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PERCEPTIONS OF RELIGIOSITY SPIRITUALITY IN CLINICAL PRACTICE

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ABSTRACT

In the last decades, the number of studies relating spirituality and health has increased. This article reviews the literature on the relationship between religiosity and spirituality in clinical practice, showing concepts and scientific evidence. Religious people have lower overall mortality and cardiovascular disease, lower hypertension, less depression, lower rates of interleukin-6 and cortisol. Patients want the spiritual aspects to be addressed in coping with the disease, even though there are barriers in the practical approach.

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INTRODUCTION

The connection between medicine and spirituality comes from antiquity, as the link between the doctor's day and the honorable Saint Luke, entitled as doctor of men and souls (LUCCHETTI *ET AL* 2010). However, as time went by, science and religion were separated, with a negative effect attributed to religiosity / spirituality in clinical practice, mainly in the field of mental health. Religion was neglected, considered something separate from physical and mental health, and was often considered as part of the pathology, relating it to various psychopathies (SIMS, 1994). Such theories were disseminated without a concrete epidemiological basis, only with personal opinions (STROPPA, 2008). In the last decades, there have been numerous researches on the relationship between spirituality and health, seeking to assess how beliefs and behaviors interfere in the health-disease process. Saad *et al* (2001), named it as evidence-based spirituality.

The concept of health proposed by the World Health Organization is multidimensional and spirituality is part of it (WHO, 1998). Currently, there is a premise in medical schools, worldwide, of the introduction of disciplines aimed at the theme spirituality / religiosity, with the aim of promoting the training of professionals with a broader and more humanized perception of the theme (REGIANATTO 2016).
This article aims to study the relationship between religiosity / spirituality in physical and mental health, through a literature review, explaining the need for applicability in medical practice.

CONCEPTS

It is necessary to understand that religion is an organized system of beliefs, rituals, symbols and practices, which facilitate the connection with the sacred. Religiosity is how much the individual believes and practices the chosen religion. Spirituality, in turn, is linked to a personal search to understand the meaning of life, the relationship with the

sacred, which may or may not lead to religion (KOENIG *et al*, 2001). Spirituality is not necessarily linked to a specific religious faith or deity. In the United States, for example, people define themselves more and more as spiritual and not as religious (SHREVE-NEIGER, EDELSTEIN, 2004).

CLINICAL EVIDENCE: The influence of religiosity / spirituality has demonstrated, at the academic level, impacts on various aspects of health, related to treatment, prevention and even mortality (DA CUNHA, SCORSOLINI-COMIN 2019). In one study, analyzing the mortality rate from cardiovascular causes, with 21,204 cases, it was concluded that non-religious people had 1.87 times the risk of death compared to people who attended religious institutions (HUMMER *et al* 1999). In another study, entitled Third National Health and Nutrition Examination Survey (NHANES III), with 14,475 people, the blood pressure measurements of groups that attended and did not attend religious services were compared, concluding that more religious patients had lower levels of blood pressure (GILLUN, INGRAM, 2006). These results may be related to aspects involving the religious lifestyle, such as food care practices and social activities. However, this relationship should not be considered absolute: in a meta-analysis comprising 91 studies, it showed that religiosity / spirituality was associated with reduced mortality in general, regardless of acquired behavioral factors (smoking, drinking, exercising and socioeconomic status), affection negative and social support, organizational activity, such as attending groups, churches (CHIDA *et al*, 2009).

Regarding the endocrine system, a study was carried out with 60 people aged 17 to 39 years, submitted to a stress test, and basal cortisol measurement of salivary samples before and after the task. People with higher scores related to religiosity and spirituality showed lower cortisol responses, supporting potential physiological mechanisms as a link between religious and spiritual factors and health (TARTARO, 2005). Another study related to cortisol, was carried out with 264 HIV-positive patients, relating to symptoms of depression. Religious practice was associated with lower rates of cortisol and depressive symptoms (CARRICO *et al*, 2006). Regarding depression, there are more studies: a review with analysis of 147 studies that performed a correlation between religiosity and depressive symptoms, showed that greater religiosity was slightly associated with less depressive symptoms (SMITH *et al*, 2003). This fact is also linked to the issue of suicide: people with affected mental health constitute a population at risk for suicide. Rasic *et al* (2009) showed that the population that attended religious communities, at least once a year, had fewer occurrences of suicide attempts (RASIC *et al*, 2009). Depressive conditions are at increased risk in people with cancer and other chronic conditions. A study of 100 patients with gynecological cancer concluded that spirituality and spiritual coping are important and that health professionals should consider these issues (BOSCAGLIA *et al*, 2005).

In the immune system, religiosity / spirituality has been associated with lower levels of interleukin (IL-6). IL-6 is a multifunctional cytokine that plays a role in the pathogenesis of diseases such as osteoporosis, coronary heart disease, sarcopenia. IL-6 increases with age, and high dosage is related to higher mortality. A study of 557 people aged 65 to 89, looking at the relationship between religious attendance and IL-6 levels and mortality rates, comparing people who never went to church versus those who went more than once a week, found significant associations, showing lower levels of IL-6 and lower mortality rates among those who visit religious temples (LUTGENDORF 2004). Studies were also carried out with measures of C-reactive protein, related to inflammatory processes, which were shown to be lower in spiritualized people (KING, 2002). In another study that evaluated the religiosity / spirituality of 100 patients after being diagnosed with HIV, following up for 4 years, found that 45% increased religious practices, concluding that the change in the practice of religious activities was a predictive factor for reducing viral load and increasing of CD4, regardless of the type of religious practice, medications used, sex, age and acquired life habits (CARRICO 2006).

QUALITY OF LIFE: There are studies that analyze the relationship between quality of life and religious / spiritual variables. The field of quality of life encompasses and transcends the health field, involving broader and multidimensional aspects. The evaluation has been positive, showing that religious organizations contribute to integration and interpersonal relationships. Religious principles usually attract people who are willing to be happy, and religion can explain a purpose in life, promoting well-being. Another variable related to quality of life is religious / spiritual coping, religion / spirituality is used to deal with stress, daily problems, the process of illness and grief, allowing a way to understand, accept and face the imposed situation. (PANZINI, 2007; DA CUNHA, SCORSOLINI-COMIN 2019).

PRACTICAL APPROACH: The American Psychiatric Association, (2014) recognizes that religious and / or spiritual issues are part of the context of clinical practice and can be the focus of consultation and treatment. The barriers interposed by the vast majority of professionals to approach spirituality are related to the lack of knowledge of the theme, discomfort and fear of addressing, in addition to the unequivocal judgment that this approach is not the role of the health professional. (LUCCHETTI *et al*, 2010) Mental health is closely linked to the process of coping with the disease, mainly because the spiritually ill person has more resources to cope with stressful situations, a less anxious and more adaptive act (KOENIN, 2012). To address spirituality, researchers have created instruments that facilitate clinical practice, which can be used at the time of anamnesis (LUCCHETTI, 2010, KOENIG 2005). The approach with validated instruments tends to become more natural, pleasant. When patients are not religious, the focus should be on how the patient lives with the disease, what the meaning and purpose he believes (STROPPA, 2008). In addition, true listening and understanding the patient's needs improve the professional-patient relationship. The patient's religious / spiritual dimension is part of professional practice in the context of therapy (DA CUNHA, SCORSOLINI-COMIN 2019).

The Association of American Medical College argues that in academic medical education there is a beneficial confrontation of religiosity / spirituality in medical practice, making the study and understanding of spirituality a health-related factor. Spirituality, cultural beliefs must be incorporated into the patient care plan, explaining the perception of the health-disease process and in interpersonal interactions (REGIANATTO 2016). Studies have shown that patients report feeling more confident in the doctor they address about religion / spirituality (MCCORD *et al* 2004).

Thus, this academic development is necessary, resolving the difficulties and unknowns of how to proceed in the face of possible clashes between the conception of the professional and the patient on the theme of religiosity / spirituality. The insertion of the theme since graduation allows natural familiarity with the theme, with less inconvenience and prejudice when exercising in practice (DA CUNHA, SCORSOLINI-COMIN 2019).

NEGATIVE EFFECTS: Despite so many positive effects addressed, it should be noted that there are negative effects related to religiosity. Situations that can lead the patient to feel "punished", and make it difficult to deal with the disease. In other cases, it can lead to refusal, non-acceptance of the clinical picture, leading the patient to deny formal treatments to the detriment of "spiritual healing", in addition to situations of neglect for placing belief as the only solution to the disease, disregarding scientific knowledge (KOENIG 2005, LUCHECT ET ELA 2010).

CONCLUSION

Nowadays, there is a greater relationship between health and religiosity / spirituality. There is a wide field of consistent investigation, reporting the connection with the sacred and the improvement of physical and mental health. Scientific knowledge complements clinical practice, avoiding conflicts in the doctor-patient relationship and optimizing treatment. There is an urgent need to raise the professionals' awareness of an integrative and humanized view of the health-disease process, with the aim of better therapeutic intervention.

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