Religare, ISSN: 19826605, v.18, n.1, julho de 2021, p.230-246

Brazilian inpatients perspectives on spirituality, religiosity and the healthcare relationship regarding spirituality and religiosity in a university hospital

As perspectivas de pacientes brasileiros sobre a espiritualidade, religiosidade e cuidados à saúde relacionados à espiritualidade e religiosidade em um hospital universitário

Vanessa Viana Marques[1]
Tânia Cristina de Oliveira[2]
Ana Paula Rodrigues Cavalcanti[3]

Abstract

Spiritual and religious care is essential to help individuals overcome suffering and cope with the disease. OBJECTIVE: We investigated in a sample of 25 Brazilian patients hospitalized in medical and surgical shared wards of a university hospital their preferences about spirituality/religiosity(S/R) in the care provided. METHOD: It was used the Collective Subject Discourse (CSD) method. RESULTS: The results showed that for interviewed patients the needs related to the S/R were less critical than their relationship with the health team and their medical needs, and some of them considered the hospital ward an inappropriate place to talk about S/R. CONCLUSION AND IMPLICATION FOR PRACTICE: These findings emphasize the role of the patient-health team relationship in the patient's perspective about the need to insert the S/R approach in care and indicate that better understanding about patient's S/R and personal preferences is urgent for clinical practice and healthcare education.

Keywords: Spirituality; Religion; Patient Care.

[1] Graduada em Enfermagem pela Unirio.
[2] Pós-Doutora em Psicologia Médica e Psiquiatria da Faculdade de Ciências Médicas da Unicamp e em Antropologia da Ciência pelo Instituto de Estudos Brasileiros da USP; Professora Associada do Departamento de Saúde Coletiva da Unirio.
[3] Doutora em Psicologia Social pela Universidade Federal da Paraíba – UFPB; Professora adjunta do Departamento de Ciências das Religiões da Universidade Federal da Paraíba – UFPB.

Resumo

O cuidado espiritual e religioso vem sendo considerado essencial para superar o sofrimento ligado à doença. OBJETIVO: Investigou-se em uma amostra de 25 pacientes brasileiros internados em enfermarias médicas e cirúrgicas de um hospital universitário as preferências sobre espiritualidade/religiosidade (S/R) no atendimento prestado. MÉTODO: Utilizou-se o método do discurso do sujeito coletivo (DSC). RESULTADOS: Os resultados mostraram que, para os pacientes entrevistados, as necessidades médicas e a relação com a equipe de saúde foram mais importantes do que o atendimento relacionado à S/R e alguns deles consideraram a enfermaria um local inadequado para falar sobre S/R. CONCLUSÃO E IMPLICAÇÕES PARA A PRÁTICA: Esses achados enfatizam o papel do relacionamento equipe-saúde nos cuidados sobre a necessidade de inserir a abordagem S / R e indicam que é urgente um melhor entendimento sobre as preferências pessoais dos pacientes para o aprimoramento da prática clínica e a educação em saúde.

Palavras-chave: Espiritualidade; Religião; Assistência ao Paciente

Introduction

In the late 20th century, research addressing the importance of spirituality/religiosity (S/R) on healthcare, providing support for the expansion of the biopsychosociospiritual view of healthcare in the international and Brazillian scientific medical scene (ABDULLA; HOSSAIN; BARLA, 2019; OLIVEIRA; ANDERSON; LUCCHETTI et al, 2018).

Spirituality has been pointed out as an essential dimension of life (SCHMIDT; NAUTA; PATTERSON; ELLIS, 2018; COLLIER; JAMES; SAINT; HOWELL, 2020). When considering the spiritual aspect of patients, the health professional is sending an important message - that they concern about the holistic approach of care – improving the relationship between the caregiver and the patient and increasing the impact of health interventions (PUCHALSKI, 2008; PANZINI et al., 2017).

The recognition of the holistic model relevance in patient care that includes all human dimensions (spiritual, religious, and existential issues), has

improved in recent years. Suffering and search for meaning, an attempt to understand an overwhelming experience, is always present in the diagnosis of serious diseases. Beliefs shape these meanings and link stories of faith and understanding about the sacred. The sacred can refers to God, the divine, something of higher value or a philosophical commitment, and its search and understanding can occur in several ways, and among them are religion and spirituality (KOENIG; PETEET; VANDERWEELE, 2020).

Spirituality is usually confused with religiosity, so there is a need to clarify both concepts. Religion is defined (KOENIG, 2020; KOENIG; PETEET; VANDERWEELE, 2020) as an organized system of beliefs, practices, rituals, and symbols to facilitate the proximity with the sacred or transcendent, making an environment of social relationships between the members of a community. Spirituality is defined as a personal journey to understand the answers to the fundamental questions of life, which may or not be improved by religious rituals and religious community participation. The sacred is present in religion and spirituality, but while religion is a formal system focused on community, oriented towards the behavior and for ceremonial practices, spirituality is less structured and systematic, is concentrated on the individual, and is guided by emotion (PUCHALSKI, 2014).

Purpose and meaning of life are something that many people search throughout their lives. However, the major challenge, especially for people affected by severe diseases, is to find meaning and purpose when facing these new conditions of life.

Although the literature confirm that S / R are essential factors for coping with the disease (PANZINI, 2017; BEST; MCARDLE; HUANG et al, 2019), this can be not a significant issue in-hospital care for Brazilian inpatients. Due to the lack of data about that in the literature, this study aimed to investigate the preferences about S/R in the healthcare provided to a sample of Brazilian

inpatients, highlighting relevant aspects to be considered to include S/R in the healthcare in Brazil.

Methods

This research has a descriptive, exploratory, and qualitative approach. The scenario was the medical and surgical wards of Rio de Janeiro Federal State University Medical School Hospital, located in Rio de Janeiro, Brazil. Twenty-five inpatients were randomly selected without any distinction of sex, age, or any other features, only under the condition of agreeing to participate in the study. Inclusion criteria were defined as to be conscient, able to be interviewed, and to have more than two days as a length of stay. It is important to emphasize that in the studied hospital, there are only collective wards.

The study was carried out according to ethical principles in research and approved by the Research Ethics Committee of the Rio de Janeiro Federal State University registered and approved under the number 86430, 8/30/2012.

The data were collected in two periods, from October to November of 2014 and from June to July of 2015, according to the criterion of saturation to finish the data collection period. Semi-structured interviews with six questions were conducted, guided by the script previously proposed by Heabert et al. (2001), validated by a reverse translation, which included the following questions: (1) what are essential aspects of S/R for you? (2) have you ever discussed your S/R beliefs with your doctor or other healthcare professionals? (3) was there a time when you would like to have addressed S/R beliefs or practices with health professionals, but didn't? (4) what aspects of your religious or spiritual activities would you like to discuss with your doctor or other healthcare professionals? (5) how and when the doctors who care for you could incorporate your S/R beliefs in your treatment? (6) what would be the only thing about your religious practices and ideas related to your health/illness

process that you could tell the professionals who care for you, that you think they don't know/understand?

The interviews were fully recorded and transcribed under colloquial speech. These data were analyzed, qualitatively, and quantitatively, using the Collective Subject Discourse (CSD) method (LEFEVRE et al, 2014) using the Social Representations Theory. It lists and articulates a series of statements, linking individual opinions or expressions with similar meanings that are grouped into general semantic categories, called key phrases (KE) which have the same central idea (CI), resulting in jointed statements made up by different individual comments. Each one of them represents a determined opinion or position, and it is written in the first singular person, aiming to produce in the receptor the effect of a collective idea, expressed as an empirical fact, through the "mouth" of a single individual. The Discourse of the Collective Subject is a proposal for reconstitution of a collective being or entity, stating his/her opinion as a subject of spoken discourse in the first person. Through CSD, the statements are reconstructed together, maintaining the link between their original and jointed dimensions.

Results and discussion:

Table 1 shows the demographic characteristics of the participants. The median age was 54 years (ranging from 84 to 32). All respondents were from Rio de Janeiro State. Religious practitioners were 84% of the sample. Most of the respondents were suffering from chronic diseases ranging from light to severe complications and hospitalization. The average hospital stay was one week, and the main reasons for admission were: Elective surgical procedures, palliative care, and stabilization of acute severe pulmonary obstructive disease crises.

Table 1

Demographic Characteristics of the Participants (N = 25)

	n	**%**
Gender		

Male	7	28
Female	18	72
Educational Level		
Incomplete elementary school	3	12
Full elementary school	4	16
High school	15	60
University	3	12
Marital Status		
Single	4	16
Married	16	64
Divorced	2	8
Widowed	3	12
Religion		
Evangelical	12	54
Catholic	6	23
"Christian"	4	12
Spiritualist	1	4
Jehovah's Witness	1	4
Buddhist	1	4

The CSD and the Central Ideas that emerged from each one of the six questions were grouped and divided by themes, are shown in Tables 2, 3, and 4.

Four Central Ideas emerged regarding the first question **(What are the essential aspects of S/R for you?**): "To believe in God as the most important aspect of spirituality/religiosity"; "God as support"; "Religion as a way to get in touch with God"; "Religion as a social coping." Table 2 shows the collective subject discourse:

Table 2

Central ideas contained in DSC of hospitalized patients concerning Question 1 (*What are the most important aspects of spirituality/religiosity for you?*)

Question	**Central Ideas**	**The collective subject discourse**
(1) What are the most important aspects of spirituality/religiosity for you?	To believe in God is the most critical aspect of spirituality/religiosity	*You see, the most important thing is that you must have faith because everything is*

		possible for those who believe. To have faith in all ... support ... provision ... You must to believe, right? I believe so much in God, and I have had answers, that it is above all! I believe that without God we are nobody, we rely on him for everything!
	God as a support	*The strength that God gives, the faith that I'm sure that holds me! It is a real force, spiritual, divine, for your comfort ... it is a support that we have, right? I think that God is the only thing you can really hold. It's the only thing for us to get inspired, to be able to talk, to ask ... It's what sometimes we remain attached, right now, right here, in the hospital, we hang on too much in God.*
	Religions and religious practices as a way to be in contact with God	*You take religion, and it must have a goal. It has to fit into you're living, right? I had another life, I knew a God, but that was not the God I know at present, that I seek ... talk to, you understand? I have intimacy with Him. So I pray, and I ask for what I need. Prayer is communion with God, I think. The prayer removes mountains.*

	Religion as a social support/coping	*Well, the essential part of spirituality, is what you do to your brother... right? It does not just have a religion; it is a way of life, do you understand? Also, there is support! We are partners that support one to others, and that is very good! It makes you feel not so helpless. So, for me, religion, religiosity, ought to offer this… support.*

About the CI/CSD regarding the first question, the belief in God was the most critical aspect of S/R for respondents and that God represents a figure of support in stressful situations. Religious beliefs and practices can reduce the feeling of helplessness that follows the illness and that the perception of a relationship with God can offer a way to surpass the suffering and disease, bringing meaning to life.

Religiosity, through practices of each one's religion, acts as a way of communication with God. Besides, the members of a religious community establish a social network with each other, making religion a source of coping and support to their faith. The connection and support associated with the involvement among members improve social integration and increases in the quality of life.

Regarding the second question **(Have you ever discussed your beliefs with S/R health professionals?)**, two central ideas emerged:

> [...]*There is no need to discuss beliefs with health professionals" and "The health professionals do not speak about this theme* [...]

For the third question (**Was there a time when you would like to have discussed spiritual beliefs or practices with health professionals, but didn't?**), just one central idea was revealed:

[...]*There is a right moment to talk about religion* [...]

Table 3 describes the fundamental concepts and themes of each speech concerning Questions (2) and (3)

Table 3
The central ideas and collective subject discourse of hospitalized patients relating to Questions 2 and 3

Question	Central Ideas	The collective subject discourse
Question 2: Have you ever discussed your spiritual or religious beliefs with your doctor or other healthcare professionals?	There is no need to discuss my beliefs with healthcare professionals	*I have never considered because there was no need. Also, no one has ever asked. Because the doctors don't get involved in that subject, right? Moreover, I even think it's challenging for a doctor, nurse ... to talk about that. Because there is not much time, right? They are always working… I haven't also had an appropriated moment, and I didn't feel the necessity to talk. So, I had never discussed, nor with the doctor, nor with other healthcare professionals, but with people who are close to me in the same ward.*
	Health professionals do not talk about this issue	
Question 3: Was there a time when you would like to have discussed spiritual beliefs or practices with health professionals, but didn't?	There is a right moment to talk about religion	*At the hospital, and places like that, I don't have to talk so much about this subject in terms of religion, because religion business is very relative. I came here to care about my health. Sometimes there is a*

		willingness to talk, but sometimes the worker is in a hurry, you understand? Sometimes we don't have the opportunity. It's hard for them to talk about it with us, because when the doctor comes to speak or to ask something, he comes with a specific question, huh? What he wants to know... Then you focus on that, and you don't change to another issue, understand?

In the CI/CSD related to questions 2 and 3, it's clear that the respondents did not feel the need to discuss their beliefs with healthcare professionals. In Quebec, PUJOL e cols (2016) found that inpatients did not expected help from the hospital to handle spiritual issues, but they wished that their spiritual dimension was recognized merely as a part of their identity and dignity. Another study (BANIN et al., 2013) found that 70 % of studied patients would like their doctor's address S/R issues. Abdullla Abdulla, Hossain e Barla (2019) cited an interesting case about disagreement between patient and doctor point of view about religiosity and healthcare and Ehman pointed that two thirds os 177 patients would welcome to the question ""Do you have spiritual or religious beliefs that would influence your medical decisions if you become gravely ill?".

In our research, it was a desire to talk about it, but the patients did not find a specific time for this discussion because the hospital's staff was bustling. In this context, according to Barros (2002).

> Even though many professionals admit the existence of individual or emotional components that can influence diseases whose organic evidence is explicit, they often did not feel comfortable to deal with that, because, as a rule, they were not

> prepared for this. The biomedical model encourages doctors to follow an extremely cartesian approach with a rupture between the observer (the physician) and the observed (the patient). The division of the individual into pieces significantly contributes to hind the appreciation of all.

Also, the attitude of professionals facing this issue shows that usually, they are not able to understand how the patient's manifested S/R influence the way by patients deal with illness, according with Schmidt et al (2018). Patients who have already been asked about S/R by their doctors before were more comfortable to talk about this issue again in a consultation (BANIN et al., 2013). Although is known that S/R beliefs are a guidance source for sick individuals, it was possible to note in the speech of participants the strong desire to be in a hospital for treatment and potential cure of the disease, that is still the primary focus of attention of professionals and patients, excluding the biopsicossocioespiritual approach.

Concerning to the fourth question **(What aspects of your S/R activities would you like to discuss with your doctor or with other health professionals?)** two central ideas emerged: "I would like to talk about religious principles" and "The hospital is not a place for this." The same has occurred with the fifth question (**How and when the doctors who care for you could incorporate your religious beliefs/spiritual in your treatment?)**: "words of comfort"; "religion and science don't mix." It is noteworthy that for the answers to the sixth question **(What could you tell the professionals who care of you about your religious practices and beliefs related to your health-disease, that you think they don't know/understand?)** just one central idea emerged: "divine power."

The synthesis of the central ideas and speeches concerning questions (4), (5), and (6), can be found in Table 4.

Table 4

Central ideas contained in DSC of hospitalized patients concerning questions (4) to (6)

Question	Central Ideas	The collective subject discourse
(4) What aspects of your religious or spiritual activities would you like to discuss with your doctor or other healthcare professionals?	The hospital is not a place for this.	*I never thought about that... Because here, we're so anxious to get out, we focus more on the health problem than, sometimes, about God, you know? So I think the doctor should emphasize the disease problem. At the Church, with the pastor, is the place for [talk about] the religious issue*
	I would like to talk about religious principles	*The religion itself, it means to love, right? So I would show some points of the Bible because they're very skeptical. They do not believe a lot…if they could open up their minds a little more to this question of religiousness, maybe they would show a little more reliable, strength, or understand us a little more. Also, they could know the power of faith, prayer, this positive energy that may transform some things like diseases and difficulties, because the cure is a critical aspect of religion*
(5) How and when the doctors who care for you could incorporate your religious/spiritual beliefs in your treatment?	Religion and science don't mix	*There is no moment that I felt that science had some influence on spiritual support. I think if we mix religion with science, we could somehow jeopardize the doctor's scientific work. Faith is a private affair, and the doctor takes care of the disease, right? So, with no interference, we are already helping ... even if the healthcare worker doesn't want to discuss religiosity.*
	Words of comfort	*Before and during treatment, because above all, we're anxious here, right? We are worried and spend much time alone. So also, because we're fragile. Alternatively, whenever it is necessary ... just a kind word! It could be a stimulus for our health for our treatment. When they give a smile back to us when we say "thank you" to them…when there is affection in the handshake. Yes, strength! It is about when they could change their place with us*

(6) What could you say to the professionals who care of you about your S/R practices and beliefs related to your disease, that you think they don't know/understand?	Divine power	*Well, what they might know, but they do not understand, is that God makes miracles, right? Also, that faith moves mountains, yeah! So, to believe in God does move mountains. The healthcare workers don't understand how a person can have so much faith, so much strength, and to be not discouraged. I always talk a little bit with God, and I ask for a direction because I want to be cured. And that's something that the doctor doesn't believe! That when one is ill, he goes to the church and heals himself. Healing comes from God, yeah! I think it would be nice someday to speak to them about it, and even if they have or not faith, I believe that it would enrich a little bit how they feel about religion.*

The central ideas and collective subject discourse related to questions 4, 5, and 6, discuss the importance of S/R principles and their practice in daily life, as a way of life (BANIN et al., 2013; PENHA et al, 2012). It is possible to note that for respondents, S/R beliefs are apart from what they expect during treatment in a hospital. However, it is also clear the power of words of comfort and support; and this is a good reason to incorporate S/R care in the clinical treatment.

On the other hand, we can note again that the respondents reveal no need of S/R support during the hospital stay, reinforcing the thought imposed by the hegemonic biomedical model that science and religion should not be linked, because it may interfere negatively in scientific thinking and, consequently, in the medical care. Most of the international and Brazilian schools of medicine teach to their students in this way (COLLIER; JAMES; SAINT; HOWELL, 2020; BEST; MCARDLE; HUANG et al, 2019; LUCHETTI et al, 2012). Furthermore, the Brazilian public health system faces struggles and the difficulties to get a hospital stay, especially at the Rio de Janeiro State, are probably some factors that contribute to the respondents to seem more interested in having their health problems resolved during the hospitalization than in the insertion of S/R in their treatment by the healthcare team. For S/R

issues, our study found that the Brazilian patients always has other people, because the respondents are in a shared ward.

The CSD about divine power revealed that respondents expressed that health professionals appeared do not have S/R beliefs or do not know/understand about that. It is obvious the importance of the belief in a divine power for the respondents, to achieve a cure for their suffering, and a support in the fight against the distress caused by the illness.

Conclusions and implications for practice

Interviewed inpatients revealed that their preferences regarding the way of insertion of spirituality/religiosity in healthcare during hospitalization were: There is no need to talk about religious beliefs with health professionals. If the need arises, there is a time to do it; also, the hospitalized patients would like to hear words of comfort and talk about their religious principles with health professionals (LUCCHETTI et al, 2012). As well as to believe in God emerged as a central aspect. These findings revealed that for studied inpatients, the S/R needs seem to be less critical than medical needs, and for some of them, the hospital is not a place to talk about S/R. Despite this, it is necessary better understanding about the S/R meaning to connect the healthcare team with inpatients.

It is important to emphasize that these findings area against previously published studies on this subject, which showed that patients want and even need the religious beliefs to approach during hospitalization ((ZARZYCKA; TYCHMANOWICZ; KROK, 2020; FERREIRA; FREIRE; SILVEIRA et al, 2020). Otherwise, the respondents pointed to the possibility that, for Brazilian patients, the sharing of spiritual/religious needs with other people, such as companions or other patients admitted to the same ward, can supply this need.

However, the small number of patients included in this study is a limiting factor for this type of idea, with the need for further studies on the subject.

Brazil, for its dimension, religious diversity, growing scientific production, and relevance in the global scenario, has a great potential to be a leading country in advancing knowledge and integrating spirituality into health. In this sense, it is urgent the understanding of the religious and personal issues enrolled in the healthcare and how it is related to the goals of attention here in our country, with the peculiarities of our culture. It demands accurate sensitivity to identify standards based on the needs of patients from other countries with health care systems that are very diverse from ours. It positively will contribute to the planning of more adequate forms of clinical practice, and the construction of new nuances in education for more humanized professionals.

References

ABDULLA, Aza; HOSSAIN, Mashrur; BARLA, Cristian. Toward Comprehensive Medicine: listening to spiritual and religious needs of patients. *Gerontology And Geriatric Medicine*, [S.L.], v. 5, p. 233372141984370, jan. 2019. SAGE Publications. http://dx.doi.org/10.1177/2333721419843703.

BANIN, Luciana Burgugi; SUZART, Nadielle Brandani; GUIMARÃES, Fernando Augusto Garcia; LUCCHETTI, Alessandra L. G.; JESUS, Marcos Antonio Santos de; LUCCHETTI, Giancarlo. Religious Beliefs or Physicians' Behavior: what makes a patient more prone to accept a physician to address his/her spiritual issues? *Journal Of Religion And Health*, [s.l.], v. 53, n. 3, p. 917-928, 19 fev. 2013. Springer Science and Business Media LLC. http://dx.doi.org/10.1007/s10943-013-9685-2

BARROS, José Augusto C.. Pensando o processo saúde doença: a que responde o modelo biomédico? *Saúde e Sociedade*, [s.l.], v. 11, n. 1, p. 67-84, jul. 2002. FapUNIFESP (SciELO). http://dx.doi.org/10.1590/s0104-12902002000100008.

BEST, Megan; MCARDLE, Madeleine B.; HUANG, Yi-Jing; CLAYTON, Josephine; BUTOW, Phyllis. How and how much is spirituality discussed in palliative care consultations for advanced cancer patients with and without a question prompt list? *Patient Education And Counseling*, [S.L.], v. 102, n. 12, p. 2208-2213, dez. 2019. Elsevier BV. http://dx.doi.org/10.1016/j.pec.2019.06.016

COLLIER, Kristin M.; JAMES, Cornelius A.; SAINT, Sanjay; HOWELL, Joel D.. Is It Time to More Fully Address Teaching Religion and Spirituality in Medicine? *Annals Of Internal Medicine*, [S.L.], v. 172, n. 12, p. 817-818, 16 jun. 2020. American College of Physicians. http://dx.doi.org/10.7326/m20-0446.

EHMAN, John W.; OTT, Barbara B.; SHORT, Thomas H.; CIAMPA, Ralph C.; HANSEN-FLASCHEN, John. Do Patients Want Physicians to Inquire About Their Spiritual or Religious Beliefs If They Become Gravely Ill? *Archives of Internal Medicine*, [s.l.], v. 159, n. 15, p. 1803, 9 ago. 1999. American Medical Association (AMA). http://dx.doi.org/10.1001/archinte.159.15.1803.

FERREIRA, Laura Fernandes; FREIRE, Alyssa de Pinho; SILVEIRA, Ana Luiza Cunha; SILVA, Anthony Pereira Martins; SÁ, Hermon Corrêa de; SOUZA, Igor Soares; GARCIA, Lohane Stefany Araújo; PERALTA, Rafael Silva; ARAUJO, Laís Moreira Borges. A Influência da Espiritualidade e da Religiosidade na Aceitação da Doença e no Tratamento de Pacientes Oncológicos: revisão integrativa da literatura. *Revista Brasileira de Cancerologia*, [S.L.], v. 66, n. 2, p. 1-13, 25 maio 2020. Revista Brasileira De Cancerologia (RBC). http://dx.doi.org/10.32635/2176-9745.rbc.2020v66n2.422.

HEABERT, Randy S.; JENCKES, Mollie W.; FORD, Daniel E.; O'CONNOR, Debra R.; COOPER, Lisa A.. Patient perspectives on spirituality and the patient-physician relationship. *Journal of General Internal Medicine*, [s.l.], v. 16, n. 10, p. 685-692, out. 2001. Springer Science and Business Media LLC. http://dx.doi.org/10.1111/j.1525-1497.2001.01034.x.

KOENIG, Harold G.; PETEET, John R.; VANDERWEELE, Tyler J.. Religion and psychiatry: clinical applications. *Biosych Advances*, [S.L.], p. 1-9, 27 fev. 2020. Royal College of Psychiatrists. http://dx.doi.org/10.1192/bja.2020.11.

KOENIG, Harold; ROSMARIN, David. *Handbook of Spirituality, Religion, and Mental Health*. 2. ed. Oxford: Academic Press, 2020.

LEFEVRE, Fernando; LEFEVRE, Ana Maria Cavalcanti. Discourse of the collective subject: social representations and communication interventions. *Texto & Contexto - Enfermagem*, [s.l.], v. 23, n. 2, p. 502-507, jun. 2014. FapUNIFESP (SciELO). http://dx.doi.org/10.1590/0104-07072014000000014.

LUCCHETTI, Giancarlo; LUCCHETTI, Alessandra Lamas Granero; ESPINHA, Daniele Corcioli Mendes; OLIVEIRA, Leandro Romani de; LEITE, José Roberto; KOENIG, Harold G. Spirituality and health in the curricula of medical schools in Brazil. *BMC Medical Education*, [s.l.], v. 12, n. 1, p. 18-25, 18 ago. 2012. Springer Science and Business Media LLC. http://dx.doi.org/10.1186/1472-6920-12-78

OLIVEIRA, Janaine Aline Camargo de; ANDERSON, Maria Inez Padula; LUCCHETTI, Giancarlo; PIRES, Eric Vinícius Ávila; GONÇALVES, Lídia Maria. Approaching Spirituality Using the Patient-Centered Clinical Method. *Journal of Religion And Health*, [S.L.], v. 58, n. 1, p. 109-118, 27 jan. 2018. Springer Science and Business Media LLC. http://dx.doi.org/10.1007/s10943-017-0534-6.

PANZINI, Raquel Gehrke et al. Quality-of-life and spirituality. *International Review of Psychiatry*, [s.l.], v. 29, n. 3, p.263-282, 4 maio 2017. Informa UK Limited. http://dx.doi.org/10.1080/09540261.2017.1285553.

PENHA, Ramon Moraes; SILVA, Maria Júlia Paes da. Significado de espiritualidade para a enfermagem em cuidados intensivos. *Texto & Contexto - Enfermagem*, [s.l.], v. 21, n. 2, p. 260-268, jun. 2012. FapUNIFESP (SciELO). http://dx.doi.org/10.1590/s0104-07072012000200002.

PUCHALSKI, Christina M.. Addressing The Spiritual Needs Of Patients. *Ethical Issues in Cancer Patient Care Second Edition*, [s.l.], p.79-91, 2008. Springer US. http://dx.doi.org/10.1007/978-0-387-73639-6_6.

PUCHALSKI, Christina M.; VITILLO, Robert; HULL, Sharon K.; RELLER, Nancy. Improving the Spiritual Dimension of Whole Person Care: reaching national and international consensus. *Journal of Palliative Medicine*, [s.l.], v. 17, n. 6, p. 642-656, jun. 2014. Mary Ann Liebert Inc. http://dx.doi.org/10.1089/jpm.2014.9427.

PUJOL, Nicolas; JOBIN, Guy; BELOUCIF, Sadek. 'Spiritual care is not the hospital's business': a qualitative study on the perspectives of patients about the integration of spirituality in healthcare settings. *Journal of Medical Ethics*, [s.l.], v. 42, n. 11, p. 733-737, 24 ago. 2016. BMJ. http://dx.doi.org/10.1136/medethics-2016-103565

SCHMIDT, Cindy; NAUTA, Loes; PATTERSON, Melissa; ELLIS, Adam. Medical Students' (Dis)comfort with Assessing Religious and Spiritual Needs in a Standardized Patient Encounter. *Journal of Religion And Health*, [S.L.], v. 58, n. 1, p. 246-258, 10 out. 2018. Springer Science and Business Media LLC. http://dx.doi.org/10.1007/s10943-018-0714-z.

ZARZYCKA, Beata; TYCHMANOWICZ, Anna; KROK, Dariusz. Religious Struggle and Psychological Well-Being: the mediating role of religious support and meaning making. *Religions*, [S.L.], v. 11, n. 3, p. 149, 24 mar. 2020. MDPI AG. http://dx.doi.org/10.3390/rel11030149.

Recebido em 29-07-2020.
Aprovado em 16-06-2021.