

EDITORIAL

“Spirituality and Health”: from scientific evidence to clinical practice

“Saúde e Espiritualidade”: das evidências científicas para a prática clínica

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The relationship between “Health and Spirituality” (H/E) is a long-standing one, being present in the most remote times by healers, and also going through the opening of hospitals and care for the sick by religious institutions, until the era of “Spirituality based on evidence” from the 1970s and 1980s (KOENIG, 2012). Although, over the years, a lot has grown in this field, a lot of discussions remain open, such as definitions and concepts. Although there is no consensus, religion is usually defined as “an organized system of beliefs, practices, rituals and symbols designed to facilitate access to the sacred, the transcendent (God, higher power, supreme truth...)”. (KOENIG, 2012).

The term spirituality has a broader meaning. Two important authors in the H/E field have different views on these definitions (BRITO SENA et al, 2021). According to Harold Koenig (2012), spirituality “is a personal quest to understand questions related to the end of life, to its meaning, about relationships with the sacred or transcendent that, may or may not, lead to the development of religious practices or formations of religious communities”. On the other hand, Christina Puchalski (et al., 2009) brings an even broader concept, including not

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only the sacred or transcendent, but expanding to other aspects, as we see below: “it is an aspect of humanity that deals with how individuals seek and express meaning and purpose, as well as how they express their connection to the moment, to themselves, to others, to nature and to the sacred”. Regardless of the adopted concept, it is clear that an individual can have a spirituality, but not be religious.

Regarding the Brazilian context, religious and spiritual beliefs are very important, influencing health and permeating medical decisions and ethical issues within the health-disease process (LUCCHETTI et al, 2014). A brief search in the Pubmed database of articles carried out in November 2022, using the expression (spiritual* OR religio*), resulted in 88555 articles, demonstrating the magnitude and growth of research in that field. The H/E field has grown considerably in recent years, driven by growing scientific evidence and the publication of guidelines for its incorporation into clinical practice. (G. LUCCHETTI; LUCCHETTI, 2014).

The evidences point out to a significant influence of the individual's beliefs both for physical and mental health, as well as for well-being and for other positive health markers. A systematic review conducted in 2012 (KOENIG, 2012) evaluated 3300 articles and found that about 80% of the scientific evidence in the area is related to mental health. Most studies, in fact, show that religiosity and/or spirituality (R/S) are generally associated with greater well-being, quality of life, happiness, hope, optimism, meaning and self-esteem. On the other hand, R/S are associated with lower levels of depressive and anxious symptoms and lower prevalence of substance use and delinquency. (KOENIG, 2012; G. LUCCHETTI, KOENIG, & LUCCHETTI, 2021).

Regarding studies that address physical health, although less numerous, they show that people with higher levels of R/S generally have lower cardiovascular risk (lower prevalence of smoking and alcoholism, healthier diets, higher levels of physical activity), lower levels of blood pressure, lower prevalence of cerebrovascular diseases, less progression of cognitive decline, better immune function, less pain sensation and longer survival. (KOENIG, 2012).

Although most of the evidence is positive and promising, it is important to note that about 15% of individuals will use their beliefs negatively (i.e., in a dysfunctional way), questioning God’s love and nurturing a feeling that God is chastising and punishing the human being (HEBERT; ZDANIUK; SCHULZ; SCHEIER, 2009). This religious/spiritual suffering could, on the other hand, lead to worse health outcomes, being associated with higher mortality and worse markers of mental health, and in this sense it should be considered by the health professional. (PARGAMENT et al., 2001).

Several mechanisms by which an individual’s belief can influence their health are presented here. In fact, R/S influence social support, healthy behaviors in relation to health, positive thoughts, mental health and, this ends up affecting inflammatory markers (such as fibrinogen, C-reactive protein, Interleukin-6), markers immunological (CD4, viral load, immunoglobulins), cardiovascular markers (such as autonomic control and blood pressure reactivity) and stress markers (such as cortisol). These markers will ultimately result in the different outcomes observed by studies referring to physical health. (KOENIG, 2012; G. LUCCHETTI et al., 2010).

Based on all the evidence shown above, several international organizations (World Health Organization, American College of Physicians, World Psychiatry Association, North American Nursing Diagnosis Association, American Medical Association) and Brazilian organizations (Associação Brasileira de Psiquiatria, Sociedade Brasileira de Cardiologia and Associação Brasileira de Educação Médica) have already included this subject in their events and/or publications, which will guide the clinical practice of health professionals.

Despite these advances, there is still a gap between the importance given by patients regarding this subject, in which 70.5% would like their physicians to address their beliefs in clinical practice (BEST; BUTOW; OLVER, 2015) and the small approach of health professionals (about 1 in 10) regarding the topic (BEST, BUTOW, & OLVER, 2016). Much of this obvious dichotomy is due to the lack of greater clarification by health professionals regarding the subject and the absence of appropriate training. Although 90% of North American, 59% of British and 40% of Brazilian medical schools have H/E content in their curricula (G.

Lucchetti et al., 2012), most of it is still done electively and without practical applicability, often making professionals unable to take such an approach and perpetuating the barriers that prevent this approach, such as “fear of offending the patient”, “fear of imposing beliefs” and “lack of knowledge” (G. LUCCHETTI et al., 2013).

Training to address the subject being discussed here is essential for students and health professionals to have confidence and feel comfortable with this approach, as a result, there is a benefit to the patient and can cause a better health professional-patient relationship, greater adherence to treatment, better coping with the disease and better response to treatment (ASTROW; SULMASY, 2004; MOREIRA-ALMEIDA et al., 2014). However, it should be based on some precautions, and should be centered on the patient, without imposing one's own beliefs and proselytism, showing genuine interest and respect for the patient's beliefs and, when the patient raises the subject, avoid coldness reaction, such as, for example, “diverting from the subject”. (MOREIRA-ALMEIDA et al., 2014).

There is no single moment or right moment to approach an individual's beliefs. It should usually be done when the patient is being followed up, when the patient is admitted to the hospital, or when some medical or ethical decision may be influenced by the individual's beliefs. In this sense, the spiritual history (also known as spiritual anamnesis) can be inserted within the general anamnesis or even be conducted in isolation. (G. LUCCHETTI; BASSI; LUCCHETTI, 2013).

Within scientific literature, there are several instruments to facilitate the approach of spirituality in clinical practice, such as FICA, SPIRITual History, FAITH and HOPE, among others. A previous systematic review pointed to FICA as the most appropriate, short, fast and inclusive instrument (G. LUCCHETTI, BASSI, et al., 2013). FICA is an acronym that is understood as follows: (F): (meaning, faith), (I) (meaning importance or influence), (C) meaning community and (A) meaning Address/Action in Care. For each of these dimensions, there are propitiatory questions that are asked to the patient. One of the great advantages of FICA is that it can apply to individuals without religious or spiritual beliefs such as atheists, since, in these cases, it seeks to understand what gives meaning

to one's life (nature, science, friends, Family, etc). (BORNEMAN; FERRELL; PUCHALSKI, 2010).

In conclusion, the field of “Health and Spirituality” has been growing in recent decades, driven by evidence and the interest of health professionals who yearn for broader health care. The evidence is solid regarding the influence of R/E on physical and mental outcomes, given that, in most cases, the results are positive for the patient. Health professionals should know such evidence and be trained to address the issue in clinical practice.

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