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SPIRITUALITY AND HEALTH AND THE IMPACTS ON CLINICAL PRACTICE: STATE OF THE ART[1]

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ABSTRACT

Spirituality, historically neglected in medical practice, has been gaining ground in scientific discussions due to its positive impact on physical and mental health. This review aims to analyze the scientific evidence on the relationship between spirituality/religiosity and health, with a focus on clinical practice. Articles, dissertations and documents from international organizations were reviewed. Studies indicate that spirituality contributes to well-being, quality of life, and adherence to treatment, especially in patients with chronic diseases such as cancer and cardiovascular disease. It is concluded that the spiritual approach should be considered in medical care, respecting individual beliefs, and integrated with professional training.

Keywords: Spirituality. Mental health. Quality of life. Religiousness. Evidence-based medicine.

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INTRODUCTION

The World Health Organization (WHO), in 1946, defined health as a state of complete physical, mental and social well-being, and not just the absence of disease (FLECK, 2000). Over time, it was recognized that this definition lacked a fundamental dimension of human experience: spirituality. In 1984, the WHO began to consider spiritual well-being as part of the state of health, later including it in the quality of life assessment instrument (WHOQOL) (PANZINI et al., 2011). Despite this, traditional medical practice still tends to neglect non-physical aspects of existence, such as personal beliefs, values, and meanings. Spirituality has come to be recognized as an element capable of influencing the health-disease process, therapeutic adherence, coping with suffering and clinical outcomes in various medical specialties (COLINA; PARGAMENT, 2003).

In recent decades, several studies have shown a positive association between spirituality/religiosity and physical and mental health indicators. More spiritual patients, for example, have a lower prevalence of depression, greater adherence to treatment, and better perception of quality of life (MIRANDA et al., 2015; PANZINI et al., 2007). In the field of cardiology, a reduction in mortality and cardiovascular events was observed among those who regularly practice religious activities (LUCCHETTI et al., 2011). In oncology, spirituality has been associated with reframing the disease, overcoming the fear of death, and improving the response to treatment (TOLOI et al., 2022). Even so, many health professionals report not addressing the topic due to lack of preparation, fear of imposing personal beliefs, or time constraints (NOGUEIRA et al., 2024; OLIVE TREE; PETEET, 2021).

Spirituality, although subjective and multifaceted, should not be confused exclusively with religiosity. It concerns the individual search for purpose, connection and meaning in life, which may or may not be linked to an institutionalized faith (COLINA; PARGAMENT, 2003). Religiosity, in turn, involves practices, rituals, and beliefs shared by organized communities. Both dimensions, however, influence the way individuals perceive, cope and elaborate the experience of falling ill. In an increasingly patient-centered clinical setting, it is imperative to recognize and integrate these dimensions into care, especially in contexts of suffering, chronicity, terminality, and psychosocial vulnerability.

In Brazil, a country of wide religious diversity and where more than 90% of the population declares itself to be a believer in some faith, the inclusion of spirituality in medical training and clinical practice represents a challenge and, at the same time, an

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opportunity (FORTI et al., 2020). The construction of a more ethical, empathetic, and humanized care involves the recognition of spirituality as a resource for coping with and promoting health (SILVA, 2021). In addition, considering the spiritual aspects of patients favors a holistic approach, which respects the integrality of the human being. Thus, it is essential that health professionals are prepared to identify, welcome and, when necessary, forward spiritual demands, always in an ethical, respectful and individual-centered manner.

METHODOLOGY

This is a narrative literature review. Scientific articles, dissertations, theses, and documents from international organizations published between 1980 and 2024 were used. The databases used included SciELO, PubMed, LILACS, and BIREME, with the descriptors: "spirituality", "religiosity", "health", "quality of life", and "medical practice". Studies focusing on adult and adolescent patients in clinical settings were included. The selection considered studies that related spirituality/religiosity with physical and mental health outcomes.

RESULTS AND DISCUSSION

The results found reveal a significant association between spirituality/religiosity and physical and mental health. In several populations, including patients with cancer, cardiovascular diseases and adolescents with malformations, spirituality has been shown to be an important protective factor, associated with reduced depression, greater psychological well-being and better adherence to treatment. Patients with greater spiritual involvement had lower levels of cortisol and inflammatory markers, such as C-reactive protein (CRP), and better indicators of quality of life, especially in advanced stages of the disease. Spirituality has also been shown to be relevant in cardiac rehabilitation contexts, being associated with reduced blood pressure and all-cause mortality.

Studies carried out with physicians reveal a positive perception of the importance of the topic, although many report difficulties in addressing it due to the lack of preparation during academic training. Instruments such as the Duke Religiosity Index (P-DUREL) and the Scale of Attitudes Related to Spirituality (ARES) were presented as valid tools for measuring spirituality in the Brazilian context. In addition, spirituality was perceived as promoting empathy and bonding between doctor and patient, contributing to a more

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humanized care. Studies with adolescents with cleft lip and palate have shown that spirituality can positively influence self-esteem and psychosocial adaptation.

It was also observed that patients with well-structured religious beliefs cope better with illness, presenting greater resilience, hope, and less existential suffering. However, when misinterpreted, such beliefs can also generate feelings of guilt or withdrawal from conventional treatment. Spirituality, therefore, must be approached with sensitivity, respecting the ethical limits and beliefs of each patient. The inclusion of this theme in curricular guidelines and health training programs is fundamental for the construction of comprehensive, evidence-based and person-centered care.

FINAL CONSIDERATIONS

The present review reinforces the relevance of spirituality as an essential dimension in health care. Scientific evidence indicates that more spiritual patients have better physical and mental health indicators, greater adherence to treatment, better quality of life and greater resilience in the face of situations of suffering and disease. Spirituality also contributes to strengthening the doctor-patient bond, promoting empathy, welcoming, and a more humanized approach.

Despite the proven benefits, institutional initiatives to incorporate spirituality into clinical practice are still scarce. Barriers such as the absence of specific training, the fear of exceeding ethical limits and lack of time are frequently pointed out by health professionals. In view of this, it is essential to include content on spirituality in the curricula of medical schools and in residency programs, training professionals to carry out respectful, ethical and evidence-based approaches.

The recognition of spirituality as a legitimate component of the health-disease process requires overcoming reductionist paradigms and valuing comprehensive care for human beings. Spirituality is not restricted to institutional religious practices, but encompasses subjective dimensions that give meaning to life and the experience of falling ill. Their inclusion in medical practice should not be seen as a differential, but as a necessity to ensure person-centered care.

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DEDICATION

To my children, Maria Helena and João Pedro, for their unconditional love and reasons for my existence. To my husband, Rafael for the love, support, gratitude and for cheering for me. To my sister Geylene, for her help and support, which facilitated and expanded my access to scientific literature. To my parents, Lúcia and Teomir, and my brother Teolúcio, who helped me in my personal journey and for support. To Dr. Igor Marcelo, doctor and advisor, for helping me, encouraging and complementing my professional growth and specialization. And also to God who is my source of faith and support, for a long time has been guiding, helping and blessing me throughout my life and journey in a broad way.

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