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INTEGRATIVE REVIEW ARTICLE

SPIRITUAL ANAMNESIS FOR HEALTH CARE INTEGRALITY

A ANAMNESE ESPIRITUAL COMO BASE PARA A INTEGRALIDADE DO CUIDADO EM SAÚDE

ANAMNESIS ESPIRITUAL COMO BASE PARA LA INTEGRALIDAD DE LA ATENCIÓN EN SALUD

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ABSTRACT

***Objective*:** to analyze the knowledge produced about the use of spiritual anamnesis in health care. ***Method*:** integrative review in order to answer the question "What is the knowledge produced on the use of spiritual anamnesis in health care?" through access to MEDLINE, CINAHL, LILACS, BDENF and SciELO virtual library databases by crossing descriptors in English, Portuguese and Spanish. ***Results*:** 17 articles were analyzed, of which three topics emerged: the importance of religion and spirituality on health, the relation of spirituality and quality of life and the relation between spirituality and beliefs with other variables. ***Conclusion*:** it was found that the application of a spiritual anamnesis to health care is being poorly made. This makes it impossible to carry out interventions based on the spiritual history of patients. There is also the absence of nurses involved in research and care related to this topic. ***Descriptors*:** Anamnesis; Spirituality; Nursing; Health; Spiritual Anamnesis.

RESUMO

***Objetivo*:** analisar o conhecimento produzido sobre a utilização da anamnese espiritual no cuidado em saúde. ***Método*:** revisão integrativa com o propósito de responder a questão << Qual o conhecimento produzido sobre a utilização da anamnese espiritual no cuidado em saúde? >> mediante acesso às Bases de dados MEDLINE, CINAHL, LILACS, BDENF e biblioteca virtual SciELO, por meio do cruzamento dos descritores, nos idiomas Português, Inglês e Espanhol. ***Resultados*:** foram analisados 17 artigos dos quais surgiram três temáticas: importância da religiosidade e da espiritualidade na saúde, relação da espiritualidade com a qualidade de vida e relação da espiritualidade e crenças com outras variáveis. ***Conclusão*:** verificou-se que a aplicação da anamnese espiritual no cuidado em saúde está sendo infimamente realizada, causa esta que inviabiliza realizar intervenções tomando por base a história espiritual dos pacientes, além da ausência de enfermeiros no envolvimento em pesquisas e cuidados referentes à temática. ***Descritores*:** Anamnese; Espiritualidade; Enfermagem; Saúde; Anamnese Espiritual.

RESUMEN

***Objetivo*:** analizar el conocimiento producido sobre el uso de la anamnesis espiritual en la atención en salud. ***Método*:** revisión integradora con el fin de responder a la pregunta << ¿Qué conocimiento se produce sobre el uso de la anamnesis espiritual en la atención en salud? >> mediante el acceso a las bases de datos MEDLINE, CINAHL, LILACS, BDENF y biblioteca virtual SciELO, por medio de la comparación de los descriptores, en los idiomas Portugués, Inglés y Español. ***Resultados*:** Se analizaron 17 artículos, de los cuales surgieron tres temáticas: la importancia de la religión y la espiritualidad en la salud, la relación de la espiritualidad con la calidad de vida y la relación de la espiritualidad y las creencias con otras variables. ***Conclusión*:** se verificó que se utiliza muy poco la aplicación de la anamnesis espiritual en la atención en salud, y esto hace que sea impracticable llevar a cabo intervenciones a partir de la historia espiritual de los pacientes, además de no haber enfermeros que participen en las investigaciones y la atención relacionadas con el tema. ***Descriptores*:** Anamnesis; Espiritualidad; Enfermería; Salud; Anamnesis Espiritual.

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INTRODUCTION

Spiritual anamnesis as a basis for a health care integrality is the subject of this article. Spiritual anamnesis is here understood as a process of research on the perception of beliefs and values of an individual, as well as the meaning it gives to faith, life and spirituality, and how it can influence on its health and the treatment.[1]

Religion and spirituality are occasionally mentioned as synonyms. Yet, it is important to distinguish both concepts. Religion is defined as "the belief in the existence of a supernatural power, a creator and controller of the universe, which gives men a spiritual nature that continues to exist after the death of its body". Religiosity is "the extent to which an individual believes, follows and practices a religion".[2:12] Spirituality, in turn, can be defined as "a human propensity to seek meaning in life through concepts that transcend the tangible: a sense of connection to something larger than oneself, which may or may not include a religious participation".[3:89]

There has been a growing interest among the scientific community about spirituality as a dimension of care and the association of health and religious or spiritual beliefs on the results of care and its influence on quality of life.

Studies confirm the positive influence of religious and spiritual beliefs on healing treatments, rehabilitation or palliative care,[1,4] because "religious experience, upon inspiring thoughts of optimism and hope and positive expectations, according to some researchers, works as a placebo"[5:15]. However, even with scientific confirmation of the benefits of religion and spirituality to health, as well as the understanding of human beings as multidimensional, it is clear that, in practice, spiritual anamnesis is not conducted and is not considered in treatments and care plans, given the fact that patient files have no records on the subject.

Prejudice among the scientific community on the subject is also a factor that prohibits the introduction of spirituality in the context of holistic care. In addition, many professionals fail to dissociate religion from spirituality, or to understand it as something that gives "meaning to the phenomenal chaos of experience and [that] enables people to give meaning to their suffering".[2:16]

Health care, since its beginnings, has been linked to religious care. Before science, nursing arose from this secular context of care. However, when it became a science with Florence Nightingale, the religious perspective, according to which care occurred over time, was not dissociated from the profession because Florence always considered man as a spiritual being. Nursing as a spiritual practice is implicit when Florence established it with subjects centered on the involvement and human welfare.[6]

After Florence, other authors on nursing, such as Jean Watson (Theory of Transpersonal Care), Katherine Kolcaba (Comfort Theory), Myra Estrin Levine (Holistic Theory), Martha E. Rogers (Theory of Humanist Care Science), Madeleine M. Leininger (Transcultural Nursing Theory) and Wanda A. Horta (Theory of Basic Human Needs), continued to emphasize the importance of care in its entirety, holistically, considering cultural factors, individual needs, adaptation to nursing care and other variables. However, nursing, despite the prospect of a multidimensional care, hardly introduces in the Systematization of Nursing Assistance (SNA) the spiritual history of a patient seeking to understand its needs beyond medical diagnoses and physical conditions, which reflect only a fragment of the whole. SNA enables to devise an action plan directed to patient needs[7] covering much more than the pathology, requiring from the nurse nursing diagnoses that address the needs of the whole being.

Despite this connection of care with religious issues, of science itself slowly breaking the health connection with the spiritual well-being and being the care continually mentioned and encouraged considering the human being in its entirety, *i.e.*, as a whole, there is still a gap in education of care considering religious and spiritual aspects, preventing the individual from being nicely assisted in health improvement and/or quality of life.

The relevance of this study is to explore the gap of existing knowledge in the literature on the subject, providing scientific support to show how spirituality and religion have been considered in the reality of health care, nursing and research. Therefore, this study helps to provide an understanding of the importance of working with religiosity and spirituality in health care for people seeking assistance, for nursing and also for other health professionals.

Considering the foregoing, this study sought to answer the following question: what is the knowledge produced on the use of spiritual anamnesis in health care? To answer such a question, the following goal was intended to be achieved:

● To analyze the knowledge produced on the use of spiritual anamnesis in health care.

METHOD

Seeking to achieve the proposed goal the Integrative Review (IR) method was chosen; which allows summarizing research and reaching conclusions starting from a topic of interest and a guiding question. The following steps to scheming this review were used: (1) identification of the study object, research question and descriptors; (2) establishment of studies' inclusion and exclusion criteria; (3) definition of the information to be extracted from the selected studies; and (4) evaluation and discussion of IR results.

Spiritual anamnesis as a basis for health care integrality is this paper's object of study. The guiding question was "What is the knowledge produced on the use of spiritual anamnesis in health care?", using health terminology, specifically Descriptors in Health Sciences (DHS). The following controlled descriptors were selected: anamnesis and spirituality. To expand the selection of articles, the following uncontrolled descriptors were selected: spiritual anamnesis, health and health care.

The inclusion criteria adopted for the inclusion of publications were articles published in Portuguese, English and Spanish between 2003-2013, electronically available for free in its entirety and indexed in the *Medical Literature Analysis and Retrieval System Online*, *Medline*, *Cumulative Index to Nursing and Allied Health Literature* (CINAHL), Latin American Literature on Health Sciences (LILACS), Nursing Database (BDENF) and *Scientific Electronic Library Online* (SciELO).

We adopted as an exclusion criterion letters to the editor, editorials, experience reports, theses, dissertations, papers with considerations and other literature reviews outside the time frame in addition to articles that did not answer the guiding question, and repeated articles in more than one search source.

The survey was conducted between April and October 2013 through Virtual Health Library (VHL), selecting MEDLINE, CINAHL, LILACS, BDENF and SciELO virtual library databases as research sources. The controlled descriptors were Anamnesis and Spirituality; the non-controlled descriptors were Health Care, Health and Spiritual Anamnesis. The connection between the descriptors was carried out with the Boolean AND operator using the language of the relevant database. The search strategies included Anamnesis AND Spirituality, Spiritual Anamnesis AND Health and Spiritual Anamnesis AND Health Care.

Following the pre-selection of articles, the exclusion comprised first time frame, then unavailability of the full text and then the reading of the summaries, analyzing whether they were related to theme or not. The pre-selected articles underwent a second analysis by close reading for inclusion or exclusion.

Articles that answered the guiding question were entered to a recording instrument containing the following information collected from these articles: author, article title, place of publication, indexing base, nature of work, year, country of study, objectives, methodology, type of study, subjects and summary of the study on the issue of research.

After analyzed, extracted and the information synthesized to the instrument, the productions were categorized into themes according to the primary focus given by the article for a better understanding of the discussion of results.

RESULTS

After the close reading, only seventeen publications were included and are presented in Figure 1 in chronological order of publication.

N	Authors / Year	Article Title	Indexed base/Country of study
A1	Ai AL, Peterson C, Rodgers W, Tice TN, 2005.[8]	Effects of faith and secular factors on locus of control in middle-aged and older cardiac patients.	CINAHL/ USA
A2	Jesse E., Graham M, Swanson M, 2006.[9]	Psychosocial and Spiritual Factors associated with smoking and substance use during pregnancy in African American and white low-income women.	MEDLINE / USA
A3	Holmes S.M, Rabow MW, Dibble SL, 2006.[10]	Screening the soul: Communication regarding spiritual concerns among primary care physicians and seriously ill patients approaching the end of life.	MEDLINE / USA
A4	Mrus JM, Leonard AC, Yi MS, Sherman SN, Fultz SL, Justice AC, Tsevat J, 2006.[11]	Health-Related Quality of Life in Veterans and Nonveterans with HIV/AIDS.	MEDLINE / USA
A5	Quillin JM, McClish DK, Jones RM, Burruss K, Bodurtha JN, 2006.[12]	Spiritual Coping, Family History, and perceived risk for breast cancer—can we make sense of it?	MEDLINE / USA
A6	Lis CG, Gupta D, Granicki J, Grutsch JF, 2006.[13]	Can patient satisfaction with quality of life predict survival in advanced colorectal cancer?	MEDLINE/ USA
A7	Lis CG, Gupta D, Grutsch JF, 2006.[14]	Patient Satisfaction with Quality of Life as a Predictor of Survival in Pancreatic Cancer.	MEDLINE/ USA
A8	Gupta D, Lis CG, Grutsch JF, 2007.[15]	The Relationship Between Cancer-Related Fatigue and Patient Satisfaction with Quality of Life in Cancer.	MEDLINE/ USA
A9	Bellamy CD, Jarrett NC, Mowbray O, MacFarlane P, Mowbray CT, Hotter MC, 2007.[16]	Relevance of spirituality for people with mental illness attending consumer-centered services.	MEDLINE/ USA
A10	Lis CG, Gupta D, Grutsch JF, 2008.[17]	Patient Satisfaction with Health-Related Quality of Life: Implications for Prognosis in Prostate Cancer.	MEDLINE/ USA
A11	Shih FJ, Wang SS, Hsiao SM, Tseng PH, Chu SS, 2008.[18]	Comparison of the psychospiritual needs of chinese heart transplant recipients at pre and postoperative stages.	MEDLINE/ China
A12	Skjeldestad FE, Rannestad T, 2009.[19]	Urinary incontinence and quality of life in long-term gynecological cancer survivors: A population-based cross-sectional study.	MEDLINE/ Norway
A13	Taylor D, Mulekar MS, Luterman A, Meyer FN, Richards WO, Rodning CB, 2011.[20]	Spirituality Within the Patient-Surgeon Relationship.	MEDLINE/ USA
A14	Lucchetti G, Lucchetti ALG, Badan-Neto AM, Peres PT, Peres MFT, Moreira-Almeida A, et al, 2011.[21]	Religiousness affects mental health, pain and quality of life in older people in an outpatient rehabilitation setting.	MEDLINE/ Brazil
A15	Rodin G, Yuen D, Mischitelle A, Minden MD, Brandwein J, Schimmer A, et al, 2011.[22]	Traumatic stress in acute leukemia.	MEDLINE/ Canada
A16	Peirano AH, Franz RW, 2012.[23]	Spirituality and Quality of Life in Limb Amputees.	MEDLINE/ USA and Canada
A17	Bernstein K., D'Angelo LJ, Lyon ME, 2012.[24]	An exploratory study of HIV+ Adolescents' Spirituality: Will you pray with me?	MEDLINE/ USA

Figure 1. Characterization of the articles included in the integrative review, Maceió (AL), 2013.

Of the selected articles, all were published in international journals, 16 were indexed in MEDLINE and one in CINAHL. It was possible to infer that little emphasis is given to studies on spiritual anamnesis in Latin America and Brazil (LILACS, BDENF and SciELO), since there were no selected productions in the databases that index the productions from those places. The number of publications found upon searching was also reduced. In international databases (MEDLINE and CINAHL), the number of productions was higher. All articles discussed here come from these bases (Figure 2).

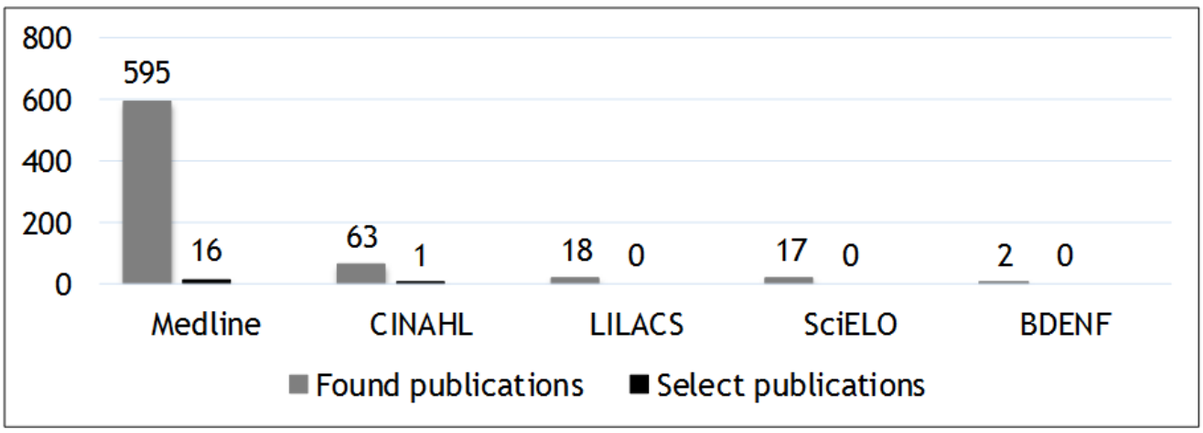

Figure 2. Comparison of found and selected publications according to database used. Maceió (AL), 2013.

Regarding year of publication, the predominance of studies was in 2006, with six productions; 2011 with 3 productions; 2007, 2008 and 2012 with 2 productions each; and 2005 and 2009 with 1 production each. "Country of study" had 12 search results in the United States; Brazil, Canada, China and Norway had one each, and one of them was jointly conducted in the US and Canada.

Scientific productions showed that their investigations were conducted in patients with diagnosis of cancer or already treated (7), healthy individuals (1), HIV positive (2), heart disease (1), surgery (2), pregnant women (1), psychiatric disorders (1), old age (1), amputee members (1) and terminal patients (1). The locations where data were collected were 13 in hospitals and three in health clinics. In a study, collection was unlike the others. It was conducted by recruiting patients by their doctors and support groups.

The following tools were used to obtain the spiritual history of research subjects: Brief Multidimensional Measure of Religiosity/Spirituality, adapted (1); Brief COPE (1); Brief RCOPE (1); Paloutzian and Ellison Spiritual Well-being Scale (1); Spiritual Perspective Scale (1); Jarel's Scale of Spiritual Wellbeing (1); individual and social Religious Practices Scale translated into Portuguese (1); Scale with three religious factors (1); Individual Prayer Use Scale as a means of coping (1); FACIT- Sp (1); FACIT-SPEX (1); Duke Religion Index (1); Quality of Life Index (3); Ferrans and Powers' Quality of Life Index (2); Quality of Pediatric Life Inventory 4.0 (1); developed by the authors adapting other instruments (3); and qualitative research with content analysis (1).

Altogether, 15 instruments were used to measure issues of R/S, three of which are not specific measurement scales. Three studies did not use existing and validated instruments and did not cite the source of adaptation of questions used to collect the history or even if the questions were created by the authors themselves.

As to topics, it was observed that the studies involved three approaches. Thus, information extracted from the articles was incorporated into three categories (Figure 3), which will be addressed in the discussion. The articles will be presented in relation to their identification number.

Thematic Category	Articles
Spirituality relation, quality of life with serious health hazard	A4, A6, A7, A8, A10, A12, A16.
Importance of Religiosity and Spirituality in health care	A3, A11, A13, A17.
Relation of Religiosity and Spirituality with other variables	A1, A2, A5, A9, A14, A15.

Figure 3. Thematic category and its respective articles.

DISCUSSION

♦Relation of spirituality and quality of life with serious health hazard

Numerous definitions have been created to conceptualize QoL. In the development process seeking its definition, it could be seen that indicators of standard of living no longer measure QoL and it became associated with subjective and cultural perceptions from the individual.

From this perspective, the WHOQOL group conceptualized QoL as "the individual's perception of its position in life in the context of culture and value systems in which it lives and in relation to its goals, expectations, standards and concerns".[25:107] This research tool evaluates QoL through individual's judgments regarding satisfaction with health, physical, social, economic, psychological, spiritual and family functioning.

The same authors, using non-specific scales, conducted the studies A6, A7, A8 and A10. In three of them, there was no discussion on R/S, stating, in one study, that these variables lost their significance due to the discussion of more important findings.[17] Only the article A8 had some discussion: the more fatigued the individual is, the lower the psychological and spiritual scores and the satisfaction with health.[15]

The articles A4, A12 and A16 used specific instruments when discussing the findings. The study A4 linked the disease with a lower QoL. However, uncomfortable symptoms, lower time compensation and risk patterns were related to a higher spirituality, and organized religious activities had higher scores associated with improved health outcomes.[11] The study A12 corroborated the study A4 because it also related a lower QoL index to the disease, where women who had urinary incontinence after gynecological cancer surgery, stress or mixed incontinence had lower scores both related to QoL and health/functioning, psychological and spiritual, socioeconomic and family domain, compared to women who had no connection to the issue.[19]

The study A16, conducted with 108 amputees, aimed to determine if spirituality is related to QoL. It concluded that spirituality was used as a support for coping with limb amputation and that existential spirituality was a significant predictor of satisfaction with life, health and social integration.[23] Guimarães and Avezum,[3] from Dante Pazzanese Institute in São Paulo, performed a systematic review in international databases selecting 250 items from around the world that related R/S as a health promoter. They concluded that the regular practice of religious activities (whatever they are) could reduce the risk of death by 30%, for such conduct promotes a psychological well-being that encourages positive thoughts, healthy habits, lower heart risks that lead to heart attacks and strokes, enhances the immune responses of the organism and affords an improved quality of life.

The study by Guimarães and Avezum[3] supports the findings in studies of this category, making it clear that spirituality and religiosity are directly proportional to improvement of health, well-being and quality of life, and that the reverse is also true. QoL maintains a multidimensional health context, as is the human being, after all "religiosity, spirituality and personal beliefs are topics not unrelated to the concept of QoL; they are actually one of its dimensions."[25:107]

Despite this link, the studies A6, A7, A8 and A10, which used the Quality of Life Index (QoLI), statistically cited the findings related to psychological/spiritual approaches, being indifferent to this variable in their discussions, possibly because they did not understand that spirituality is related to QoL and its importance for personal well-being, coping, higher levels of hope and happiness, being these results important to be discussed and related to other variables that involved data collection instruments used.

♦ Importance of Religiosity and Spirituality in health care

In the study A3, which aimed to explore spiritual concerns of patients severely ill and spiritual care practices of Primary Care Doctors, the authors considered important that the medical professional met the R/S needs of their patients. However, patients reported in greater numbers that they did not consider the doctor as the professional who should provide support for this issue.[10] Although both have confirmed the importance of addressing these R/S issues in health care, doctors said they did not provide such care.[10]

The study A11 sought to investigate if there were psycho-spiritual concerns (theology, ethics and philosophy of life) related to the condition of a patient directed to heart transplant surgery. The concerns were confirmed, showing the importance of collecting data on this subject. Because of this understanding, the researchers suggested that the nursing care plan should cover evaluation and spiritual support, which should introduce religious support in caring and include religious advisers among members of the health staff.[18]

The study A13 sought to understand the role of spirituality in the relationship of surgeons with their patients. Most respondents reported that religious beliefs and personal faith were important to them and, even though they relied on it in the perspective to guide them through a serious illness or injury.[20] Patients also agreed that surgeons should be aware of their religious beliefs, spiritual practices and personal faith.[20]

In the study A17, three objectives were proposed: determine if teenagers find acceptable that doctors explore their spiritual beliefs as part of the medical treatment; characterize the role of spirituality and religious beliefs in adolescents with and without HIV; and examine the associations between spirituality/religion and quality of life. The highest scores on spirituality and religion and on being questioned about their

beliefs by doctors were among adolescents with HIV positive. They were also more likely to feel the presence of God, which they are part of a larger force, which God has left them, in addition to reporting that they want their physicians to pray with them.[24]

It is noticed that there still is a difficulty in looking at the sick person in its entirety and not only at the disease that affects it, making it difficult to search for other factors that can contribute to improving health. Looking at the disease, we focus on biological aspects, forgetting the subjectivity of the individual and how it experiences the disease process. Thus, "patients want to be treated as people, not as diseases, and be observed as a whole, including physical, emotional, social and spiritual aspects".[26:140]

Harold Koenig[27], a psychiatrist and director of the Center for Study of Religion, Spirituality and Health at Duke University, North Carolina, USA, mentions in one of his books entitled "Spirituality in patient care" that some of the barriers that lead to the non-realization of spiritual anamneses are related to the lack of knowledge, lack of training, lack of time, discomfort with the subject, fear of imposing religious views on patients, that knowledge of religion is not relevant to medical treatment or that they consider that religious affairs are not part of their job.

A survey conducted with students from the ninth graduation semester in Nursing at the Federal University of Paraíba concluded that they understood spirituality as a dimension of care. However, because it is little discussed during graduation, they feel insecure in applying it.[28]

Therefore, it can be inferred that these are some of the causes that hinder the performance of the health professional, and more specifically nurses, concerning the conducting of spiritual anamneses of its patient and, from collecting this spiritual history, considering this dimension in therapeutic and care plans.

♦ Relation of religiosity and spirituality with other variables

The study A1 related prayer to a greater internal control. However, it was negatively related to religious subjectivity as it demonstrated a dependence of a Higher Being.[8] Here, the negative coping of religiosity is presented, because, when the person finds God or a Higher Being as responsible for the events of life, it stagnates, waiting for divine intervention, it is not proactive nor nourishes forces with the Divine to act.

The study A5 explored the spiritual coping mechanism and risk perceptions for developing breast cancer and found that higher spiritual coping levels are negatively associated to preventive health practices, since they reduce the risk perception of the disease.[12] Thus, confidence that faith can promote physical health creates a barrier in some individuals seeking a preventive medical evaluation.

It can be seen, still in the study A5, the negative religious coping, because the subjective way by which the individual understands God and his powers hinders the understanding of the importance of seeking preventive health care. Although the religious coping may be negative, research indicate that there is a "considerably higher use of positive religious coping than its negative use for different samples under different stressful situations of life."[29:3]

Religion must not be dissociated from science and science must always respect the beliefs and personal values of the individual. John Paul II[30] wisely warned us about the importance of this union when he said in his encyclical called "Faith and Reason", that "faith and reason are like two wings of the same bird that flies towards absolute truth. A man leaning on a single wing is made impossible to fly."

The study A9 aimed to explore the relation between spirituality and demographic data, history of psychiatric illness and psychological structures of people with mental illness involved in specialist support services and found that spirituality was important to 2/3 of the members of the study and the variables that were significantly more related to spirituality were age (older people) and gender (female).[16] This important finding was also reported in studies A3, A13 and A17.

The researchers also mentioned, in the study A9, that the lack of using a specific collection instrument hindered a better relation of spirituality with the variables mentioned (age, gender, history of psychiatric illness and psychological structure) as well as to measure its significance in the context[16], which was demonstrated in studies A6, A7, A8 and A10.

The study A2 aimed to determine the association between socio-demographic, psychosocial and spiritual factors for risk behaviors to health during pregnancy of African-American women and low-income white women. As a result, higher rates of R/S are not associated with substance abuse.[9]

The study A14 was the only selected study conducted in Brazil. Its goal was to evaluate

the relation between religiosity and mental health, hospitalization, pain, disability and quality of life with elderly in a rehabilitation scenario. It concluded that religiosity is associated with significantly fewer depressive symptoms, better quality of life, less cognitive impairment and lower perception of pain.[21]

The results found in the studies A2 and A14 were corroborated by another study, in which Backes et al.[31] legitimize this fact when they refer that

> Regarding mental health, there is scientific evidence that religion and spirituality have a positive association in 50% of the cases, and are considered protective factors against suicide, use or abuse of drugs and alcohol, delinquent behavior, marital satisfaction, psychological suffering and some functional psychoses diagnoses.[30:1255]

The study by Harrison[32] was able to identify which patients with sickle cell anemia who attended a religious temple regularly had lower pain scores. A large number of studies indicate that higher levels of religious involvement act as positive factors of psychological well-being, life satisfaction, happiness, positive affection, higher morale, better physical and mental health and lower perception of pain.

This allows stating that faith, belief and prayer, considered as an alternative therapy, integrative or complementary to conventional therapies in health, besides reducing the individual's exposure to invasive and drug measures, also reduce spending on health, for, in order to use them, only the patient's will is required, its use is free, there is no contraindication and its access is universal.

The study A15 showed that a lower spiritual well-being is related to increased symptoms of Post-Traumatic Stress Disorder (PTSD). These symptoms are directly related to a higher number of physical symptoms and distress related to PTSD as well as to increased anxiety and poor communication with health care providers.[22] In studies A4 and A12, similar results are presented.

It is possible to verify, from these studies, that religiosity and spirituality are mostly positively related to some variables such as age, gender, health, lower risk behavior, pain and mental health; lower religiosity rates are negatively related to the above factors, confirming that to consider the patient's religion and spirituality issues brings great benefits for it.

CONCLUSION

It was found that it would be important to use a specific collection instrument of spiritual history, given the fact that the studies that did not use such instruments had difficulties correlating religious and spiritual issues with other variables, leaving little clear presentation of results and discussion of theme. It is understood, therefore, that specific instruments provide more conclusive findings about history and spiritual needs.

Spiritual anamneses in health care is little used and no intervention based on the spiritual history of patients was observed. It is observed that, although greatly explored, the spirituality in the scientific community is being given little attention in the training environment of healthcare, as there is also a gap in scientific production involving nurses in research and its acting in spiritual anamneses.

To add spirituality and religiosity to care plans and know when and how to approach it depend on the training that the professional had about the matter. However, the deficiency presented in teaching to conduct a comprehensive health care, excluding these matters, preclude the construction of critical thinking and the development of skills for the satisfactory decision-making based on the unique needs of the person receiving care.

It is understood that the realization of a holistic health care must be the goal for the excellence of care. Fragmenting it is to do it to humans and choose which part of this fragment receives care; it is to neglect and dehumanize care. To try to separate spirituality and nursing is also causing it to lose its essence.

Knowing the spirituality and religiosity contributions to health and understanding the human being as multidimensional, why insist on excluding this issue from the academic environment, making it impossible to build a skilled, critical and humanized professional?

It is necessary to nursing and to other health professionals that a deepening in the theme of spiritual history takes place in order to better understand the need to raise the spiritual history of the patient and intervene satisfactorily, thereby allowing this human dimension to provide what science has proven, acting as an equilibrium, hope, strength and well-being agent.

A greater emphasis on research about the nurse's performance in carrying out diagnostics guided by the religious and spiritual beliefs of the patient is suggested, and also possible related interventions in addition to analyzing the effects those interventions can promote to improve the quality of life and well-being of the patient.

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