INFLUENCE OF RELIGIOUSITY / SPIRITUALITY OF HEALTH PROFESSIONALS IN THE VALORIZATION OF THE SPIRITUAL DIMENSION OF THE CRITICAL

INFLUÊNCIA DA RELIGIOSIDADE/ESPIRITUALIDADE DOS PROFISSIONAIS DA SAÚDE NA VALORIZAÇÃO DA DIMENSÃO ESPIRITUAL DO PACIENTE CRÍTICO

INFLUENCIA DE LA RELIGIOSIDAD/ESPIRITUALIDAD DE PROFESIONALES DE LA SALUD EN EL APRECIO DE LA DIMENSIÓN ESPIRITUAL DEL PACIENTE CRÍTICO

ABSTRACT

Objective: to identify if the religiosity/spirituality of health professionals collaborates to the valuing of the spiritual dimension of critical patients. Method: a descriptive, cross - sectional study with a quantitative approach, carried out with 53 professionals working in Intensive Care Units in the interior of Brazil. Data collected from a questionnaire adapted from the SEBRAME multicentre study and the Spirituality Self Rating Scale. A descriptive analysis of the data and association was performed, using Fisher's exact test, with a significance level of 5%. Results: professionals with a high level of spirituality were the ones who most recognized the influence of religiosity/spirituality on the patient’s health and those who most wanted to approach or even had already addressed this issue with their patients. Conclusion: the religiosity/spirituality of the health professional contributes to the appreciation of the spiritual dimension of the serious patient.

Descriptors: Spirituality; Intensive Care Unit; Healthcare Professionals.

RESUMO

Objetivo: identificar se a religiosidade/espiritualidade dos profissionais da saúde colabora para a valorização da dimensão espiritual dos pacientes críticos. Método: estudo descritivo, transversal, com abordagem quantitativa, realizado com 53 profissionais que atuavam em Unidades de Terapia Intensiva no interior do Brasil. Dados coletados a partir de questionário adaptado do estudo multicêntrico SEBRAME e escala Spirituality Self Rating Scale. Realizada análise descritiva dos dados e de associação, utilizando o teste exato de Fisher, com nível de significância de 5%. Resultados: os profissionais com elevado índice de espiritualidade foram os que mais reconhecem a influência da religiosidade/espiritualidade na saúde do paciente e os que mais desejavam abordar ou, mesmo, já haviam abordado este tema com seus pacientes. Conclusão: a religiosidade/espiritualidade do profissional de saúde colabora para a valorização da dimensão espiritual do paciente grave. Descritores: Espiritualidade; Religião; Unidade de Terapia Intensiva; Profissional de Saúde.

RESUMEN

Objetivo: identificar si la religiosidad/espiritualidad de profesionales de la salud colabora para la apreciación de la dimensión espiritual de los pacientes críticos. Método: estudio transversal, descriptivo con enfoque cuantitativo, llevado a cabo con 53 profesionales que trabajan en unidades de cuidados intensivos en el interior de Brasil. Datos recolectados del cuestionario adaptado del estudio multicéntrico SEBRAME y escala Spirituality Self Rating Scale. Llevado a cabo análisis descriptivo de los datos y de la asociación, utilizando la prueba exacta de Fisher, con un nivel de significancia del 5%. Resultados: los profesionales con alto nivel de espiritualidad fueron los que más reconocieron la influencia de la religiosidad/espiritualidad en el cuidado del paciente y la dirección más deseada o, incluso, habían discutido a este tema con sus pacientes. Conclusión: la religiosidad / espiritualidad del profesional de salud colabora para la apreciación de la dimensión espiritual del paciente grave. Descriptores: Espiritualidad; Unidad de Terapia Intensiva; Profesional de Salud.
Influence of religiosity / spirituality of health professionals on the recovery and quality of life of critically ill patients in Intensive Care Units.

INTRODUCTION

The implications of health-related religiosity / spirituality have been themes of several studies in recent years, since they are recognized as resources that help in coping with adversities.¹

Spirituality can be understood as a personal search to understand the meaning of life, the relationship with the sacred and issues related to the end of earthly life, and may or may not lead to religious practices. Religiousness is how much the individual believes, follows and practices a religion, which is institutional, dogmatic and systematized.²

The value of religiosity/spirituality, during the care provided, positively influences the patients’ well-being³ and allows the professional an integral vision of health when approaching the patient in its various dimensions, surpassing the model centered only on the biological aspects of the process Health and illness.⁴

The recognition of the importance of the spiritual dimension of the patient, in the process of coping with the disease, is a new paradigm in health care⁵, including, critical patient care in the Intensive Care Unit (ICU). These units provide specialized care to critically ill patients at imminent risk of death, ensuring a quality, humanized and integral care that must take into account the human being in its bio-psychosocial and spiritual dimensions.⁶

In these situations of hospitalization for intensive care, religiousness / spirituality can be an important aspect to be approached, due to the state of greater fragility, fear of the unknown and the outcome of the situation⁷, which may contribute to personal well-being and reduction of morbidity and mortality.³

Many patients consider the influence of the spiritual dimension in their recovery and recognize the importance of approaching religious and spiritual aspects in the elaboration of their therapeutic plan. There are also reports of patients who would like their caregivers to approach their religiosity / spirituality, contributing to a more empathetic and trustworthy professional-patient relationship.⁸

Health professionals recognize the positive influence of the religiosity/spirituality approach during care-giving, but many of them report that they do not feel prepared for such an approach, and that the training does not include in their curriculum development of this ability.⁵ They also show concern about the various dimensions of the health service user, who present an expanded and humanized concept of health, and recognize that, humanized attendance, involves all dimensions of the user, including the spiritual.⁴

The search and study of spirituality, by health professionals, is essential for integral care and is also a harmonizing component of the relationships in the health work process, providing well-being and quality of life to the professional.⁷

Thus, it is questioned whether the religiosity / spirituality of health professionals influences the importance attributed to the spiritual dimension of the patient who is assisted in the Intensive Care Unit. This study is justified by the contribution in the expansion of knowledge about the influence of the religious / spirituality of health professionals, as well as in the recognition and appreciation of the spiritual dimension of the patient as part of his therapeutic plan. Thus, discussions and reflections on the importance of this dimension in the direction of care can be made, aiming at a more humane, dignified, integral and ethical assistance.

OBJECTIVE

- Identify if the religiosity / spirituality of health professionals collaborates to value the spiritual dimension of critical patients.

MÉTODO

A descriptive, cross-sectional study with a quantitative approach, performed with health professionals who worked in critical patient care in Intensive Care Units. Data collection was performed at the Adult ICU of the Prado Valadares General Hospital (PVGH) and at the Adult ICU of the Santa Helena Hospital (SHH), both located in the Jequié Municipality, in the southwest region of Bahia, Brazil. The Prado Valadares General Hospital has 176 operational beds and ten beds of ICU, being considered one of the main public hospitals of reference for the southwest region of the State of Bahia. The Hospital Santa Helena has 74 beds and seven beds of ICUs and currently attends only health plans and agreements.¹⁰

The data collection instrument was the questionnaire adapted from the SEBRAME Multicenter (Spirituality and Brazilian Medical Education) coordinated by the Federal University of São Paulo (UNIFESP), the Federal University of Juiz de Fora and the Brazilian Spiritist Medical Association.¹¹ The adaptations Conducted in this questionnaire involve changes in the nomenclature of the participants that, in the SEBRAME study, were
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Influence of religiosity / spirituality of health professionals and, in this study, are health professionals. Socio-demographic data on the time of performance as health professionals and time of operation in the ICU was also added.

This questionnaire was composed of the following questions:

A) Socio-demographic data: gender, age, length of service, race / ethnicity, length of service as health professionals, time spent in the ICU and family income;

B) Clinical practice, the patient and spirituality: knowledge and opinions about the relationship between spirituality and health in clinical practice;

C) The academic formation and the theme spirituality: how the training schools approach the theme during the formation and how they could be offered the contents related to health and spirituality;

D) Religious dimension: different aspects of the participant's religiosity are evaluated through religious affiliation and questions that are part of the Duke Religious Index (DUREL).

In addition to this questionnaire, the Spirituality Self Rating Scale (SSRS), a translated and adapted scale for Brazil, was included, in the collection instrument, which has six items that evaluate aspects of the spirituality of the individual. These items reflect how important the practitioner considers the questions about their spiritual dimension and whether they are applied in their daily lives. Participants scored one of five response options ranging from one, totally disagree (Likert Scale). According to the author, to analyze the scale, it was necessary to recode the punctuation, being possible to cite like examples: the answer five becomes one, four becomes two and so on. After recoding the points, these were added to define the score of each participant.

The SSRS has a score of six to 30 points and, according to the author of this scale, the higher the score, the greater the spirituality. In this study, minimum score of 16 and maximum of 30 points were obtained with a mean of 24.5, a median of 25 and a standard deviation of 3.38. The median (25) was considered, as a cutoff point, considering values up to 24 points as a lower spirituality and, from 25 points, greater spirituality.

The questionnaires were applied during the period from March first to April 30, 2015, in the Intensive Care Units of the PVHG and MSM, using, as inclusion criteria: being a health professional, providing on-call care to the PVHG and MSM intensive care units and to be active in the service in this period. We excluded from this study those who worked in the ICU, but who were not health professionals (hygienic professionals, secretaries), professionals who were on vacation or medical leave at the time of collection, and those professionals who only attended the patient eventually Medical).

Initially, a survey of the number of professionals was carried out, making a list with name and profession of each one. The PVHG ICU assistance team consisted of 59 health professionals, of whom, seven physicians, 12 nurses, 32 Nursing technicians, seven physiotherapists and one psychologist. The ICU of Santa Helena Hospital had a team of 27 professionals composed of eight physicians, three physiotherapists, six nurses and ten Nursing technicians.

Subsequently, all health workers at these ICUs, who met the inclusion criteria, were invited to participate in the study during the period of duty. After explaining the objectives of the research, its risks and relevance, the Free and Informed Consent Form was delivered, being duly signed by those who accepted to participate in the research. The questionnaires were then delivered and returned to the researcher after being filled out by the participant. Participated, in this research, 53 professionals who worked in direct assistance to the critical patient in these ICUs.

After the data collection, the data were tabulated in the Microsoft Excel program and transferred to the statistical program SPSS, version 21.0, for data analysis. A descriptive data analysis was performed by means of the absolute and relative frequency distribution for the categorical variables and measures of central tendency (mean and standard deviation) for the continuous variables.

For the analysis of the association between the degree of spirituality of the health professionals and questions that point to the spiritual dimension of the hospitalized patient, Fisher's exact test was used, with a significance level of 5% (p <0.05).

This research is the result of Master's Dissertation, presented to the Post-Graduation Program in Nursing and Health of the State University of Southwest of Bahia and, as a project, was sent to the Research Ethics Committee of the State University of Southwest of Bahia. CAAE number 32197814.9.0000.0055. Only after approval, under the number of opinion 805.380 of the report of September 17, 2014, data were collected. All the participants in this research signed the Informed Consent Term, and all the ethical aspects included in Resolution 466/12
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This study had the participation of 53 professionals who worked in direct assistance to critical patients in the Intensive Care Unit. The subjects were mostly female (77.4%), self-reported non-white color (67.9%) and Evangelical/Protestant religion (35.9%), followed by Catholic religion (34%). The participants’ ages ranged from 26 to 63 years, with an average of 37 years, with a predominant income (66%) of up to seven minimum wages. The average time of service as a health professional was 11 years and of acting in the ICU, was four years.

When questioned about “how much religiousness/spirituality influenced the health of their patients”, 96.2% of these professionals answered that this dimension influenced a lot and, for most, this influence was positive, as described in table 1.

<table>
<thead>
<tr>
<th>How much spirituality does religiosity/spirituality influence the health of the patient?</th>
<th>A lot</th>
<th>A little</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>51 (96.2)</td>
<td>2 (3.8)</td>
<td>53 (100)</td>
</tr>
<tr>
<td>Negative</td>
<td>11 (20.8)</td>
<td>19 (35.8)</td>
<td>30 (56.6)</td>
</tr>
<tr>
<td>Equally positive and negative</td>
<td>11 (20.8)</td>
<td>12 (22.6)</td>
<td>23 (43.4)</td>
</tr>
<tr>
<td>Does not influence</td>
<td>3 (5.6)</td>
<td>8 (15.1)</td>
<td>11 (20.8)</td>
</tr>
</tbody>
</table>

Approximately 80% of respondents reported that they wanted to approach the topic of faith and spirituality with their patients in the ICU and 64.2% said they had already asked about the religiosity/spirituality of their patient, as described in table 2.

<table>
<thead>
<tr>
<th>Do you feel like addressing faith and spirituality with patients?</th>
<th>Have you ever asked about your patient’s religiosity/spirituality?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>N (%)</td>
</tr>
<tr>
<td>42 (79.2)</td>
<td>34 (64.2)</td>
</tr>
<tr>
<td>No</td>
<td>11 (20.8)</td>
</tr>
<tr>
<td>6 (11.3)</td>
<td>12 (22.6)</td>
</tr>
<tr>
<td>30 (56.6)</td>
<td>11 (20.8)</td>
</tr>
</tbody>
</table>

When correlating the degree of spirituality of professionals with their opinion about the influence of religiosity and spirituality on the health of the critical patient, it was verified that those who had greater spirituality were those who answered that there was much influence of this dimension for the health of the patient. In addition, according to the data in table 3, the professionals with the highest index of spirituality were those who most wanted to approach faith and spirituality with their patients and had already asked about this dimension.

<table>
<thead>
<tr>
<th>Influence of religiosity/spirituality on critical patient health</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>More spirituality n (%)</td>
<td>51 (96.2)</td>
</tr>
<tr>
<td>Less spirituality n (%)</td>
<td>2 (3.8)</td>
</tr>
</tbody>
</table>

* Fisher’s exact test
Influence of religiosity / spirituality of health...

When asked if they wanted to approach the topic of faith and spirituality with the patients, about 80% of the professionals who participated in this study reported that yes, but only 64.2% reported that they had already asked about the religiousness / spirituality of the hospitalized patient in the ICU.

The results showed that, the greater the degree of spirituality of the health professional, the greater the recognition of the influence of religiosity / spirituality on the health of the critically assisted patient. In addition, the greater number of those who expressed a desire to approach faith and spirituality and had the attitude of asking the patient about their religiousness / spirituality was also the one with the highest spirituality (Table 3). Although it was observed that most of the professionals who presented high spirituality were those who recognized the positive influence of religiosity / spirituality on the health of the critical patient or felt a desire to address this issue with the patient, this association was not statistically significant.

In a study that examined how palliative care professionals perform spiritual care in Spain, 94% of the participants recognized spiritual accompaniment as part of their work, but also recognized the need for improvement in the current training and care model.5

Another study evaluating the religious / spirituality role in the lives of cancer patients and the professionals who attend these patients showed that 94% of the patients consider it important that health professionals approach their spiritual dimension, since 99% of them use religiosity/spirituality as during cancer treatment. Among health professionals, 98% recognized spiritual and religious support as necessary in oncology care.18

These data demonstrate the need for a reflection on the role of current training of health professionals, since they recognize the spiritual dimension as an important factor to be considered for the well-being and recovery of patients, but they make it clear that there is no offer of sufficient knowledge about this subject, in academic training. It is important to mention that current research reports patients' opinions that demonstrate the desire that their religiousness/spirituality be approached by health professionals. In Nigeria, a study evaluating maternal service and the need for spiritual care has shown that for most pregnant women, spiritual support during pregnancy and childbirth was indispensable.19

From the total of the interviewees, 96.2% consider that religiousness/spirituality greatly influences the patient's health, most of which is positive, as shown in Table 1.

A comparative study on the opinions and attitudes of teachers and students of the Nursing course on religiosity, spirituality and health, indicated similar results. In this research, 96% of the participants also reported that religiousness/spirituality had a great influence on the health of the patients, although few professionals approached this subject with the patients assisted. In addition, about half of the teachers and students reported that spirituality influenced the assistance itself.13

Regarding the positive aspects of the spiritual dimension in the patients' lives, a longitudinal study, conducted in the USA with HIV patients, demonstrated that religiosity/spirituality is used as a coping and results in a positive impact on the survival of these individuals.14 A prospective study pointed out that adults who attached importance to their religious/spiritual life reduced their chances of developing depression by as much as 90%, showing that this dimension is positively associated with people's quality of life.15 This positive aspect is also perceived in Relatives of patients, as concluded in a survey conducted in hospitals in the State of São Paulo with relatives of patients who were admitted to the ICU. Most of these relatives believe that religiosity/spirituality was used as a positive coping strategy during the hospitalization of a family member in the ICU, helping to reduce hospital-related stress.7

There is, now a recognition among the health professionals of the spiritual dimension as a factor that contributes to the health and quality of life of the individuals and the positive impact for the recovery of people facing illness situations, as demonstrated in the studies cited.

Studies indicate the positive aspects as predominant2-14,5, however, there are negative aspects that were not mentioned by any participant in this research. These aspects are associated with thoughts that God is punishing, spiritual discontent and questioning of the divine powers that lead to religious suffering, related to higher mortality and unfavorable clinical outcomes.16 In addition, negative religious confrontation is associated with suicidal ideation and depression, being important the recognition of negative influence by health professionals.
In looking at how the spiritual needs approach has been in the professional health-patient relationship, research indicates that approximately 86% of patients had never been questioned about their beliefs during the care they received. More than 80% of them considered that the health professional should recognize their religious or spiritual needs as part of the therapeutic plan, since, for 84% of them, health care includes being attended to in their religious and spiritual needs, and reported believing that this dimension helps to understand and deal with the health-disease process.

Other studies corroborate these data, such as the Boston study, of cancer patients, which sought to understand the relationship between spiritual care and the quality of life of patients with cancer. For these patients, spirituality is used as a way of coping with the disease in order to minimize suffering or gain greater hope, impacting on their quality of life. These results highlight the importance of spiritual assistance as a coping strategy that should be considered in assistance planning.

Thus, enhancement of the spiritual dimension of ICU assisted patients can contribute to their recovery, better understanding and acceptance of their current condition, contributing to a better balance and quality of life, preserving their dignity during the ICU stay, as Consider the studies mentioned above.

**CONCLUSION**

The greater the spirituality of the health professionals who work in the ICU, the greater the recognition of the positive influence of religiosity/spirituality for the recovery of the person assisted in this sector. In addition, the professionals who had a higher level of spirituality were the ones who felt the most desire to approach faith and spirituality and also those who had already asked the patients about this dimension. This demonstrates that the religiosity/spirituality of professionals working in the Intensive Care Unit collaborates so that they value the spiritual dimension of the assisted patient.

This study had as a limitation the size of the sample that, because it has a small number of professionals, can consider the results found only for the study population. Thus, it is suggested that further research be carried out involving larger samples of professionals working in the Intensive Care Unit.

The results of this research are expected to contribute to reflections on the impact of the spiritual dimension of health professionals on their work practice and on improving the quality of life and work, as well as the influence on the care provided, with a view to the most humane, dignified care, Integral and ethical.

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