background had an impact on how you perceived the impact of crises on your mental health as compare to your colleagues. 5.3 What do you think are the factors that contributed to your mental health during time of crisis?

		5.4 Kindly explain how these factors have contributed to your mental health.
6. Exploring actions or interventions that managers should consider to assist professional nurses to be emotionally and psychologically prepared during a crisis.	6.1 What do you think managers should consider in order to supports or prepare you for crisis?	6.1 Kindly provide details of support/intervention that you think may assist you during any time of crisis.

Appendix H: Chapter 3 Reference List

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Appendix I: Language Editing Certificate

CERTIFICATE OF COMPREHENSIVE EDITING

072 073 5867
info@totallyshane.com

This certificate certifies that I have edited the manuscript indicated below for English language, grammar, spelling, clarity, and scholarly writing style.

Manuscript Title:
Workplace Spirituality, Resilience, and Mental Health During a time of Crisis among Professional Nurses in KwaZulu-Natal, South Africa: Developing a Guideline for Psychosocial Support through Intervention Mapping

Student: Nompumelelo Penny Mahlaba
Student Number: 222130715
Date issued: 25 November 2025

The author's subject matter contents and intentions were unaltered during the editing process. Manuscripts with this certification should be grammatically ready for publication. However, the student/author has the final choice to accept or reject the suggestions and changes.

Any queries may be routed to the editor via the contact details above.

Shane VJ Stoffels
Professional Editor for 18 Years
Dip Editing Principles and Practices (UP)
NDip Public Management (TUT), BTech Public Management (TUT)
BA International Relations and Psychology (Wits)

We should not write so that it is possible for the reader to understand us, but so that it is impossible for him to misunderstand us.
QUINTILIAN