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RESEARCH

Religiosity and spirituality in the hospital treatment of addictions

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Abstract

In this qualitative research it was analyzed how the religiosity and spirituality is approached in the treatment of additions in a secular institution. Data were collected from July to September 2016 at the Unidade de Internação de Adição do Hospital de Clínicas de Porto Alegre (Addition Hospital of the Hospital de Clínicas of Porto Alegre), using data from multiple sources such as: participant observation, consultation of institutional documents and interviews with patients and professionals. The results described the approach of the religiosity and/or spirituality dimension and its significance for patients and professionals, dividing the activities between spiritual and religious approaches, which are less aligned with secularism.
Keywords: Spirituality. Substance-related disorders. Rehabilitation services.

Resumo

Religiosidade e espiritualidade no tratamento hospitalar das adições

Nesta pesquisa qualitativa analisou-se o modo como a religiosidade e a espiritualidade são abordadas no tratamento das adições em instituição laica. A coleta de dados ocorreu entre julho e setembro de 2016 na Unidade de Internação em Adição do Hospital de Clínicas de Porto Alegre. Para tanto, utilizaram-se múltiplos recursos, como observação participante, documentos institucionais e entrevistas com pacientes e profissionais. Os resultados consistem na descrição da abordagem da dimensão religiosa e espiritual e de seu significado para pacientes e profissionais, dividindo as atividades entre essas duas esferas, que são menos alinhadas ao princípio da laicidade.
Palavras-chave: Espiritualidade. Transtornos relacionados ao uso de substâncias. Serviços de reabilitação.

Resumen

Religiosidad y espiritualidad en el tratamiento hospitalario de las adiciones

En esta investigación cualitativa se analizó cómo la religiosidad y espiritualidad es abordada en el tratamiento de las adicciones en una institución laica. La recolección de datos tuvo lugar desde julio a septiembre de 2016 en la Unidad de Internación de Adição do Hospital de Clínicas de Porto Alegre (Adicción del Hospital de Clínicas de Porto Alegre), utilizando datos provenientes de múltiples fuentes como: observación participante, consulta a documentos institucionales y entrevistas con pacientes y profesionales. Los resultados describieron el abordaje de la dimensión religiosidad y espiritualidad y su significación para pacientes y profesionales, dividiéndose las actividades entre abordaje espiritual y religioso, estando éstos menos alineados con el principio de la laicidad.
Palabras clave: Espiritualidad. Trastornos relacionados con sustancias. Servicios de rehabilitación.

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Declaram não haver conflito de interesse.

Substance use disorder (SUD) is considered to be a disorder of a complex and not fully understood etiology that demands multi-professional intervention and continuous follow-up [1]. In the current scenario, research on aspects that increase the likelihood of remission of problems related to compulsive use of substances emphasize the positive influence of *religiosity and spirituality* (RS) both in the prevention and reduction of drug abuse and in the maintenance of abstinence [2-5].

These two aspects are dimensions that, although categorized together, have different meanings for some authors. Spirituality can be defined as the personal search for understanding the ultimate questions of life, its meaning and relationship to the sacred, the transcendental, without necessarily leading or giving rise to religious rituals. On the other hand, religiousness is understood as a belief that the individual practices in an organized way, by attending temples, praying and reading religious books [6].

Despite the great contribution of scientific studies supporting the benefits of RS in the treatment of SUD, in practice these dimensions are addressed almost exclusively by religious institutions. In this context, "treatments" expand in three main lines: 1) mutual aid groups in churches; 2) religious cults; and 3) therapeutic communities (TCs) with an emphasis on behavioral change based on religious support, which replaces or improves other forms of care [4,7].

In the scope of public health, the Política de Atenção Integral ao Usuário de Álcool e outras Drogas (Policy of Integral Care for the User of Alcohol and Other Drugs) [8], the regulation of the National Health Surveillance Agency (Agência Nacional de Vigilância Sanitária - ANVISA) through the Resolução da Diretoria Colegiada - RDC Anvisa 101/2001 (Resolution of the Collegiate Board of Directors) [9], as well as the effective resolution RDC Anvisa 29/2011 [10], presented very flexible criteria for regulating TC, allowing the adjustment of many of these entities, which are co-financed by the government. It is estimated that they are currently responsible for about 80% of the drug treatment capacity in Brazil [8,11].

The inclusion of TC in the service network has generated tension in some sectors, which denounce "religious treatment" (conversion offered by many TCs) as a threat to the constitutional principle of secularity. From this perspective, the transfer of resources to these institutions is seen as an easy exit that promotes the precariousness of the service to users in the public mental health network [7,12].

On the other hand, one cannot disregard the importance of the religious/spiritual dimension in the treatment of the SUD, nor the fundamental role of some TCs and other spaces of religious assistance in the singular therapeutic project of people who seek treatment. In this way, inserting into the health care services the topic of RS in the care system becomes a challenge and a necessity.

In this transposition, it is indispensable to deepen the concept of secularity in order to recognize the importance of manifesting the diversity of beliefs and religions, without interfering in state actions. Public health services, such as the Centros de Atenção Psicossocial Álcool e Drogas - Caps AD (Centers for Alcohol and Drugs Psychosocial Care), referral hospitals and other associated services that also follow the sector legislation can incorporate RS in daily interventions. However, their representatives should not express any particular creed in order to avoid coercive and discriminatory acts.

The analysis presented here is the result of the professional practice in the Serviço de Adição do Hospital de Clínicas de Porto Alegre - HCPA (Porto Alegre Clinical Hospital Addiction Service), where a final residency project (FRP) was developed to understand the religious and spiritual approach towards hospitalized patients for treatment of SUD. The research was carried out at the Addiction Inpatient Unit of the HCPA and, in addition to the above, had as an objective to know the patients' and professionals' view on the subject.

With the results of this article, it is hoped to gather data that point to a treatment model that considers the RS dimension in secular institutions, and to carry forward the discussion regarding the principle of integrality in health care.

Methodology

Data collection

This is a qualitative, descriptive research, of the case study type. The data collection took place between July and September 2016, at the Addiction Inpatient Unit of the HCPA. Multiple resources were used, such as bibliographic research, participant observation in RS-related groups, recording in field diaries, consulting institutional documents, and semi-structured interviews with patients and professionals involved in interventions related to these two aspects.

Sample

To define the sample, we used the theoretical sampling method [13], in which the number of

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participants was not defined *a priori*, but during the research. Thus, individuals were selected according to their abilities to contribute to the proposed topic. Of the ten patients and four professionals invited to collaborate, all agreed, with no refusals or dropouts. To close the sample, the theoretical saturation criterion [14] was used, that is, the inclusion of cases was interrupted when the researchers understood that there was no more new information.

The research patients were hospitalized at the unit for more than 15 days and were inserted into group activities with RS topics (dialogues and religious expressions). Those excluded from the sample had acute psychiatric symptoms, or moderate to severe cognitive deficits, which could make it impossible for them to understand the questions asked. The inclusion criteria for the professionals were that they worked in the inpatient unit and with the development of activities focused on spirituality. Professionals with an institutional affiliation shorter than six months by the time of the data collection were excluded from the sample. In data collection, we used an instrument to describe interventions and two sets of semi-structured questions for professionals and patients.

Data collection instruments

Based on closed questions, sociodemographic data (religious denomination and RS practices, as well as information on substance use), were collected. The open questions followed a semi-structured script to check if the patient had already been treated. If so, we sought to know what these other treatment venues were like and if spirituality was addressed in them. This research also sought to determine whether, and how, RS topics were discussed during hospitalization concomitant to the study, as well as whether the patient considered the spiritual dimension important for his/her recovery.

In the interview with professionals, we inquired about sociodemographic data, time worked in the institution, religious denomination, and regular religious and spiritual practices. The script of semi-structured interviews questioned whether the professional considered it important to approach spirituality to rehabilitate the patient, whether there were spaces for such practices, and what was, in his/her opinion, the best way to deal with the topic. The instruments used are listed at the end of the article. The interviews took place in the Addiction Inpatient Unit of the HCPA itself, in a private room, and had only the interviewer and interviewee present.

Data analysis

Sociodemographic and profile information of the participants were entered in an Excel spreadsheet and later transformed into graphs. The interviews were transcribed and analyzed following the method presented by Minayo [14], which suggests ten steps to structure qualitative research, culminating in the creation and interpretation of empirical categories or units of meaning that were understood, interpreted and dialectized.

Due to the limits imposed by the structure of the article, the categories and subcategories found in the interviews were grouped in two nuclei: importance of RS for treatment of SUD; and patients' and professionals' views on interventions in SR in the unit researched.

Ethical criteria

This study obeyed the ethical criteria of the Conselho Nacional de Saúde - CNS (Brazilian National Health Council), Resolution CNS 466/12 [15], being submitted and approved by the Research Ethics Committee of the HCPA. All participants were informed of the research objectives and signed a free and informed consent form.

Results

Description of the searched unit

The Unidade Álvaro Alvim (Álvaro Alvim Unit) was inaugurated in 2011, based on a project of the Secretaria Nacional de Políticas sobre Drogas - Senad (Brazilian National Secretariat for Policy on Drugs) in partnership with the HCPA. It is a referral hospital service that carries out short-term hospitalizations, with the possibility of continuing the follow-up in the Addiction Clinic located in the same place or in other mental health services in the country. It has twenty adult male beds and a multiprofessional team with more than one hundred effective members, as well as residents and trainees. Patients are referred from two psychiatric emergency units and from the Municipal Centers for Alcohol and Drugs Psychosocial Care, controlled by a central bed monitoring unit. Admission is voluntary, with more alcoholic patients than users of other substances.

The hospitalization program is divided into stages, and patient progress is measured by criteria of treatment appropriation, accountability, and understanding of the proposed topics. The routine in the unit is organized into weekly activity grids, coordinated by professionals from different fields.

There were 35 groups, with an average of five per day, nine of them related to RS topics: dialogues on spirituality (1); weekend meditation (2); study of the Twelve Steps conducted by professionals from the unit (2); meetings of religious expressions (2); Narcotic and Alcoholic Anonymous panels, which receive volunteers from the community (2).

Participant observation of the groups was part of the research, noting that the activities carried out by the professionals contemplated broader spiritual issues, such as the search for the meaning of life and self-knowledge. On the other hand, activities conducted by volunteers, such as Narcotic and Alcoholic Anonymous panels and groups of religious expressions, were directed to the exposition of concepts and practices of the entities represented by the volunteers: for example, study of the Twelve Steps, Spiritist doctrine, laying on of hands, evangelization and worship.

Respondents' profiles

The patients' ages ranged from 21 to 64 years, with an average of 49.8 years. All interviewees reported use of alcohol; two of them still associated with the use of other substances (marijuana and cocaine). Of the ten participants, eight professed religion, distributed among evangelicals (n = 4), catholics (n = 3) and spiritist (n = 1). Two denied religious affiliation, but reported regular religious/ spiritual practices, such as prayer and meditation. Only one patient, a self-styled Catholic, denied any kind of religious or spiritual practice. The others (n=9) classified as frequent their participation in religious cults, as well as reading of the bible, prayers and contemplative practices.

As for the profile of the professionals who were interviewed, there were one man and three women, aged between 31 and 55 years, all of whom were employees of the unit for four years. One of them was a nursing technician and three were nurses who had completed tertiary education. The four stated that they had a religion - catholic (1), spiritist (2) and spiritualist (1) - and that they maintained regular religious/spiritual practices, such as prayers, participation in worship, meditation, among others.

Importance of religion/spirituality in treatment

The accounts of the study patients reveals the spiritual dimension as an essential factor in their own survival, with senses and meanings related to the treatment: "*Who put me in here was God. If it were not for the will of God I would not be here, I would already be dead" (*Patient 2). They also reveal the extreme importance attached to this dimension in the maintenance of abstinence: *"When I distance myself [from religion], I fall. But when I really focus, it brings me peace, tranquility"* (Patient 2).

In the interviews with the professionals, the RS dimension was shown to have recognized therapeutic potential, not only for the spiritual contribution, but also for the psychological and moral contributions. RS is understood as *"one of the pillars that help patients to maintain hope, an internal force to overcome difficulties"* (Professional 1); and also as *"a positive instrument for the patient to have quality of life and to have fortitude in his life"* (Professional 4).

The professionals also point out that RS contributes to a greater sense of belonging, creating opportunities for social interaction and building meaningful links: *"it is not only religion, it is all the social contribution that religion gives* (...) *it is not religion, but it is a group, to have a network of people, this spirituality and religion provide plenty"* (Professional 4). This last fact appears clearly in the speech of one of the patients interviewed, who mentions an evangelical pastor as one of the most important figures in the treatment: *"The pastor has been a friend, because it is not everyone who does this, especially for an alcoholic"* (Patient 1).

Some interviewed patients understand that post-discharge religious/spiritual insertion is fundamental to recovery: *"So my plan is to establish myself in the church that I most identify with* (…) *I want to get closer to God, the church in this case is just a place for connection"* (Patient 6). Throughout the interviews, possibilities of religious insertion are outlined according to personal beliefs, as one of the professionals describes:

"In fact, what I realize regarding addiction is that people during the abstinence period had a belief, (...) then they sort of dropped out and went back to using drugs, so they are abstinent again and they want to get that back (...) It is unlikely that a person who never had [RS} and will now want it" (Professional 4).

Corroborating the professional's testimony, one of the patients reports: *"I have a cousin of mine who is a evangelical, I'm not going to go there, shoot myself and scream, this cousin of mine was totally inside out, a crook, a bad natured person; nowadays he is a pastor ... I like him a lot, but I feel better somewhere else"* (Patient 10).

From the above, it can be verified that the patients interviewed attach great importance to

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the exercise of the RS dimension, and each of them understands it according to their own concepts. They seek strength in beliefs and use them as a valuable aid to recovery and abstinence. Professionals also recognize the relevance of RS to the rehabilitation process, understanding it as a valid resource, capable of providing motivation for individuals to remain abstinent based on the construction of a social and support network.

Approach to spirituality in the Addition Unit

Of the ten interviewees, seven had already been admitted to other treatment centers for SUD and, including some of these, seven had undergone prior outpatient treatment. It can be said, therefore, that the majority were theoretically able to make comparisons and reflect on possible benefits of the current hospitalization. Thus, the intention was to evaluate if the patients recognized and understood the RS interventions offered by the program.

When asked about the RS matter in previous treatments (hospital and outpatient clinics), five reported this type of intervention in Alcoholic Anonymous meetings (n = 2), punctual actions in hospitalizations (n = 2) and services and worship in an evangelical therapeutic community (n = 1).

Regarding the opportunities to develop spirituality in the current hospitalization, all patients reported activities related to the topic: *"Yes, it is well discussed, very discussed. We have conversation circles regarding this subject. Meditation also deals very much with spirituality, a conscious contact with God"* (Patient 7). The professionals confirm the existence of these spaces and describe the activities developed: *"It is always offered. From the beginning, when the unit was opened, these spaces were created within the Twelve-Steps study groups and directed towards understanding spirituality, dialogue groups on spirituality, relaxation practices"* (Professional 1).

Both patients and professionals from the unit describe the groups as spaces for activities without discourses or practices linked to any particular belief: *"We work well on this broad issue, not on the side of religion, where we discuss some topics such as the sense and meaning of life"* (Professional 4).

The spaces for religious expression are opened through voluntary and systematic visits by representatives of religious institutions, from two to three times a week. These entities are previously registered with the HCPA and they indicate members to assist in the unit: *"We receive regular visits from religious institutions, right? We have invited some churches to come, some of them come frequently to us at the request of the patients"* (Professional 1).

During the research, teams from a Universal church and a Kardecist spiritist center were performing these activities. To participate in these activities during hospitalization, patients register their names in a book that is in the nursing station, informing their interest. Only after that are they notified of visits by the team.

The ailing evaluated this activity as positive, and some said they participated in activities of a religion other than their own: *"There are also the religious people who come here, for example... The Chico Xavier people came, the evangelicals come too. I participate in both, because they speak of God"* (Patient 2). The voluntary character is highlighted by another interviewee: *"Yesterday there was a talk about spirituality. I did not go because it was aimed at the Spiritist side, as I do not share this philosophy, I did not participate"* (Patient 6). One patient points out that religious interaction has enhanced his treatment: *"There were some people from the church here. I liked* (...) *From then on, I started to feel lighter, calmer; after these church people came, I improved 80, 90% "*(Patient 3).

Although there are appropriate spaces for religious expression, this issue often appears in groups that deal with other topics, requiring constant management by the team, who introduce explanations about the concepts of ethics, religiosity and spirituality: *"When forming discussion groups, it is always said at the outset that the discussion is independent of religion,* (...) *and yet it is difficult for them not to impart their beliefs or want the other to have the same belief, and they have already done it a lot"* (Professional 3).

This particular point appears in the interview with a Catholic patient. He reports that in a Dialogues on Spirituality group, another patient (possibly evangelical) questioned the validity of the image of Jesus Christ nailed to the cross, which provoked a confrontation: *"So I questioned this at the time, I even got to the point of becoming violent in my responses, somewhat aggressive, saying* (...) *that symbolizes a story that happened"* (Patient 5). The religious dogmatism perceptible in some discourses is reinforced by the religious interventions in the unit: *"Some church people came here. I liked.* (...) *But there were people who did not like it. Who do not like to speak about God, to speak about Jesus. But we have to somehow try to evangelize these people"* (Patient 3).

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Regarding the idea of good practices in the approach of RS in patients with SUD, we highlight the understanding of one professional who was interviewed, for whom the spiritual dimension is *"another tool of care that one can have in treating chemical dependence"* (Professional 4). In the daily life of professionals, this topic shows itself as one of the multiple dimensions that compose the universe of the patient attended, and should be treated holistically. All the patients interviewed acknowledged that there were RS activities in the studied unit, considering them part of the treatment, although only half of them had undergone such experiences in previous treatments.

The RS practices performed by professionals focus more on the concept of spirituality, while activities conducted by volunteers of religious entities focused more on religiosity. Some patients have difficulty differentiating the two concepts and the moments to express them, which requires management by the team. This difficulty, manifested by dogmatism and reinforced by visits by religious volunteers, eventually contributes to a divide between patients of different religions or those whose beliefs are not considered by these interventions. Although lay discourse prevails among professionals, the offer of activities linked to specific religions reveals incongruity, since the discourse of religious volunteers, as noted in the observed period, points to a perspective of converting others.

Discussion

The concept of secularity, in general, can be understood as the non-association of government with any type of religious faith, that is, impartiality before the diversity of beliefs, ideologies and religions. Therefore, it is not a question of opposition to practices of this nature, but rather assuming a neutral position [16]. Along this line of understanding, it is understood that the concept of secularism is opposed to the so-called State Religion, ensuring the non-favoring of any religious view, including atheism, considering that the latter assumes a characteristically religious position, even if in a negative sense [17].

Spirituality is inherent in many people - it is at the root of their identities as human beings and gives their lives meaning and purpose. Spiritual needs become particularly strong when illnesses threaten life or lifestyle [3]. Therefore, the RS approach by health professionals should take into account the history of beliefs and values of the individual under their care: 1) to engage with the religious/spiritual beliefs of their patients and understand how they view medical treatment; 2) to understand the role of religion in the face of illness or stress; 3) to identify spiritual needs that require follow-up [3].

When it comes to patients with SUD, cross-sectional studies prove the efficacy of spiritual matters in the prevention and treatment of addictive disorders, especially as a way to obtain social support and develop internal resources to maintain abstinence [4]. In addition, scientific evidence indicates that patients who are users of substances have better recovery rates when *the treatment is permeated by a spiritual approach, of any origin, when compared to patients who are treated exclusively by medical means* [18]. Thus, evidence highlights that spirituality is one of the main components of change in additive behavior [5].

Regarding the profile of the patients interviewed, most of the sample believes in some religion and engage in spiritual practices frequently. Therefore, they are people who already have a system of unique beliefs and practices. These data are similar to sociodemographic research in Brazil, which shows that 98% of the population professes religion, 64.6% are Catholics, 22.2% are Evangelicals and 2% are Spiritists. These are the three most mentioned religions, while 3% of Brazilians declare that they follow other religions [19].

It should be noted that in each religious denomination there are specific strands. The publication "New map of religions" [20], based on data from the last census of the Brazilian Institute of Geography and Statistics (IBGE), pointed to the existence of at least 25 branches within the three main denominations (Catholic, Evangelical and Spiritist), apart from other beliefs, such as Islam, Hinduism, Buddhism, which do not fall into the first three groups.

It is known that in Brazil most people *form the basis of their spiritual beliefs and values through religious choices, and sometimes there may be, on this basis, a composition of different religions and also self-knowledge practices* [21]. That is, the spiritual dimension of each subject assumes singular expressions, which may include one or more religions, or none in particular. In this sense, it is the patient's right to have his or her spiritual beliefs and values respected and integrated into care [22].

The results of the study indicate that patients hospitalized for SUD treatment: 1) have defined spiritual/religious beliefs; 2) recognize the importance of the spiritual approach to treatment; and 3) can benefit from community bonds linked to their beliefs.

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Both patients and professionals acknowledge that there are RS interventions in the unit researched and consider that they benefit from them.

As discussed earlier, spirituality differs from religiosity because it embraces broader phenomena. For clinical purposes, the focus on the first dimension is more inclusive. In the academic literature there are several definitions of "spirituality" that converge on some fundamentals: it emphasizes the meaning of life, the integration of final values and the connection with the transcendent, topics that can be treated more broadly than in the context of a specific religion [23].

The RS activities in the unit researched can be considered spaces that deal with spiritual issues in a secular way. This is done through interventions and study groups coordinated by unit professionals and volunteers from groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

However, religious groups end up contradicting the prerogatives of secular hospitals, as was verified during the research observation period. The discourse of religious volunteers reinforces dogmatism by stating that "only churches can take care of spiritual matters" and that "health services only take care of the biological part".

The offer of two religious perspectives, with different systems of moral regulation and beliefs, contributes to forming small groups, which can generate conflicts between patients. Subjects begin to affirm their beliefs in the presence of those who profess another "faith" or declare themselves atheists. In this way, "group cohesion", an essential therapeutic element for group treatment in the area of addiction, can be seriously compromised [24].

However, the dogmatism inherent in some religions can be reinforced by interventions linked to RS in the unit. For example, the presence of discourses with moral reinforcement of guilt, prejudice, stigmatization or single salvation by means of a specific belief (mistakenly identified by external religious agents as "faith") was noted, to the detriment of other actions that are part of the treatment.

Religious intervention in the treatment of substance users has been criticized by several sectors of Brazilian society. As they are inserted in the context of public health, these practices end up being seen as an imposition of religious creed and moral based therapeutic projects. At the same time, the possibility of a universal policy that would benefit the whole population is ignored [7].

In view of the results of this study, it is important that public institutions strengthen ties with affiliated entities, such as TCs and private clinics, in order to ensure the implementation of public health policy, offering secular treatment environments where interventions related to RS are regulated ethically and controlled by professionals trained to work with this dimension of health.

The observation of the Addiction Unit of the HCPA pointed to the need to expand and diversify activities that deal with patients' spiritual issues, to the detriment of group activities focused on religious beliefs in particular. These should be considered and dealt with in treatment, especially at the individual level through appropriate resources: spiritual case history and other instruments already validated and recognized for this purpose, as suggested in a recent publication by the HCPA bioethics research group [25].

Finally, the adoption of a secular perspective of spirituality in treatments depends on the qualification of the professionals involved, primarily in relation to the concept of secularity and the therapeutic possibilities of using RS in patient care. For this, other professional categories, besides nursing (which has traditionally dealt with these issues), need to study and debate the topic.

Final considerations

This study aimed to describe the approach of RS in a secular institution that offers short-term hospitalizations to users of psychoactive substances. It sought to know the vision of professionals and patients on the importance of this aspect and its interventions in the treatment of the unit. The study found that both patients and professionals recognize the relevance of RS in the recovery and maintenance of abstinence, since it allows mobilizing important internal resources such as motivation and faith, while providing opportunities to build meaningful social bonds.

The RS interventions at the place of study can be divided into those of a spiritual nature, carried out by professionals from the unit and by AA and NA volunteers, and those of a religious nature, coordinated by volunteers from two religious institutions. It is understood that patients with SUD attribute importance to RS because they know that this subject points to the meaning of life and can give moral comfort in the face of adversities and injustices of daily life. Dogmatism, in this circumstance, is well accepted by those who already profess religion, for it would emphatically point out ways to soften the

adverse situation in which the person finds himself. Thus the acceptance of dogmatic roots seems to be related to fear and uncertainty about abstinence, abandonment of addiction, and relapse.

On the one hand, the data analysis showed that the activities of religious volunteers were restricted to only two religions and did not contemplate Brazilian religious diversity. However, for those who professed these religions, the effect of the interventions was positive. It is understood, therefore, that the actions of religious volunteers, besides being the right of patients when hospitalized in a hospital environment, can be a good therapeutic resource, enhanced by the increase of individual visits from members of religious entities to which the patient belongs or that he might request, including as mobilizers of social resources after discharge.

While this article was produced, its contributions were already being problematized in the unit, which can result in changes in the organization of activities. It is suggested to expand existing secular spaces of spirituality, and to train professionals from various areas to deal with RS, which can contribute to the implementation of integral care.

The limitations of this research were the number of subjects interviewed, as well as the methodological impossibility of analyzing other variables of interest for the understanding of the phenomena studied, such as: the spirituality and health conceptions of professionals from different areas; the impact of RS interventions on recovery; religious insertion as a contributory factor in seeking treatment; religious coping, among other subjects that can be clarified in future research.

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Referências

1. National Institute on Drug Abuse. Principles of drug addiction treatment: a research-based guide. 3ª ed. Bethesda: NIH Publication; 2012.
2. Geppert C, Bogenschutz MP, Miller WR. Development of a bibliography on religion, spirituality and addictions. Drug Alcohol Rev [Internet]. 2007 [acesso 4 out 2018];26(4):389-95. Disponível: https://bit.ly/2PQr9Yb
3. Koenig HG. Medicina, religião e saúde: o encontro da ciência e da espiritualidade. Porto Alegr e: L&PM; 2012.
4. Sanchez ZVDM, Ribeiro LA, Nappo SA. Religiosidade e espiritualidade. In: Ribeiro M, Laranjeiras R, organizadores. O tratamento do usuário de crack. Porto Alegre: Artmed; 2012. p. 483-94.
5. Treloar HR, Dubreuil ME, Miranda Jr R. Spirituality and treatment of addictive disorders. R I Med J [Internet]. 2014 [acesso 4 out 2018];97(3):36-8. Disponível: https://bit.ly/2QxltzA
6. Koenig HG, King DE, Carson VB. Handbook of religion and health. 2ª ed. New York: Oxford University Press; 2012.
7. Ribeiro FML, Minayo MCS. As comunidades terapêuticas religiosas na recuperação de dependentes de drogas: o caso de Manguinhos, RJ, Brasil. Interface Comum Saúde Educ [Internet]. 2015 [acesso 4 out 2018];19(54):515-26. Disponível: https://bit.ly/2PNj3iT
8. Brasil. Ministério da Saúde. Coordenação Nacional de DST e Aids. A política do Ministério da Saúde para a atenção integral a usuários de álcool e outras drogas [Internet]. Brasília: Ministério da Saúde; 2003 [acesso 5 out 2018]. Disponível: https://bit.ly/2zGrbbb
9. Agência Nacional de Vigilância Sanitária. Resolução RDC nº 101, de 30 de maio de 2001. Estabelece Regulamento Técnico disciplinando as exigências mínimas para o funcionamento de serviços de atenção a pessoas com transtornos decorrentes do uso ou abuso de substâncias psicoativas, segundo modelo psicossocial, também conhecidos como Comunidades Terapêuticas [Internet]. Diário Oficial da União. Brasília; 30 maio 2018 [acesso 4 out 2018]. Disponível: https://bit.ly/2OBlLYd
10. Agência Nacional de Vigilância Sanitária. Resolução RDC Anvisa nº 29, de 30 de junho de 2011. Dispõe sobre os requisitos de segurança sanitária para o funcionamento de instituições que prestem serviços de atenção a pessoas com transtornos decorrentes do uso, abuso ou dependência de substâncias psicoativas [Internet]. Diário Oficial da União. Brasília; 30 jun 2001 [acesso 4 out 2018]. Disponível: https://bit.ly/2zSNbRn
11. Brasil. Senado Federal. Comunidades terapêuticas oferecem 80% das vagas para tratamento de dependentes químicos. Em Discussão [Internet]. 2011 [acesso 20 out 2016];2(8):60-2. Disponível: https://bit.ly/2x6fNEQ
12. Conselho Federal de Psicologia. Relatório da 4ª Inspeção Nacional de Direitos Humanos: locais de internação para usuários de drogas. 2ª ed. Brasília: CFP; 2011.
13. Flick U. Introdução à pesquisa qualitativa. 3ª ed. Porto Alegre: Artmed; 2009.

Research

14. Minayo MCS. Análise qualitativa: teoria, passos e fidedignidade. Ciênc Saúde Coletiva [Internet]. 2012 [acesso 5 out 2018];17(3):621-6. Disponível: https://bit.ly/2FfryQ1
15. Conselho Nacional de Saúde. Resolução CNS nº 466, de 12 de dezembro de 2012. Aprova diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos [Internet]. Diário Oficial da União. Brasília, nº 12, p. 59, 13 jun 2013 [acesso 5 out 2018]. Disponível: https://bit.ly/20ZpTyq
16. Raymundo MM, Martinez DG. Compreendendo a laicidade e sua aplicação em saúde pública. Rev HCPA [Internet]. 2010 [acesso 8 out 2018];30(2):180-4. Disponível: https://bit.ly/2FcIOoK
17. Lacerda GB. Sobre as relações entre Igreja e Estado: conceituando a laicidade. In: Conselho Nacional do Ministério Público. Ministério Público em defesa do estado laico. Brasília: CNMP; 2014. p. 179-205.
18. Sanchez ZM, Nappo SA. A religiosidade, a espiritualidade e o consumo de drogas. Rev Psiquiatr Clín [Internet]. 2007 [acesso 8 out 2018];34(Supl 1):73-81. Disponível: https://bit.ly/2PiPtlX
19. Instituto Brasileiro de Geografia e Estatística. Censo Demográfico 2010: características gerais da população, religião e pessoas com deficiência [Internet]. Rio de Janeiro: IBGE; 2010 [acesso 8 out 2018]. Disponível: https://bit.ly/2PiPtlX
20. Neri MC, coordenador. Novo mapa das religiões [Internet]. Rio de Janeiro: FGV: CPS; 2011 [acesso 8 out 2018]. Disponível: https://bit.ly/2QuWXil
21. Dezorzi LM, Raymundo MM, Goldim JR. Religiões e credos no Brasil: um guia breve para profissionais de saúde. Porto Alegre: WW Livros; 2016.
22. Hospital de Clínicas de Porto Alegre. Carta de direitos e deveres dos pacientes [Internet]. Porto Alegre: HCPA; [s.d.] [acesso 10 nov 2016]. Disponível: https://bit.ly/2Mumsxs
23. Gedge E, Querney D. The silent dimension: speaking of spirituality in addictions treatment. J Soc Work Values Ethics [Internet]. 2014 [acesso 8 out 2018];11(2):41-51. Disponível: https://bit.ly/2JRkRC2
24. Yalom ID, Leszcs M. Psicoterapia de grupo: teoria e prática. 5ª ed. Porto Alegre: Artmed; 2006.
25. Dezorzi LW, Raymundo MM, Goldim JR. Espiritualidade na atenção a pacientes/famílias em cuidados paliativos: um guia de apoio para profissionais de saúde. Porto Alegre: WW Livros; 2016.

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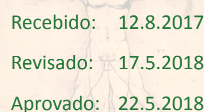
Participation of the Authors

The authors jointly participated in the elaboration of the work.



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Appendix

a. Patient interview script

1. Patient data

Name: ______________________________________ Date of birth: ___ / ___ / ____

Gender: ______________ Age: ___________ Marital Status: ________________

Housing situation in the last month:

(   ) live alone (   ) live with relatives (   ) street situation (   ) other _____________________________

Years of study: ____

Are you currently working? (   ) Yes (   ) No

If yes, doing what? ____

Religion: ___________________ Practitioner: (   ) yes (   ) no

Regular Spiritual Practices: (   ) Yes, which ones? ___________________________________ (   ) No

2. Substance use

Are you being treated for the use of which substances:

(   ) Alcohol (   ) Marijuana (   ) Tobacco (   ) Cocaine (   ) Others

3. Treatment

Have you been hospitalized before? (   ) no (   ) yes, how many times? ______________________

How were the places where you were hospitalized?

Besides hospitalization, do you attend or have you attended other treatment facilities?

(   ) no (   ) yes, which ones? ____

In the places where you sought treatment, where there spaces for spirituality? (   ) no (   ) yes, what were they like? ________

Do you realize that spirituality is being addressed during this hospitalization? (   ) no (   ) yes, in what way? ______________

Do you consider that addressing spirituality is important for your recovery?

(   ) no (   ) yes, why? _____________________

b. Interview script with professionals

1. Data of the professional

Name: ______________________________________

Gender: ______________ Age: ___________ Marital Status: ________________

Education: ____

Time worked at the institution _____________________

Religion: ___________________ Practitioner: (   ) yes (   ) no

Regular Spiritual Practices: (   ) Yes, which ones? _______________________________ (   ) No

2. Care practice

Do you consider that addressing spirituality is important for the rehabilitation of the SUD?

Do you realize that patients are offered space to exercise their spirituality? If so, in what way?

In your opinion, what would be the best way to approach this topic?