

## EDITORIAL

### **DOES THE INTEGRATION OF THE SPIRITUAL DIMENSION IN HEALTH CARE MAKE SENSE?<sup>1</sup>**

#### ***A INTEGRAÇÃO DA DIMENSÃO ESPIRITUAL NO CUIDADO EM SAÚDE FAZ SENTIDO?***

#### ***LA INTEGRACIÓN DE LA DIMENSIÓN ESPIRITUAL EN LA ATENCIÓN A LA SALUD, ¿TIENE SENTIDO?***

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In the last two decades, the academic community has seen the birth of a field of knowledge that has been gaining more and more attention: the field of religion, spirituality and health. The researchers who deal with such topics are no longer treated with suspicion or strangeness, nor is it taken that the interest in this field is merely a reflection of the personal religious choices of those who deal with it. This is because, on the one hand, it has already been recognized that *scientific neutrality* is an impossibility, an *arrogant illusion*. The *speaking position*, or *perspective* from which discourses of truth arise, reflects the colors and nuances of our own subjectivity, including our beliefs and disbeliefs of a religious and spiritual nature. On the other hand, in addition to being more open to research on these topics, the academic community has also shown itself to be mature and competent in applying the criteria to assess the scientific accuracy of the designs of these investigations.

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Some studies in this field show that when the ill hospitalized people have their spiritual needs met, there are: lower prevalence of depression (KOENIG; GEORGE; PETERSON, 1998); better coping with symptoms in mental health context (HEFTI, 2011); less pain and more energy in cancer patients; greater adherence to treatment; (SHERMAN et al., 2005); less work for nursing teams (KOENIG; MCCULLOUGH; LARSON, 2001); the re-hospitalization rate is lower (BALBONI et al. 2014) and a greater sense of well-being has been reported (BALBONI M.; BALBONI T., 2019; BALBONI T. et al., 2017; BALBONI et al., 2010; BALBONI T. et al., 2011; GIJSBERTS et al., 2019). There are also studies that point to a decrease in financial costs, especially because of less use of Intensive Care Units (BALBONI et al. 2011) and less hospitalization time (CUMMINGS; PARGAMENT, 2010). A particular highlight is reported by Cummings and Pargament (2010, p. 44) by bringing the study of Iler, Obenschain and Camac (2001) regarding a significant reduction in hospitalization time, 3.3 days less, than the control group that did not receive spiritual care or any visit from the hospital chaplain. Leget (2017a; 2017b) has also emphasized that spiritual help to the ill person collaborates in ethical decision-making and resolution of psychological and spiritual conflicts in the process of terminality, and can be one of the greatest indicators of good end-of-life care (WILLIAMS, 2006). The *total pain* issue pointed out by Cicely Saunders (2000) as indicative of the need for spiritual care for people in Palliative Care is not a small matter. The perception and understanding of total pain was one of the main elements that made the philosophy of Palliative Care proliferate (SAUNDERS, 2004). Cicely Saunders found some patients were resistant to high doses of morphine administered for pain control. The author thus observed that pain is more difficult to control when there is no care for the ill person in all its dimensions, including the spiritual.

Despite this amount of evidence and greater awareness of issues related to the integration of spirituality in healthcare, in Brazil, some note that health professionals, in general, have difficulties in identifying the spiritual needs of the ill and addressing them (MATOS et al., 2017; MARINHO, 2010). In the studies conducted by Marinho (2010), less than 15% of hospitalized patients had their spiritual needs met or received psychological support. The author also points out that the nursing team frequently neglects the spiritual suffering dimension. They often confuse the spiritual dimension with religiosity and, as a result, consider it to be a private matter. (MARINHO, 2010, p. 131).

Numerous factors will contribute to why healthcare professionals do not listen to the spiritual dimension, beyond the belief that it is a private and personal aspect of individuals. For many of them, the invisibility of this area happens because of the lack of training for this

type of listening, either from a theoretical or practical point of view, also in technical-professional training courses, including those held in universities, and in postgraduate programs. The teachers' perception of the importance of including this topic in the curriculum seems to be related to their own spirituality (SILVA et al., 2021). In a recent update study on how the education of medical professionals has been on issues related to integrating spirituality in health care, Lucchetti et al. (2023) has observed that most medical school representatives agree that this subject is important in medical education and that more space is needed in the curriculum. However, they recognize several barriers, such as the lack of knowledge of medical teachers on the subject and the usual and claimed lack of time for not including the subject in teaching plans. A certain predominant conception of a quantitative approach, which is very focused on evidence-based knowledge that can be generalized in diagnostic, prognostic, and therapeutic proposals, also hinders the inclusion of the subject in teaching plans. While evidence-based actions generate a gain for biomedical knowledge, on the other hand, it does not mean that it is the only way to access patients and their sufferings in their various dimensions. The very dimension of spirituality often escapes clear perspectives, requiring a listening that captures the uniqueness of each patient and, simultaneously, can read subtle signs that are not always apparent or capable of generalization in relation to their applicability to all people.

In addition, the very reality of health professionals often prevents the inner availability for this listening, such as stressful and overloaded patient care routines and administrative actions. However, one of the biggest factors for the invisibility of this area is the very difficulty of many health professionals to listen to their own spirituality, deal with it and cultivate it (BERMEJO; SANTAMARÍA, 2007, p. 150). Not as a necessarily religious aspect, but, above all, as a dimension of construction of deep meaning in existence, capacity for transcendence and connection (whether with oneself, with others, with nature and the Sacred), besides the ability to integrate the various dimensions of one's own existence and life. Although some studies show religious professionals are more likely to integrate spiritual issues into care practice (ESPERANDIO et al., 2021), it is important to understand that spiritual care can be delivered regardless of the health professional's personal beliefs, not mattering whether he/she is religious, spiritual, atheist, etc. and not even if he/she shares the same beliefs as the ill person.

Although the scientific research to date leaves no doubt about the impact of integrating the spiritual dimension on health outcomes, it has given greater emphasis to the positive results of this integration, as evidenced in the studies listed above. Empirical studies

that discuss this theme with specific populations, such as the LGBTQIA+ population (ROSA; ESPERANDIO, 2022); caretakers of people with intellectual disabilities (XAVIER; ESPERANDIO, 2023) and the spiritual conflicts experienced by these groups, are scarcely available.

In expansion in Brazil, there is also the development of studies with emphasis on the role of popular religiosity and religion (especially some specific groups) in health practices, as shown by the various researches conducted at the Federal University of Juiz de Fora, guided by Professor Alexander Moreira-Almeida (SILVA; MOREIRA-ALMEIDA, 2023), including a study on cognitive-behavioral therapy adapted to Spiritist religiosity (COSTA; MOREIRA-ALMEIDA, 2023).

It should be remembered that although scientific studies have emphasized the spiritual/religious dimension as an important source of resources for coping with situations when health is threatened, spirituality is more than a *coping resource* in stressful situations. Spirituality concerns to the dimension of meaning and purpose of existence. It is related to the connection that a person develops with themselves, with others, with the wider environment, including nature and/or a transcendence or that which is sacred to them. Spirituality can be expressed religiously, but also apart from institutional-religious domains.

Thus, for advancing studies in this field, especially in Brazil, it is necessary to look closely at some topics that remain under-investigated and/or neglected. As a suggestion for future research, it is worth highlighting, among other topics:

- a) The toxic and negative aspects that can be present in certain religious manifestations, such as the issue of religious and spiritual conflicts, in its potency to act as a cause and effect of psychological problems and worse health outcomes (including deaths by suicide);
- b) The need for theoretical-conceptual studies on the terms spirituality, religiosity, the sacred, faith and their mutual relationships and differentiations and the forms of human flourishing (or development of the spirit and expansion of inner space).
- c) The concept of spiritual care and practical proposals for culturally sensitive spiritual care detached from the traditional notion of religious-confessional chaplaincy;
- d) Scientifically based ways of identifying spiritual needs;
- e) Relationship between health professionals' own spirituality and the quality and form of care offered;

- f) Human flourishing as it relates to emotional maturation and global health;
- g) Concept of compassion and self-compassion in care practices and decision-making in healthcare;
- h) Effects of meditation on anxiety control and coping with depression;
- i) The attachment theory and attachment to God and the processes of mourning;
- j) The impact of the professional chaplaincy in palliative care teams;
- k) Common or close perspectives of approach to spirituality in health, with the development of central categories that favor the polysemy that characterizes this area, is not an impediment to sharing research, postures, care and approaches to patients;
- l) Spirituality approaches to non-believers, atheists and agnostics.

Because of the essentially interdisciplinary nature of this field of knowledge, these themes can be investigated from different approaches and by different disciplines, either through a theoretical-conceptual, empirical approach, or with a theoretical-methodological reference of a qualitative or quantitative nature.

Finally, in this brief reflection, after going through authors who show, through their research, the value of meeting the spiritual needs of ill people, as well as the challenges that surround those dedicated to this field of knowledge in health care environments, we return to our initial question: Does attention to the spiritual dimension make sense in health care? Based on what has been presented, we can affirm that yes, it makes sense. However, the challenges are many, especially in a society marked by consumerism and materialism, which demands efficiency, effective results and speed, even asking us to leave our human rhythm. And there are challenges inherent in approaching this human dimension which, because of its depth, is not always quickly accessible, requiring human cultivation, sensitivity in looking, listening, communicating and touching; both with the people we work with and with ourselves. However, more than challenges, they are invitations for us to develop new perspectives and conceptions of the world and to build more humanized, empathetic and compassionate relationships of help and care, in which common vulnerabilities and fragilities can be witnessed and transformed into openness to more integrative, sensitive, respectful experiences that promote personal and collective growth.

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