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Correlation between Spiritual Leadership and Occupational Conflict

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Abstract

Introduction: Nurses as the largest group among the healthcare staff sustain continual environmental pressures and changes. Hence, the incidence of conflict among nurses is something normal due to extensive interactions with various people. Managers can make the organizational activity more effective and efficient by the use of innovative leadership styles based on internal motivation and appropriate management of conflict. This study determined the correlation between spiritual leadership and occupational conflict of nurses employed at selected academic hospitals affiliated to Shahid Beheshti University of Medical Sciences in 2017.

Methods: 287 nurses employed at various wards of academic hospitals of Shahid Beheshti University of Medical Sciences, Tehran, Iran, were enrolled in this descriptive-correlational study using convenient sampling method. The data were collected using two questionnaires; "Spiritual Leadership" and "Occupational Conflict" and analyzed with SPSS.18.

Results: 261 nurses completed questionnaires and resend them. The findings showed that the maximum score obtained by nurses about their head nurse's spiritual leadership style belonged to "altruistic love" (14.46 out of 25). In addition, the highest score about their occupational conflict belonged to "interclass conflict" (10.98 out of 16). Generally, there was a significant correlation between spiritual leadership and occupational conflict ($P<0.001$, $r=0.522$).

Conclusions: The findings on the correlation between the nurses' perspectives about spiritual leadership and occupational conflict indicated that the application of innovative styles such as spiritual leadership to reduce nurses' occupational conflict in the Iranian healthcare system demands more investigations. It can serve as the managers' guide in choosing the most effective leadership style to diminish occupational conflict among nurses and reach the highest levels of outcomes in the organization.

INTRODUCTION

Today, organizations need efficient and effective personnel to achieve their goals of development [1]. In recent years, the organizations members have been exposed to psychological problems such as depression, loneliness, vanity and futility (absurdity), self-centeredness, and indecision. The science of management has addressed this problem by uncovering the humanistic values [2]. Spirituality has played a significant role in organizations affecting the personnel's perspectives and behaviors [3]. Upon emergence of spirituality in the field of organization and management in the 21st century, the managers and leaders of organizations ought to challenge this new phenomenon [4]. Thus, the leaders try to believe that the humanistic values like intimacy, honesty, love, emotion, generosity, cooperation, rectitude, kindness, and altruism can grow

and they can develop these values in their managerial activities [2]. Paying attention to the developmental course of leadership studies demonstrate that though various studies have been conducted so far on physical, mental, and emotional traits of leaders, the subject that has recently attracted much attention is the leaders' spiritual characteristics [5]. Spiritual leadership and spirituality in organizations as new management styles have the capacity for personal and organizational development [6]. Therefore, managers can make organizational activities more effective and efficient and decrease conflict among individuals through the use of innovative contributory leadership styles [7]. Conflict is an inevitable phenomenon in human life and a necessity for social life [8]. Nurses as the largest group of healthcare professionals [9] are constantly exposed to environmental pressures and modifications [10]. Consequently, the incidence of conflict in healthcare professions, especially in nursing that requires extensive interactions with different individuals, is an inevitable and natural issue [11].

Provision of high quality care demands the positive cooperation among the health care members. Today, the work environments may be threatened increasingly by interpersonal conflicts [12] that may lead to positive or negative consequences [13]. Some studies indicate that positive leadership is increasingly related to lower levels of conflict in the work milieu that is itself correlated with reduced burnout, diminished psychosomatic disorders, and negative indices of work environment, i.e., feelings of non-appreciation, ambiguity in duties and roles, rumors, and hatred toward the organization, and higher levels of work satisfaction [14].

The results of the study by Dussault et al [15]revealed that leadership styles are effective in resolving conflicts among the staff. In Sili et al.'s perspective, a coordinating leadership plays a key role in creating a healthy milieu and physical health in nurses. Kimball & Volk (2015) have predicted occupational burnout to include the status of spiritual leadership, role conflict, role ambiguity, and personal spirituality. This study determined the correlation between spiritual leadership and occupational conflict in perception of nurses employed at various wards of academic hospitals affiliated to Shahid Beheshti University of Medical Sciences, Tehran, Iran. On the basis of the following observations: the negative effects of destructive conflicts on nurses' professional performance and team therapy [11], the present researcher's conflict in nurses' work environment, various methods and styles applied by head nurses to resolve conflict, the many ambiguities and definitions of the concept of spiritual leadership as a novel paradigm which are highly affected by cultural conditions [6], and lack of sufficient research in the Iranian context on the correlation between spiritual leadership and occupational conflicts.

METHODS

A total of 287 nurses, employed at academic hospitals affiliated to Shahid Beheshti University of Medical Sciences, were selected using convenient sampling method. The inclusion criteria were: BS degree in nursing or higher, at least one-year experience of nursing, and complete consent for participation. First, the research goals and procedures were explained to the study participants and informed written consent was obtained from each nurse. Care was taken to observe the principles of information confidentiality and anonymity during data collection and the use of references was ascertained. Code of ethics no.: IR.SBMU.RETECH.REC.1395.229 dated Nov.9.2015 was given by Committee of Ethics at Shahid Beheshti University of Medical Sciences. The data were gleaned with Demographics Questionnaire, Rate of Occupational Conflict Questionnaire [16], and Fry's Spiritual Leadership Questionnaire (2015). The demographic questionnaire included 8 items on age, gender, marital status, nursing work experience, ward of employment, education level, type of employment, and work shift. The questionnaire that was developed, validated, and made reliable by Ganjizadeh (2016) was used to measure the rate of occupational conflict. This 20-item inventory used a 4-point Likert scale that assessed the rate of conflict in three dimensions: intrapersonal aspect (7 items), intraclass aspect (9 items), and interclass aspect (4 items). Considering the number of items, the minimum and maximum total scores of conflict are 20 and 80, respectively. The minimum and maximum scores of conflict are 7 and 28 in the intrapersonal aspect, 9 and 36 in the intraclass aspect, and 4 and 16 in the interclass aspect, respectively. The reliability coefficient of this tool was α=0.824 in this study. Fry et al.'s Spiritual Leadership Questionnaire was a 35-item tool that used a 5-point Likert scale ranging from 1=highly disagree to 5=highly agree. It consisted of eight (8) aspects of "organizational vision, altruistic love, hope/faith, calling, membership, inner life, organizational commitment, and Productivity. Given the number of items, the minimum and maximum scores of spiritual leadership were 35 and 175, respectively. Moreover, the minimum and maximum scores of "vision, hope/faith, calling, membership, and productivity" were 4 and 20; yet, the minimum and maximum scores of "altruistic love, inner life, and organizational commitment" were 5 and 25, respectively. The intercultural translation and validation of this inventory was done by Zagheri Tafreshi et al. (2017) in Iran [17]. The reliability coefficient of the tool was calculated and approved in this study equaling α=0.933. Statistical analyses were performed using the SPSS18. Kolmogorov–Smirnov test was used to test the normality of data and Pearson correlation test was used for assessing correlation coefficient. P-values of less than 0.05 were considered statistically significant.

RESULTS

In this study, 261 completed questionnaires were returned (response rate= 90.94%). The mean age of the nurses was 31.79 years and most (82%) were female. Most nurses (57.9%) were single, 54.8% were formally employed, 88.5% held a BS degree, 57.1% worked in rotational shifts with a mean work experience of 7.25 years and a 3.74-year work experience in the present ward. The hypothesis of normality was accepted by the Klomogrov-Smirnov test, so, parametric tests were used to analyze the inferential results. The findings suggested that the total score of spiritual leadership was 86.23±3.48 (total score=175). Additionally, the maximum mean (14.46) belonged to "altruistic love" and the minimum mean (6.95) belonged to "calling" (Table 1). Moreover, our results demonstrated that the scores of nurses' intrapersonal, intraclass, and interclass conflict were 16.52, 20.29, and 10.98, respectively (Table 2). Pearson correlation coefficient was used to determine the association between "spiritual leadership and its aspects" and "occupational conflict". The correlation indices showed a significant correlation (r=0.522) between nurses' occupational conflict and spiritual leadership (P<0.05). Regarding the correlation between subscales of occupational conflict and subscales of spiritual leadership, the findings suggested a significant correlation between intrapersonal conflict and all subscales of spiritual leadership (P<0.05) except "inner life" subscale (P=0.387). There was also a significant correlation between intraclass conflict and all subscales of spiritual leadership (P<0.05) except "inner life" subscale (P=0.296). Furthermore, there was a significant correlation between interclass conflict and four subscales of "hope/faith", "altruistic love", "inner life" and "organizational commitment"(P<0.05), but there was not a significant correlation between interclass conflict and four subscales of "vision" (P=0104), "Calling" (P=0.708), "membership" (0.108), and "Productivity" (P=0.430) (Table 3).

Table 1: Mean and Standard Deviation of Spiritual Leadership's Dimensions

Aspects	Items	Total score	Mean	SD	Mean out of 5
Vision	1-4	20	9.89	3.03	2.47
Hope/Faith	5-8	20	9.74	2.99	2.43
Altruistic love	9-13	25	14.46	4.68	2.89
Calling	14-17	20	6.95	2.75	1.73
Membership	18-21	20	10.59	3.59	2.64
Inner life	22-26	25	11.98	2.89	2.39
Organizational commitment	27-31	25	13.21	4.22	2.64
Productivity	32-35	20	9.41	3.72	2.35

Table 2: Mean and Standard Deviation of Occupational Conflict's Dimensions

Variables	Items	Total score	Mean	SD	Mean out of 4
Interpersonal conflict	1-7	28	16.52	2.97	2.36
Intraclass conflict	8-16	36	20.29	4.20	2.25
Interclass conflict	17-20	16	10.98	2.49	2.74

Table 3: Results of Pearson Analysis between Aspects of Spiritual Leadership and Aspects of Occupational Conflict

Aspects of spiritual leadership	Intrapersonal conflict		Intraclass conflict		Interclass Conflict	
	Correlation Coefficient	P-value	CorrelationCoefficient	P-value	Correlation coefficient	P-value
Vision	0.232	0.000	0.359	0.000	0.101	0.104
Hope/Faith	0.166	0.007	0.241	0.000	0.152	0.014
Altruistic Love	0.334	0.000	0.447	0.000	0.179	0.004
Calling	0.137	0.027	0.203	0.001	-0.023	0.708
Membership	0.413	0.000	0.597	0.000	0.100	0.108
Inner life	-0.054	0.387	0.065	0.296	0.212	0.001
Organizational commitment	0.389	0.000	0.458	0.000	0.144	0.020
Productivity	0.344	0.000	0.621	0.000	0.049	0.430

DISCUSSION

The results of this study showed that the total score of spiritual leadership was at a low level equaling 86.23 out of 175 with an SD=3.48. This was not consistent with the findings by Polat (2011) [2], Fry et al. (2011)[18], Maleki et al. (2011) [19], and Shojaei & Khazaei (2012) [20]. The participants in Polat's (2011) [2] and Fry et al.'s studies reported the quality of spiritual leadership at a moderate level. Maleki et al.'s study (2011) reported this rate at a high level and the study by Shojaei & Khazaei (2012) reported it at the moderate level [19, 20]. The low total score of spiritual leadership from nurses' view in the present study may be attributed to the nature of healthcare organizations in our country, which is inclined toward bureaucracy. This contrasts with the use of spiritual leadership style making its application rather impossible. Moreover, the difference

between the study population and the groups under study and cultural disparities may result in these dissimilarities [21]. Spiritual leadership is of utmost importance for contemporary organizations. The spiritual leaders prepare the required prerequisites for achieving organizational outcomes through taking measures such as creation of a common landscape for the staff, attempts for establishing organizational culture based on human values [22], and also creation of intrinsic motivations [23]. In this way, they may support the organizational dynamism in the competitive atmosphere today [22] and finally, bestow the managers, followers, and all beneficiaries with internal peace and tranquility (Meng, 2016). Hence, it is recommended that the conditions for the use of this leadership style be prepared in organizations. Our findings further suggested that nurses' intrapersonal conflict score was 16.52 out of 28, the intraclass conflict score was 20.29 out of 36, and the interclass conflict score was 10.98 out of 16 indicating that nurses' conflict score was at the moderate level. This is consistent with the findings by Turanian et al. (2011)[8], Endokaslaki et al. (2013) [1], Sili et al. (2014) [14], Ghasemiani et al. (2012) [13], Mosadegh Rad et al. (2016) [24], and Atashzadeh-Shoorideh et al. (2013) [17]. However, our findings were contradictory with the results of some other researchers. For example, the study by Seung Wan et al. (2017) obtained a high level conflict in nurses. Also, Zakari et al. (2010) [25] found that interclass and intraclass conflict were more common in nurse managers than intrapersonal conflict. Ganjizadeh (2016) [16] obtained the highest level of conflict in the intrapersonal conflict among the ICU nurses. Golparvar et al. (2013) [26] found that nurses' intrapersonal conflict level was higher than their conflict with their headnurses. Schuster et al. (2014) [27] reported lower levels of conflict among alternative decision-makers (patient's family members) and physicians of critically ill patients. Ganjizadeh (2016) [16] reported the highest level of conflict in intrapersonal conflict with a mean of 57.22 among the ICU nurses in academic hospitals affiliated to Shahid Beheshti University of Medical Sciences. Nonetheless, in our study, the highest level of conflict belonged to interclass conflict with a mean of 10.98. This is consistent with the study above. This may be due to the fact that the participants in Ganjizadeh's study were only ICU nurses while our participants worked in all wards of the target hospitals except in the operating rooms and clinics. Our findings further demonstrated a significant correlation between most aspects of spiritual leadership (Vision, hope/faith, altruistic love, calling, membership, , organizational commitment, and productivity) and occupational conflict. Despite the findings available on the correlation between leadership style and variables such as working life quality, commitment, civil behavior, individuals' performance, and organizational learning in previous studies, it appears that the application of innovative styles like spiritual leadership to reduce nurses' occupational conflict in the Iranian healthcare system demands more investigation and research. Consequently, it is advised that nurse managers adopt various innovative leadership styles as reinforcing factors to create professional work environments and reduce the rate of conflict (Zakari et al., 2010) [25]. Although conflict has been previously rendered as negative and as an issue to be avoided (Franco et al., 2012) [28], the nurse managers ought to obtain global updated information to effectively manage the conflicts (Kodama et al., 2016) [29]. Since the present challenges have focused on the healthcare systems, it is mandatory for managers and leaders to master various leadership styles (Asiri et al., 2016) and apply effective leadership performances to maintain health care in ever-changing environments (Echevarria et al., 2016) [30].

CONCLUSIONS

It is necessary for nurse managers to get familiar with various leadership styles, especially spiritual leadership and its application, to display better behavior toward their followers through the use of interpersonal communication and greater contribution. They ought to avoid imperative styles in the organization and create a confidence-filled atmosphere in their organization via establishing intimate and friendly relations that reflect a strong interrelated network of social support among the members. Moreover, they should prepare the context for creating an open and supporting atmosphere with the least amount of conflict through identifying the clear and supportive goals of the organization, creating a suitable reward system proportional to the staff services, establishing an efficient communication system, and creating the optimized methods of work performance. Since the application of modern leadership styles would lead to more opportunities for the managers and staff and enhance organizational maturity, it may be asserted that organizations with spiritual leadership can allow the staff to participate in organizational decision-makings via creation of motivation in the staff, provision of information to them, and transmission of their authority to them.

ETHICAL CONSIDERATION

The study was approved by committee of ethics at Shahid Beheshti University of Medical Sciences. Code of ethics no.: IR.SBMU.RETECH.REC.1395.229. Potential participants were given a document outlining that participation was voluntary and that collected data would be used solely for scientific purposes. We dedicate a special code for each person (not name and family name) to prevent the disclosure of information. Written and verbal consent was obtained.

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CONFLICTS OF INTEREST

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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AUTHOR'S CONTRIBUTION

M.N (first author) involved in the study conception, design, analysis/interpretation of data, drafting of the manuscript and review of content. M.Z.T (corresponding author) involved in the study conception, design, and analysis/interpretation of data. F.A.S (third author) involved in the study conception, design, acquisition of data, analysis/interpretation of data, and review of content. M.N (forth author) provided statistical technical support and involved in the study design, provision of statistical technical support.

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