

# Spirituality of relatives of patients hospitalized in intensive care unit

Espiritualidade dos familiares de pacientes internados em unidade de terapia intensiva

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## Keywords

Nursing; Nursing research; Nursing care; Spirituality; Stress, psychological

## Descritores

Enfermagem; Pesquisa em enfermagem; Cuidados de enfermagem; Espiritualidade; Estresse psicológico

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## Abstract

**Objective:** To assess spiritual/religious coping (SRC) of relatives of patients hospitalized in the Intensive Care Unit of two hospitals.

**Methods:** Quantitative descriptive study. Data were collected from 45 family members (80% female and 20% male, mean age 37.5 years) using a questionnaire for sample characterization and SRCOPE scale.

**Results:** The value of total SRCOPE scale obtained was 3.4 showing that the family participants mean made use of SRC strategies. Regarding the value of the ratio negative SRC/positive SRC, the mean value was 0.7, demonstrating that the positive SRC strategies were used more often.

**Conclusion:** Family members use positive SRC strategies more than negative during the hospitalization of a family member in the ICU, they all believe in God and most believe that spirituality has helped them to cope with the stress of hospitalization.

## Resumo

**Objetivo:** Avaliar o *coping* religioso/espiritual (CRE) dos familiares de pacientes internados em Unidade de Terapia Intensiva de duas instituições hospitalares.

**Métodos:** Estudo descritivo quantitativo. Os dados foram coletados de 45 familiares (80% do sexo feminino e 20% do sexo masculino com idade média de 37,5 anos) por meio de um questionário de caracterização da amostra e da Escala CRE.

**Resultados:** O valor do CRE total obtido foi de 3,4 mostrando que os familiares participantes fizeram uso médio de estratégias de CRE. Em relação ao valor da razão CRE negativo/CRE positivo, o valor médio encontrado foi 0,7, demonstrando que as estratégias de CRE positivas foram mais utilizadas.

**Conclusão:** Os familiares utilizam estratégias de CRE positivas mais do que negativas durante o processo de hospitalização de um familiar em UTI, todos eles acreditam em Deus e a maioria crê que a espiritualidade tem ajudado a enfrentar o estresse da hospitalização.

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## Introduction

The term spirituality derives from the Latin *spiritus* which means “the essential part of the person that controls the mind and body,” everything that brings meaning and purpose to people’s lives.<sup>(1)</sup> Therefore, spirituality refers to a matter of personal nature: response to fundamental aspects of life, relationship with the sacred or transcendent and may (or may not) lead to the development of religious rituals and the formation of communities.<sup>(2)</sup>

Religion is a belief in the supernatural or in a divine force that has power over the universe and leads to worship and obedience through a comprehensive code of ethics and philosophy.<sup>(3)</sup> It is an organized system of beliefs, practices, rituals and symbols designated to facilitate access to the sacred, the transcendent (God, Majeure Force, Supreme Truth). It involves how much an individual believes, follows and practices a religion. It can be organizational (participation in church or house of worship) or non-organizational (pray, read books, watch religious programs on television).<sup>(4)</sup>

Spirituality is a broader concept than religion. One does not need to belong to an organized religion to achieve spirituality,<sup>(5)</sup> because it refers to questions of meaning of his/her own life and reason to live, regardless of religious beliefs and practices.<sup>(5)</sup>

Spirituality can be an important aspect for those who experience a serious illness in the Intensive Care Unit (ICU) or is near death, because it helps coping and accepting pain and suffering in printing some meaning to them. A good relationship with God or a belief in a higher power allows the patient and their family the understanding and acceptance of human suffering, regardless of professed religious belief.<sup>(6,7)</sup>

Religion and spirituality may be present during a situation of hospitalization in an ICU due to fear of the unknown and the outcome. The mechanisms used to cope can manifest themselves through gestures, words or religious accessories such as: the rosary and bible. However, questions arise as to the positive or negative aspect used in this process, for example, do family members use spirituality/religion as a form of support or the blame for what is happening?

The process of facing or coping can be described as a situational process, a set of strategies used by people to adapt to stressful or adverse circumstances. The stress stimuli is any response involving a spontaneous emotional or behavioral response. The aim of coping constitutes in the intention of a response, usually, aimed at reducing stress.<sup>(8)</sup>

The Spiritual/Religious coping (SRC) is defined as the use of religious beliefs and behaviors that seek to facilitate troubleshooting, prevent or alleviate the negative emotional consequences.<sup>(9)</sup> Four assumptions support this concept: the existence of threat, harm or challenge; assessment that the person makes of the situation; available resources to cope with stress and responsibility when dealing with certain experience.<sup>(10)</sup>

The quality of life of individuals is directly affected either by the positivespiritual/religious coping (PSRC) or by negative (NSRC).<sup>(11)</sup> When it involves strategies that provide positive and beneficial effect to the individual, which may involve an expression of spirituality, a securespiritual relationship connection with God and with others, and therefore result in better quality of life. On the other handthe NSRCresultsin strategies that generate harmful consequences to the individual, such as questioning the existence, love or acts of God, delegating toGod the resolution of the problems, feeling dissatisfaction or discontent towards God or patrons and members of religious institution, redefining the stressor as divine punishment or evil forces, bringing lower rates of quality of life as a result.<sup>(12,13)</sup>

In the search for answers is the applicability of this research, it would be important that nurses could identify the type of coping used by family members of ICU patients and then start planning the care, (re)thinking the care of an expanded form, seeking to include spirituality as an element inherent to treatment and inserting the family in this context. Give spiritual assistance can be complex, so only identify spiritual needs and refer to the religious leaders present in hospitals can be a first step to a humanized and individualized assistance to these family members.

Recognizing faith and spiritual dimension in the process of recovery and facing the disease

will create a new social and cultural paradigm in nursing care.<sup>(14)</sup> The objective of this study was to evaluate the Spiritual/Religious coping of family members of patients in two intensive care units.

## Methods

A descriptive study conducted in two institutions: Charity Hospital Saint Vincent de Paul (HCSVP), a public institution located in Jundiaí and Hospital SEPACO (Social Service of Paper, Cardboard and Cork Industry of the São Paulo State), a private institution located in the capital.

In total, 45 families participated in the research and they were selected by non-probability sampling and convenience.

Inclusion criteria were: family kinship with first or second kinship degree of ICU patients; adults aged greater than 18 years and less than or equal to 65 years; to be present at the time of the visit at the time of data collection and family members of patients between the fifth and 30<sup>th</sup> day of hospitalization, ie, at the critical moment of stress and change. This period was chosen because at the beginning of hospitalization anxiety and coping mechanisms have not been triggered yet and after this period there may be adaptation of the individual.

There are three phases described in the manifestation of stress: acute reaction or alarm, which is triggered whenever our brain, independent of our will, interprets a situation as threatening; resistance phase that occurs when tension builds up and there are fluctuations in the habitual way of the individual being; and the exhaustion phase in which there is a sharp drop of the defense mechanisms of the individual. Thereafter, there may be a period of adaptation to the new situation.<sup>(15)</sup>

The exclusion criterion was elderly relatives aged greater than 65 years because of the possibility of cognitive difficulty to answer the questions of the study.

Data collection occurred between the months of August and September 2010 and the study met the national and international ethical

standards. Data were collected by the authors during hospital visits and at the end of the visit they responded to Spiritual/Religious Coping Scale (SRCOPE Scale).

Before that, a questionnaire with demographic, socioeconomic, religious and health data was applied, it has 23 questions, developed and tested in the first stage of the validation study of SRCOPE Scale to characterize the population being studied. They were then applied to Spiritual/Religious Coping Scale (SRCOPE Scale) adapted and validated in Brazil with excellent internal consistency index (0.97) of the North American Religious Coping Scale (RCOPE).<sup>(10,13)</sup>

The Spiritual/Religious Coping Scale<sup>(10)</sup> comprises the SRC strategies, divided into positive strategies (PSRC) with 66 items grouped into eight positive factors, and negative factors coping strategies (NSRC) with 21 items grouped into four negative factors, a total of 87 questions. The answers vary in intervals of five Likert, (1) “not important” (2) “somewhat important” (3) “indifferent” (4) “important” and (5) “very important” and the higher the numerical value, the greater use of spiritual/religious coping. The use of SRC may be assessed by the levels of scale scores classified as: “no or negligible”: 1.00 to 1.50, “low”: 1.51 to 2.50; “average”: 2.51 to 3.50, “high”: 3.51 to 4.50 and “very high”: 4.51 to 5.00.

To achieve the goal, the following sentence on the scale was replaced “at this time, think about the most stressful situation you have experienced in the last three years,” for “at the moment, think of the stress you are experiencing in this hospitalization situation of a family member in Intensive Care Unit.” This replacement was needed for the family focusing referring to the situation experienced having a family in the ICU and the spiritual/religious coping mechanisms involved in this process.

After data collection, the data were stored in a spreadsheet (Excel<sup>®</sup>) and analysis was performed using descriptive statistics (mean, median, standard deviation).

The study followed the development of national and international standards of ethics in research involving humans.

## Results

Among the 45 family members, 36 (80%) were female, mean age was 37.5 years (standard deviation  $\pm$  13.7), 16 (35.6%) had completed high school, 17 (37.8%) reported monthly income of up to five minimum wages, and 21 (46.7%) were married.

All believed in God ( $n = 45$ , 100%), the majority have always believed ( $n = 41$ , 91.1%), were catholic ( $n = 29$ , 64.4%) and have never changed their religion ( $n = 36$ , 80%).

Regarding the importance and frequency of religion in one's life, 19 (42.2%) of the relatives thought that religion is important to deal with stress, 31 (68.9%) said religion is very important in their lives in general, 11 (24.4%) attend religious meetings once a week and 14 (31.1%) stated that they engage into private religious activities more than once a day.

Most families ( $n = 25$ , 55.6%) believe that spirituality/religion has helped in managing to cope with stress, 20 (44.4%) reported that identify in themselves spiritual growth, 20 (44.4%) said they had grown very close to God and 14 (31.1%) reported to be growing by the religious institution.

The scores and domains in relation to Spiritual/religious coping were calculated according to the method proposed by the Brazilian validation study of SRCOPE Scale (Table 1).<sup>(10)</sup>

The total SRC in this research had a mean of 3.4 ( $\pm$  0.3 standard deviation) showing that family member-participants made mean use of general SRC strategies.

The PSRC dimension, the mean value found in the responses was 2.7 ( $\pm$  0.8 standard deviation), that is, mean usage PSRC strategies and the NSRC dimension, and the size was found to be 1.9 ( $\pm$  0.6 standard deviation), low use of NSRC strategies. The ratio NSRC/PSRC was 0.7 ( $\pm$  0.2 SD) and by having a low value, it is considered that relatives of this research made greater use of positive SRC strategies than negative.

Among the means achieved by SRC positive factors, the dimensions that showed high values were the factor (P4) "Positive position towards God" ( $3.5 \pm 0.6$  standard deviation), the factor (P8) "Distancing through God, religion and/or spirituality" ( $3, 2 \pm 1.0$  SD) and factor (P1) "Transformation of oneself and/or one's life" ( $3.0 \pm 1.0$  standard deviation), respectively.

**Table 1.** Spiritual/religious coping of patients family members hospitalized in ICU

Total SRC	Mean	Standard deviation	Median	Minimum	Maximum
Positive SRC	3.4	0.3	3.4	2.6	4.1
Negative SRC	2.7	0.8	2.7	1.4	4.5
NSRC/PSRC Ratio	1.9	0.6	1.7	1.1	3.4
Positive Factors (P)	0.7	0.2	0.7	0.4	1.4
(P1) Transformation of oneself and/or one's life					
(P2) Actions in search of spiritual help	3.0	1.0	3.1	1.3	4.8
(P3) Offering help to the other person	2.2	1.0	1.9	1.0	4.3
(P4) Positive position towards God	2.5	1.1	2.4	1.0	4.6
(P5) Personal search for spiritual knowledge	3.5	0.6	3.7	1.9	4.3
(P6) Actions in search of the institution	2.8	1.0	2.8	1.2	5.0
(P7) Personal search for spiritual knowledge	2.4	1.1	2.1	1.0	5.0
(P8) Distancing through God, religion and/or spirituality	1.8	0.9	1.6	1.0	5.0
Negative Factors (N)	3.2	1.0	3.3	1.2	4.8
(N1) Negative reassessment of God					
(N2) Negative position towards God	1.6	0.8	1.3	1.0	4.4
(N3) Negative reassessment of the meaning	2.7	0.9	2.8	1.3	5.0
(N4) Dissatisfaction with the institutional other	1.7	0.8	1.2	0.8	3.8
(N4) Insatisfação com o outro institucional	1.5	0.5	1.3	1.0	3.0

The factor P4 “Positive position towards God” is described as any behavior that SRC exposes a personal position before God about the situation and sets limits and seeks religious support in God. The factor P8 “Distancing through God, religion and/or spirituality” indicates a change in personal perspective regarding the situation in which the person moves away from the approaching problem of God and/or issues of spiritual/religious. The factor P1 “Transformation of oneself and/or one’s life” relates to the entire SRC behavior that brings about a personal transformation, whether it is a person’s own internal modification to the practice and/or a change in your external life.<sup>(10)</sup>

In terms of mean achieved by NSRC factors, the dimension with the highest mean value was (N2) “Negative position towards God” ( $2.7 \pm 0.9$  standard deviation). This factor describes the entire SRC behavior in which a person seeks or simply wait for God to take control of the situation and blame this entity for resolving it, without their individual participation.<sup>(10)</sup>

## Discussion

The SRCOPEScale was not designed to analyze the Spiritual/religious coping of a specific situation, this is a limitation of the study. Having a family member in an intensive care unit can be experienced in different ways and with different perspectives; in addition, the severity of the hospitalized patient can influence the outcome.

However, the results of this study suggest that meaningful inferences can assist nurses in care of this issue which is so important to the care of the patient and his/her family: spirituality. Family members use more positive SRC strategies than negative during the hospitalization of a loved one in an ICU, seeking support in spirituality, away from the problem, approaching God and reaching personal transformation through experience. Therefore, one may consider that spirituality in this clinical situation produces beneficial and positive effects to the participant and therefore may result in a better quality of life and well-being of the family.

The hospitalization of a loved one can generate a situation of extreme and deep stress in family members and it would be interesting that nurses could identify this need for care. Despite the growing importance of the theme of spirituality in health, considering the increased number of studies in relation to spirituality and due to two nursing diagnoses in this area are contained in the North American Nursing Diagnosis Association,<sup>(16)</sup> “Impaired Religiosity” and “Spiritual Suffering”. Unfortunately, in clinical practice patients and families related to religiosity and spirituality are poorly attended.

Factors that showed higher mean values in this study refer to Search in God the support, moves away from the problem by approaching God, personal transformation and expects God to control and resolve the situation. Factors that demonstrate that the individual seeks a divine solution and not necessarily rational in this situation of a family member illness. Personal transformation can represent a quest for greater intimacy with God and recognition of the importance of spirituality in one’s life to support and accept the possible outcomes. The questions that arise when the individual is faced with the imminent death of a loved one, for which we are hardly promptly prepared.

Studies<sup>(11,14,17)</sup> were performed to evaluate the Spiritual/religious coping in different clinical situations and illness. The SRC has been studied in men with HIV/AIDS belonging to Catholic ( $n = 50$ ) and evangelical ( $n = 30$ ) religions.<sup>(11)</sup> SRCOPE Brief-Scale was applied, and the main coping strategies were presented by subject analyzed and compared between groups of Catholics and evangelicals. The overall SRC index was 3.67 among Catholics and 3.64 among evangelicals, which demonstrates the practical use of SRC in both groups. The factor that most Catholics and evangelicals used was “Positive position towards God” (P4). Already the most negative factor used by the two groups was “Negative position towards God” (N2). Comparing groups, the differences in PSRC factor, “Transformation of oneself and/or one’s life” (P1), “Actions in search of the institution” (P6) and “Personal search for spiritual knowledge” (P7) were statistically more common in evangelical. Among the NSRC strategies,

the factors “Negative position towards God” (N2) and “Negative reassessment of the meaning” (N3) had statistically significant differences, also more common among evangelicals.

The objective of another study was to evaluate the association of SRC in quality of life related to health of 55 patients in preoperative surgery for head and neck cancer.<sup>(14)</sup> For this, the authors used the Functional Assessment Cancer Therapy-Head and Neck (FACTH & N) and the SRCOPE Scale. All participants believed in God, and most of them considered themselves Catholics (87.3%). The total SRC was 3.61. The NSRC/PSRC ratio was 0.6, indicating greater use of positive SRC strategies than negative. The factor “Positive position towards God” (P4) had the highest mean (3.92) among other PSRC factors. Considering the NSRC factors mean, the size with the highest mean value was “Negative position towards God” (N2) (2.62). Although it is possible to deduce a correlation between HRQOL and SRC constructs, it was not detected an association between the SRCOPE Scale and FACT-H & N Scale. Nevertheless, no statistically significant difference between correlations to those with high and medium Total SRC on SRCOPE Scale and the high and low scores in the areas of instrument FACT-H & N, indicating that one who has a high use of religious coping, spiritual presents best rates in the areas of quality of life related to health.

The SRCOPE Scale was applied to 30 volunteers (15 female and 15 male) undergoing cancer treatment.<sup>(17)</sup> Positive and negative SRC patterns for men and women were compared. The results showed increased use of strategies for PSRC (Mean = 3.51) than for NSRC (Mean = 2.17), there were no statistically significant differences between positive and negative mean regarding gender ( $p = 0.9$  for PSRC  $p = 0.19$  for NSRC).

Comparing these described researches<sup>(11,14,17)</sup> with our current research, it was found that the mean use of strategies of total SRC found in this investigation differs from above using total SRC found in other situations: patients with HIV/AIDS,<sup>(11)</sup> patients in the preoperative surgery for head and neck cancer<sup>(14)</sup> and patients undergoing cancer treatment.<sup>(17)</sup> In the results, this difference may be related to

the data collection period and the period required so that the coping mechanism is triggered. Nonetheless, the similarity is that subjects make more use of PSRC strategies, or use faith and belief in God to deal with a stressful situation related to health. In addition, the more used PSRC and NSRC factors in these studies were the same as in our study: P4 and N2. The results found reveals an apparent conflict, at the same time that people positively seek God for support in these crisis situations, they expect God to take control and be accountable for solving problems without the participation of the individual.

Some situations seem to refer more easily to spiritual matters. Cancer and spirituality were also studied in other studies. Strategies of the positive use of faith and spirituality play an important role demonstrated by recently diagnosed 155 women with breast cancer adaptation process after surgery. Feelings of abandonment by God and punishment was a negative coping feeling and they were found responsible for the increased level of anxiety. However, the acceptance of suffering and the use of faith decreased anxiety in these patients.<sup>(18)</sup>

In another study, the anxiety level assessed by the Trait Anxiety Inventory-State Scale was correlated with the religiousness of Personal and Rotterdam Symptom Checklist in 180 women with breast cancer.<sup>(19)</sup> The results showed that: religiosity is a factor for effectively coping and dealing with the anxiety of patients with terminal breast cancer, the stage of cancer is a differentiating factor compared to levels of anxiety revealed in the subjects studied; exacerbation of somatic symptoms did not influence the level of anxiety in terminal cancer patients and diseases without period.

The issue of chemical dependency, perhaps due to the impotence that addicts feel about the addiction, is also a situation in which spirituality can be used. The influence of religiosity and spirituality in the recovery of ten addicts was investigated in abstinence and in recovery process.<sup>(20)</sup> The results showed that seven workers attributed to religion/spirituality as a main factor to reach and remain abstinent. In addition, eight respondents cited pursue religion and spirituality develop at a more critical and more involved with alcohol/other drugs.

In a research, relatives of patients with alterations of consciousness in the ICU recorded messages. Transcription and analysis of those messages showed the category “Searching for spiritual support to overcome difficulties”<sup>(21)</sup>. Regardless of religion, the family demonstrated that they seek for spiritual support in times of uncertainty and insecurity. In the messages assessed, there was a strong expression of religiosity; words such as God, Jesus and prayer were very present in almost every speech. This spiritual attachment to this situation of having a loved one hospitalized in an ICU is often related to the need not to lose hope, the proposed changes, the promises and waiting for a miracle.

Spirituality is an important part of life for many people and cannot be neglected in the therapeutic context and should be more closely explored by health professionals who should help identify the potential of faith (positive SRC) as well as losses (negative SRC)<sup>(17)</sup>.

Health professionals, based on science and individualized care, should be concerned with the actual insertion of spiritual care in routine care, allowing academic discussions to enhance practices, aiming the wellbeing of those who need care right now, noting that, in this context, the family is an integral and important part in patient recovery.

The SRC strategies used may reveal some familiar feelings of stress experienced in that situation, and when identified, and when disclosed, these feelings can be helpful in the recovery process of the patient so that the family member does not get worse, which can be minimized with the help of the nurse, the depression, anxiety and stress, so common feelings in these crisis situations.

## Conclusion

Family members use more positive SRC strategies than negative ones during the hospitalization of a family member in the ICU, they all believe in God and most of them believe that spirituality has helped them to deal with the stress of hospitalization.

## Contribution

Schleder LP and Parejo LS participated in the project design, analysis and interpretation of data. Parejo LS; Puggina AC and Silva MJP collaborated with the writing of the article and revising it critically for important intellectual content. Puggina AC and Silva MJP stated that contributed to the final approval of the version to be published.

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