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Does the spirituality of nurses interfere in the record of spiritual suffering diagnosis?

A espiritualidade de enfermeiros assistenciais interfere no registro do diagnóstico sofrimento espiritual?

¿La espiritualidad de enfermeras asistencias interfere en el registro de lo diagnóstico sufrimiento espiritual?

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Abstract

Objectives: To assess the spirituality of nurses and relate it to personal characteristics, sector of activity, and spiritual practices; to analyze the influence of spirituality of nurses in the record of a "spiritual suffering" diagnosis. **Methods:** Quantitative cross-sectional study, using the World Health Organization's Quality of Life Instrument-Spirituality, Religion and Personal Beliefs Module (WHOQOL-SRPB). **Results:** 132 nurses were included and most of them were women (81.8%), married (56.8%), with an average age of 34 years (± 6.8). Most nurses believe in God or in a superior force (99.2%) and have never recorded a "spiritual suffering" diagnosis (78.8%). There was no association of spirituality with the sector of activity; the variable "marital status" was significant in six out of the eight factors of spirituality, and the variable "willingness to talk about spirituality" was significant in seven out of the eight factors. **Conclusion:** The spirituality of nurses does not interfere with the recording of a "spiritual suffering" diagnosis.

Keywords: Spirituality; Religion; Nursing Care.

Resumo

Objetivos: Avaliar a espiritualidade dos enfermeiros e associá-la com características pessoais, setor de atuação e práticas espirituais; analisar a influência da espiritualidade dos enfermeiros no registro do diagnóstico "Sofrimento Espiritual". **Métodos:** Estudo transversal quantitativo, utilizou-se o Instrumento de Qualidade de Vida da Organização Mundial da Saúde - Módulo Espiritualidade, Religião e Crenças Pessoais (WHOQOL-SRPB). **Resultados:** Participaram 132 enfermeiros a maioria mulheres (81,8%), casadas (56,8%), com média de idade 34 anos (± 6,8). A maioria dos enfermeiros acredita em Deus ou força superior (99,2%) e nunca registrou o diagnóstico de enfermagem "Sofrimento Espiritual" (78,8%). Não houve associação da espiritualidade com o setor de trabalho; a variável estado civil foi significativa em seis dos oito fatores da espiritualidade e a variável vontade de conversar sobre espiritualidade em sete dos oito fatores. **Conclusão:** A espiritualidade dos enfermeiros não interfere no registro do diagnóstico de enfermagem "Sofrimento Espiritual.

Palavras-chave: Espiritualidade; Religião; Cuidados de Enfermagem.

Resumen

Objetivos: Evaluar la espiritualidad de enfermeras verificando su asociación con características personales, sector de actuación y prácticas espirituales y analizar la influencia de la espiritualidad de los enfermeros en el registro del diagnóstico de "Sufrimiento Espiritual". **Métodos:** Estudio transversal cuantitativo, se utilizó el Instrumento de Calidad de Vida de la Organización Mundial de la Salud - Módulo Espiritualidad, Religión y Creencias Personales (WHOQOL-SRPB). **Resultados:** Participaron 132 enfermeras en la mayoría mujeres (81,8%), casadas (56,8%) con una media de edad 34 años (± 6,8). La mayoría de los enfermeros cree en Dios o fuerza superior (99,2%) y nunca registró el diagnóstico de enfermería "Sufrimiento Espiritual" (78,8%). No hubo asociación de la espiritualidad con el sector de trabajo; la variable estado civil fue significativa en seis de los ocho factores de la espiritualidad y la variable voluntad de conversar sobre la espiritualidad en siete de los ocho factores. **Conclusión:** La espiritualidad de los enfermeros no interfiere en el registro del diagnóstico de enfermería "Sufrimiento Espiritual.

Palabras clave: Enfermería; Espiritualidad; Religión; Atención de Enfermería.

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INTRODUCTION

Spirituality refers to a personal matter that is related to what is sacred or transcendent in the search for answers to essential aspects of life. The search for meaning and purpose with the idea that there is life beyond what we see or hear can lead to the creation of religious rituals and communities. In order to achieve spirituality, individuals do not have to belong to an established religion.[1]

Religion is defined by sociologists as a cultural system of shared beliefs and rituals which provide a sense of meaning, with a vision of reality that is sacred, comprehensive, and supernatural.[2] It is a divine power and a belief in the supernatural, worship, and submission by means of a comprehensive code of ethics and philosophy.[1] Spirituality has been pointed to as an important aspect of quality of life. The relationship between quality of life and spirituality, religious and existential beliefs involves perception and refers to personal and transcendental well-being in the individual's cultural context.[3]

Despite spirituality, religiosity, and personal beliefs being extremely valued aspects in different cultures, they have been neglected in care practice for reasons that include lack of interest, prejudice, or difficulty in measuring such complex variables.[4] With the purpose of contributing to a successful inclusion of quality of life and spirituality assessment in clinical, social, and research practice, in 2003 the World Health Organization included the WHOQOL-SRPB (World Health Organization's Quality of Life Instrument - Spirituality, Religion and Personal Beliefs Module) to the WHOQOL-100 (Word Health Organization's Quality of Life Measure).[3] Validated quantitative instruments are tools that can provide a quick and accurate diagnosis of a problem. Understanding nurses' spirituality and how they deal with it in their care practices can provide guidance on interventions.

It is essential that nurses include spiritual help in their practice, because holistic therapy is an increasing trend in nursing, and body, mind, and spirit are inseparable and part of the human being as a unit.[5]

The holistic notion of care that comprehends all aspects of human beings is related to a recovery of spirituality and an interest in it, so as to include new approaches that comply not only with technological skills, but also with those essential to the maturity and subsistence of nursing as a profession. The inclusion of spirituality is essential for comprehensiveness of care.[6]

However, the question is whether professionals are prepared to identify the spiritual needs of patients. Indeed, preparation for working with the spiritual needs of others requires preparation for dealing with one's own needs.

People certainly more easily notice what is pleasant or interesting, or has a special meaning.[7] Spirituality in health care highlights the fact that nurses need self-knowledge to be aware of their own spiritual side so as to work with spirituality in a safe manner.[8] However, for nurses to identify and perform actions related to spirituality, they first need to be aware of this matter in their own lives.

When the authors understood how spirituality permeates the process of self-care and care of others from a nursing perspective, they concluded that self-knowledge is essential to self-care and also to provide better care for others. Spirituality in self-care was evident in daily practice by means of prayers and close contact with nature, as well as the sense of connection with a superior force that provides calm, well-being, and strength to life and work.[9]

Classification of nursing practices by the North American Nursing Diagnosis Association (NANDA-I)[10] includes the diagnosis "spiritual suffering," which shows its relevance in care. This diagnosis has been suggested since 1978; it was reviewed in 2002 and it is defined as the impaired capacity of experiencing and giving meaning and purpose to life through a connection with oneself and with others, with art, music, literature, and/or a superior being.[10]

Some studies[11,12] have found a significant prevalence of the "spiritual suffering" diagnosis. A study found that 25.8% to 35.8% of patients with chronic renal failure were diagnosed with "spiritual suffering".[11] Other authors[12] found a prevalence of 38.6% of "spiritual suffering" among women with breast cancer.

However, other studies[13-17] showed a low frequency of psycho-emotional diagnoses in patient charts. Charts of patients admitted to an intensive care unit had only three nursing diagnoses related to psychosocial needs and none of them referred to psycho-spiritual needs, which shows that nurses who provide care are still oriented toward a medical-centered model, according to the analysis of records.[13]

Another similar study carried out with hospitalized women during the post-operative mastectomy period analyzed 185 charts and concluded that diagnoses that require a psychosocial approach, such as body dysmorphic disorder and spiritual suffering, had a low incidence, with those with biomedical approach being more frequent.[17]

Considering the presented issue, the objective of this study was to assess the spirituality of nurses and relate it to personal characteristics, sector of activity, and spiritual practices; and to analyze the influence of the spirituality of nurses in the recording of a "spiritual suffering" diagnosis.

METHOD

This quantitative cross-sectional study was carried out in two hospitals located in Jundiaí, one public and one philanthropic, where NANDA I is in place. The public hospital has 134 beds and provides low- and medium-complexity care services in gynecology, pediatrics, and a general and surgical clinic. The philanthropic hospital has 216 beds and provides medium- and high-complexity services in vascular surgery, heart surgery, head and neck surgery, otolaryngology, neurosurgery, general surgery, plastic surgery, oncological surgery, proctology, thoracic surgery, and hematology. The researchers had no institutional relationship with either place of study.

The population of nurses in the morning, afternoon, and night shifts consists of 151 nurses, 37 of whom were in the public hospital and 114 in the philanthropic hospital. The calculation of the representative sample of these 151 nurses was performed by STATS 2.0, considering a maximum acceptable error margin of 5%, an estimated percentage level of 50%, and a confidence interval of 95%; the minimum representative sample was 108 nurses. Professional nurses were included in the study regardless of their year of graduation or professional experience.

The data collection was carried out from June to September 2014. Nurses were approached individually at the hospital; most of them kept the questionnaires and returned them a few days later. Those who replied immediately took nearly 10 minutes to do it. Two self-administered questionnaires were used: one structured questionnaire consisted of personal characteristics, sector of activity, and spiritual practices; the other was designed to assess spirituality. The structured questionnaire was made up of 14 variables: age; gender; marital status; education; hospital department; belief in God; religion; attendance at religious meetings; commitment; importance of religion; importance of spirituality for care; diagnosis of "spiritual suffering;" request for or suggestion of a need for spiritual help; and willingness to talk about spirituality with patients. The last four variables concerned spirituality and were based on a published study.[13]

The instrument used to assess spirituality was the WHOQOL-SRPB. The choice of WHOQOL-SRPB for this study was justified by the structural characteristics of the instrument, by the satisfactory psychometric qualities shown in the validation study, and by the approach to the individual's spirituality. This included a context of quality of life that refers to the perception of spirituality in the cultural context and a system of values in which they live, and to their objectives, expectations, standards, and concerns. The validation study and the cross-cultural adaptation to the Brazilian reality of WHOQOL-SRPB was published in 2011.[4]

The objective of the WHOQOL-SRPB is to identify issues related to spirituality, religiosity, and personal beliefs. It contains 32 questions, divided into eight factors with four questions each: (1) connection to being or spiritual strength; (2) meaning of life; (3) admiration; (4) completeness and integration; (5) spiritual strength; (6) inner peace; (7) hope and optimism; and (8) faith.[4]

Individuals' responses were measured by a five-point Likert scale (1 = no/nothing to 5 = extremely). It did not contain reverse questions; that is, all questions refer to better spirituality. The total score was obtained by the sum and average of scores for each question, ranging from 32 to 160 points. Results were expressed from 0 to 100 so that comparison to other studies that used WHOQOL-SRPB was easier. The higher the score, the greater the individual's spirituality.[4]

The numerical variables were described by means of frequency, mean, standard deviation, and median. The distribution of scores was studied for its normal distribution by the Kolmogorov-Smirnov test. Because the scores did not adhere to the normal distribution curve, non-parametric tests were performed to analyze scores with regard to the studied characteristics. For variables of two categories, the Mann-Whitney U test was performed, and for three or more categories, the Kruskal-Wallis test was applied. The significance level was 5% and the software used for analysis was SAS version 9.2.

The development of the study complied with national and international rules of ethics in human research and was approved by the Ethics Committee in Human Research of Jundiaí Medical School, under number 674.642. All participants signed a Free and Informed Consent Form.

RESULTS

The total sample was made up of 132 nurses, with an average age of 34 years (± 6.8), 81.8% (n = 108) of which were women. Most were married (n = 75, 56.8%), with either a specialization or completed residency (n = 74, 56.1%), and worked in the philanthropic hospital (n = 93; 70.5%). Hospitalization was the unit with the highest number of participants (n = 58, 43.9%), followed by the intensive care unit (n = 32; 24.2%), emergency department (n = 23; 17.4%), operating room (n = 10; 7.6%), semi-intensive unit (n = 7; 5.3%), and dialysis unit (n = 2; 1.5%).

As for the responses concerning spirituality, 99.2% believe in God, power, spirit, or a superior force or intelligence. Most individuals were Catholic and attended a church/temple/center/synagogue or any other meetings of religious nature at least once a month. Time devoted to prayers, meditation or reading of sacred books was as frequent as religious meetings,

Table 1. Descriptive analysis of answers regarding spiritual experience. Jundiaí, 2014.

Questions	n	%	Questions	n	%
Do you believe in God (power, spirit, superior force or intelligence)?			Regardless of your attendance of religious meetings, how important is religion to you?		
Yes	131	99.2			
No	1	0.8			
Religion/Doctrine/Sect/Belief			Not important	3	2.3
Catholic	77	58.3	Not very important	2	1.5
Evangelical	30	22.7	Quite important	6	4.5
Spiritism	16	12.1	Important	38	28.8
Umbanda	2	1.5	Very Important	83	62.9
Spiritualized with no religion	6	4.5	How important is spirituality to nursing care?		
Atheist	1	0.8			
How often do you go to the church/temple/center/synagogue or any other religious meetings?			Not important	2	1.5
			Not very important	2	1.5
			Quite important	10	7.6
			Important	62	47.0
Never	2	1.5	Very Important	56	42.4
Hardly ever	48	36.4	Have you ever diagnosed a patient with “spiritual suffering”?		
Once a year	3	2.3			
Once a month	19	14.4			
Once a week	40	30.3			
Two to three times a week	20	15.2	Yes	28	21.2
How much time do you dedicate to private religious activities, such as prayers, meditation, or reading of sacred books?			No	104	78.8
			Have you ever requested for or suggested spiritual help to a patient?		
Never	6	4.5	Yes	77	58.3
Hardly ever	24	18.2	No	55	41.7
Once a year	2	1.5	Have you ever felt the need to talk about spirituality to a patient?		
Once a month	3	2.3			
Once a week	16	12.1			
Two to three times a week	16	12.1	Yes	105	79.5
Once a day	48	36.4	No	27	20.5
More than once a day	17	12.9			
Total	**132**	**100**	**Total**	**132**	**100**

because 45.5% of them attended collective rituals at least once a month, and 49.3% carried out daily rituals at least once a day (Table 1).

As for the importance of religion in the lives of individuals in nursing care, data showed a difference in results that possibly implies in spiritual help, as 62.9% of them considered religion as very important to themselves, and 42.4% as very important to nursing care. Therefore, there is a discrepancy among subjects regarding the importance of spirituality to themselves and to others (Table 1).

Most participants reported that they have never recorded a "spiritual suffering" diagnosis; however, they have requested or suggested spiritual help, delegating assistance to others, and/or have had the will to talk about spirituality to a patient (Table 1).

Comparing the average scores obtained by each factor, "meaning of life" and "faith" had the highest averages and "completeness and integration" and "inner peace" had the lowest averages. These data show that nurses are aware of the meaning of life and the contribution of faith to well-being; however, they have difficulties in feeling complete as body, mind, and spirit, and in being at peace with themselves (Table 2).

Table 2. Description of averages of WHOQOL-SRPB factors. Jundiaí, 2014.

Factors	μ*	σ*	μ**	σ**
Connection to being or spiritual strength	85.1	12.4	4.3	0.7
Meaning of life	87.5	11.1	4.4	0.7
Admiration	83.3	12.4	4.2	0.7
Completeness and integration	77.9	11.2	3.9	0.7
Spiritual strength	84.9	11.9	4.3	0.7
Inner peace	78.3	12.5	3.9	0.8
Hope and optimism	81.3	11.9	4.1	0.7
Faith	87.1	12.5	4.4	0.8
Total	83.2	9.9	4.2	0.5

Remark: μ: average; σ: standard deviation. * Normalized values from 0 to 100. ** Values according to the Likert scale for each factor. The Likert scale for each factor goes from 1 to 5.

The factors with the greatest number of statistically significant differences in comparison with the studied characteristics (five variables each) were: "admiration" and "faith.". "Admiration" had statistically significant differences in comparisons with age (*p*-value = 0.04), marital status (*p*-value = 0.01), importance of spirituality for nursing care (*p*-value = 0.01), request for or suggestion of spiritual help (*p*-value = 0.01), and willingness to talk about spirituality with patients (*p*-value = 0.04) (Table 3).

For "faith," significant data were found in the comparison with the variables "gender" (*p*-value = 0.04), marital status (*p*-value = 0.00), "religion/doctrine/sect/belief" (*p*-value = 0.01), importance of spirituality for nursing care (*p*-value = 0.04), and willingness to talk about spirituality with patients (*p*-value = 0.00) (Table 3).

There was a statistically significant difference in the comparison between "connection to being or spiritual strength" and three variables: marital status (*p*-value = 0.02); religion/doctrine/sect/belief (*p*-value = 0.00); and the question regarding willingness to talk about spirituality with patients (*p*-value = 0.02) (Table 3).

For "completeness and integration", data were statistically significant for variables "marital status" (*p*-value = 0.01), request or suggestion for spiritual help (0.00); and willingness to talk about spirituality with patients (*p*-value = 0.01) (Table 3).

There was a statistically significant difference in the comparison between "spiritual strength" and the variables "marital status" (*p*-value = 0.00); "religion/doctrine/sect/belief" (*p*-value = 0.01); and "willingness to talk about spirituality" (*p*-value = 0.01) (Table 3).

For "hope and optimism," data were statistically significant for two variables: "request or suggestion of spiritual help" (*p*-value = 0.05) and "willingness to talk about spirituality with patients" (*p*-value = 0.03) (Table 3).

For "meaning of life," there was a statistically significant difference in the variable "willingness to talk about spirituality" (*p*-value = 0.04) and "inner peace" in comparison with "marital status" (*p*-value = 0.00) (Table 3).

Considering the statistically significant differences mentioned above, two independent variables stand out and remain stable in the interpretation associated with the presented averages: willingness to talk about spirituality with patients and marital status (Table 3).

The variable "willingness to talk about spirituality with patients" was significant for seven out of eight factors; therefore, individuals who answered "yes" had a greater spiritual connection to deal with stress in hard times, to understand others, and to reassure themselves; they are more aware of the meaning of life; they have greater admiration and are more grateful to people and things around them; they feel more complete as body, mind, and spirit, reporting as being more balanced; they consider themselves spiritually strong; and they state that faith contributes to their well-being and to comfort themselves every day (Table 3).

The variable "marital status" was significant in six out of eight factors and showed that separated or divorced individuals have greater spiritual connection, admiration, and gratefulness; they feel complete and balanced; they report themselves as spiritually strong individuals, at peace with themselves, and have faith in daily life (Table 3).

As for the independent variables "religion/doctrine/sect/belief', "request or suggest spiritual help", 'the importance of spirituality for nursing care", "gender", and "age", we can infer that: regarding religion, umbandists felt more connected, spiritually stronger and had more faith; nurses who requested or suggested spiritual help had more admiration for life and felt more complete and hopeful; those who reported that spirituality is very important for nursing care reveal greater admiration for things around them and value faith; women believe more than men that faith contributes to their lives; and nurses aged over 41 appreciate life more intensively, they feel spiritually touched by the beauty of things, they are inspired by nature and are grateful to it (Table 3).

The association of spirituality of nurses with the sector of activity, according to WHOQOL-SRPB factors, was not statistically significant (Table 3).

Table 3. Comparison of studied characteristics of nurses with items of WHOQOL-SRPB factors. Jundiaí, 2014.

Characteristics	Connection to being or spiritual strength			Meaning of life			Admiration			Completeness and integration			Spiritual strength			Inner peace			Hope and optimism			Faith		
	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value
Age (in years old)			0.06			0.69			0.04			0.34			0.07			0.10			0.32			0.05
Under 25	4.2	0.7		4.4	0.7		3.9	0.9		3.8	0.6		4.2	0.7		3.9	0.8		4.0	0.6		4.2	0.8	
26 to 30	4.4	0.8		4.5	0.6		4.1	0.7		3.9	0.6		4.4	0.6		4.1	0.7		4.1	0.6		4.6	0.6	
31 to 40	4.1	0.7		4.3	0.7		4.1	0.8		3.9	0.6		4.1	0.7		3.8	0.7		4.0	0.7		4.2	0.8	
41 or over	4.5	0.8		4.4	0.8		4.6	0.4		4.0	0.9		4.4	0.9		4.1	1.0		4.3	0.8		4.5	0.9	
Gender*			0.32			0.12			0.58			0.24			0.68			0.45			0.35			0.04
Female	4.3	0.7		4.3	0.7		4.2	0.7		3.9	0.7		4.3	0.8		3.9	0.8		4.0	0.7		4.4	0.8	
Male	4.1	0.8		4.6	0.5		4.2	0.7		4.0	0.5		4.3	0.6		4.0	0.6		4.2	0.7		4.2	0.7	
Marital Status			0.02			0.15			0.01			0.01			0.00			0.00			0.23			0.00
Single	4.1	0.8		4.3	0.7		4.0	0.7		3.7	0.6		4.0	0.7		3.8	0.7		4.0	0.6		4.1	0.7	
Married	4.3	0.7		4.4	0.7		4.2	0.8		3.9	0.7		4.3	0.8		3.9	0.8		4.1	0.8		4.4	0.8	
Separated	4.8	0.4		4.0	0.9		4.5	0.4		4.4	0.7		4.6	0.6		4.2	0.4		4.5	0.7		4.8	0.5	
Divorced	4.7	0.5		4.7	0.6		4.8	0.3		4.3	0.5		4.9	0.2		4.7	0.6		4.3	0.6		4.9	0.3	
Education/Degree*			0.23			0.19			0.74			0.91			0.22			0.51			0.95			0.17
Higher education complete	4.3	0.7		4.5	0.6		4.1	0.8		3.9	0.6		4.4	0.6		4.0	0.8		4.1	0.7		4.5	0.6	
Specialization or Residency complete	4.2	0.8		4.3	0.8		4.2	0.7		3.9	0.7		4.2	0.8		3.9	0.8		4.1	0.7		4.3	0.9	
Sector of activity			0.66			0.21			0.35			0.79			0.66			0.37			0.70			0.07
Hospitalization Unit	4.3	0.7		4.4	0.7		4.2	0.7		3.9	0.7		4.2	0.9		3.9	0.9		4.1	0.7		4.4	0.8	
Semi-intensive	4.1	0.8		4.1	0.9		3.9	0.8		3.9	0.7		4.3	0.4		3.7	0.8		3.8	1.0		4.0	0.7	
Intensive Care Unit	4.1	0.8		4.5	0.8		4.3	0.8		4.0	0.6		4.3	0.7		4.1	0.8		4.1	0.7		4.3	0.8	
Emergency	4.3	0.8		4.2	0.7		4.0	0.8		3.8	0.7		4.4	0.6		3.8	0.6		4.1	0.7		4.4	0.7	
Dialysis	3.8	1.1		3.8	1.1		3.5	0.7		3.4	0.5		3.5	0.7		3.1	0.2		3.4	0.5		3.5	0.7	
Operating Room	4.4	0.8		4.6	0.5		4.2	0.7		3.9	0.7		4.1	0.7		3.8	0.6		4.2	0.5		4.8	0.4	
Religion/Doctrine/Sect/Belief			0.00			0.30			0.59			0.40			0.01			0.15			0.23			0.01
Catholic	4.1	0.7		4.3	0.7		4.1	0.8		3.9	0.7		4.2	0.7		3.9	0.8		4.0	0.7		4.3	0.8	
Evangelical	4.6	0.6		4.5	0.5		4.2	0.7		4.0	0.6		4.5	0.6		4.1	0.6		4.2	0.6		4.7	0.5	
Spiritism	4.6	0.4		4.6	0.5		4.5	0.5		3.9	0.6		4.5	0.5		3.8	0.6		4.2	0.6		4.6	0.5	
Umbandist	5.0	0.0		4.5	0.7		3.8	1.1		3.9	0.2		4.9	0.2		4.5	0.7		4.1	1.2		4.9	0.2	
Spiritualized with no religion	3.8	0.9		4.2	0.6		4.0	0.8		3.6	0.7		3.6	0.8		3.6	0.8		3.7	0.6		3.8	0.9	
Atheist	1.8	-		1.8	-		4.5	-		1.0	-		1.0	-		1.0	-		2.0	-		1.0	-	

Continued Table 3.

Characteristics	Connection to being or spiritual strength			Meaning of life			Admiration			Completeness and integration			Spiritual strength			Inner peace			Hope and optimism			Faith		
	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value	μ	σ	*p*-value
How important is spirituality to nursing care?			0.26			0.44			0.01			0.13			0.06			0.52			0.23			0.04
Not important	4.0	0.0		3.5	1.8		2.8	0.7		3.1	0.2		3.8	0.0		3.4	0.2		3.4	0.5		3.5	0.7	
Not very important	3.6	0.9		3.8	1.1		3.4	0.2		3.5	0.7		3.5	0.7		4.0	1.1		3.8	0.4		4.1	0.2	
Quite important	4.0	0.9		4.2	0.8		3.7	0.9		3.6	0.7		3.6	1.1		3.6	0.9		3.7	0.9		3.7	1.0	
Important	4.2	0.7		4.4	0.6		4.2	0.7		3.9	0.7		4.3	0.7		4.0	0.7		4.1	0.7		4.4	0.7	
Very Important	4.4	0.8		4.4	0.7		4.3	0.6		4.0	0.7		4.3	0.7		4.0	0.8		4.2	0.7		4.4	0.8	
Have you ever diagnosed a patient with “spiritual suffering”?*			0.53			0.15			0.67			0.10			0.47			0.70			0.52			0.45
Yes	4.1	0.9		4.2	0.8		4.2	0.9		4.0	0.9		4.1	1.0		3.9	1.0		4.1	0.9		4.2	1.0	
No	4.3	0.7		4.4	0.7		4.2	0.7		3.9	0.6		4.3	0.7		3.9	0.7		4.1	0.7		4.4	0.7	
Have you ever requested or suggested spiritual help to a patient?*			0.23			0.66			0.01			0.00			0.10			0.45			0.05			0.18
Yes	4.3	0.7		4.4	0.6		4.3	0.7		4.0	0.7		4.3	0.8		3.9	0.8		4.2	0.7		4.4	0.8	
No	4.2	0.8		4.3	0.7		4.0	0.8		3.7	0.6		4.2	0.7		3.9	0.7		3.9	0.7		4.3	0.7	
Have you ever felt the need to talk about spirituality to a patient?*			0.02			0.04			0.04			0.01			0.01			0.12			0.03			0.00
Yes	4.3	0.7		4.5	0.6		4.3	0.7		4.0	0.7		4.3	0.7		4.0	0.8		4.1	0.7		4.5	0.7	
No	3.9	0.8		4.1	0.9		3.9	0.9		3.6	0.6		3.9	0.8		3.7	0.8		3.8	0.8		4.0	0.8	

Remark: Kruskal-Wallis test/*Mann-Whitney test. Symbols: μ: average; σ: standard deviation.

DISCUSSION

This study found significant associations between spirituality and age, gender, marital status, and religion, as reported by participants. Experiences lived throughout their lives appear as important factors and they interfere in the spirituality of individuals; private religious practices are more frequent when the understanding of spirituality takes place in a broader context which depends on the self.

In addition to in our study, some authors[18] have concluded that the more mature a person is in terms of religion, regarding the search for answers about the meaning of life and true religious experience and the greater their ability to reflect upon and experience their spirituality in a healthy way. These authors[18] have also found other data that are similar to our study: 93% of participants believe in God; most of them are Catholics; and young adults stated that they devote less time to religion in collective situations and devote more time privately than teenagers.

The findings of a study regarding the spirituality of the nursing team and sectors of activity are convergent with those found in our study, because no variation between sectors was observed.[19]

The results of this study point to weaknesses and incoherence in nurses' work regarding care related to spirituality. Despite most individuals have not been diagnosed as "spiritual suffering," nurses notice the spiritual needs of patients and have a mental and empirical planning of care.

Some authors[20] reflected about something that also came up in our study: the impossibility of dissociating the personal self and the professional self, and the issue of relationships of self-care and care of others. The authors concluded that these aspects are related and are actually inseparable, because they are part of the same human being, which is unique and indivisible. Therefore, it is not possible to think of the spiritual help provided by nurses without considering their own spirituality. However, other factors may interfere with this process, such as personal culture, hospital culture, and academic education.

In line with this study, surveys[13-17] published in the literature have found that nurses acknowledge the importance of spirituality in personal and professional spheres; and they find a diagnosis, acknowledge the spiritual needs of patients and/or of their families, but do not prescribe relevant interventions. Therefore, they do not continue care and leave aside an important aspect of care.

Negligence regarding spiritual care was also found in a study carried out with health professionals and pastoralists in a hospital in Curitiba, state of Paraná. The results found show that most professionals believed that religiosity/spirituality affects health and they considered it important to be aware of this relationship. However, few of them reported the inclusion of spirituality in their practices, due to lack of information and training on these issues.[21]

The findings of this study also allowed for a discussion about the difference of perception among nurses and patients regarding spirituality, religion, and personal beliefs in the context of quality of life and health care. Other surveys[22,23] show that the scores of health professional and/or healthy individuals are always lower than those of patients according to the WHOQOL-SRPB, and this difference in the importance of spirituality can divert professionals and patients from their common goal.

The convergence of patients' needs and their acknowledgment by nurses is an essential element for quality of care. A published study[22] compared the role of spirituality/religiosity in the life of patients with cancer and the work of health professionals who cared for these patients. Despite the positive correlations between the importance of spirituality in the treatment and confrontation of the disease reported by both groups, patients had higher spirituality scores compared to health professionals. The normalized average total score of WHOQOL-SRPB for patients was 89.9 but 83.0 for professionals. Results reported by the authors[22] are in line with those found in our study with regard to health professionals, in both nurses' general score of WHOQOL-SRPB (83.0 *vs.* 83.2) and factors with higher and lower averages: meaning of life (88.0 *vs.* 87.5) and inner peace (78.5 *vs.* 78.5).

Another study published in the literature[23] confirms this discrepancy. The purpose was to assess the association between spirituality and quality of life, comparing ill and healthy people, regardless of the type of disease and age. Patients had higher scores in spirituality ($\mu = 97.2$) than healthy individuals ($\mu = 92.9$) according to WHOQOL-SRPB, and this association was significant ($p = 0.03$). In addition, spirituality was positively associated with general quality of life assessed by the WHOQOL-100; that is, it is not possible to improve the quality of life of patients with chronic diseases without considering the spiritual aspect.

These studies[22,23] are important to show the influence of diseases on the perception of spirituality. Individuals get close to their spiritual beliefs when they fall ill and feel more fragile. Therefore, including spirituality in nursing care can improve the relationship with patients, and can also be the opportunity for nurses to broaden their understanding of human condition instead of creating a narrow concept to be applied to a practice model.[24]

In addition to the differences in perceptions between nurses and patients, some studies[13,25-28] show that professionals do not feel prepared to provide spiritual help and do not have appropriate training for that.

Some authors[28] have compared the knowledge and behavior of nursing professors and students with regard to spirituality, religiosity, and health. Results showed that more than 95% of participants stated a religious belief, 96% believed that spirituality had a strong influence on patients' health, and 77% felt the need to address the topic. However, only 36% said that they were prepared to do it, and most of them believed that the university did not provide all of the necessary information about the subject. The main barriers to addressing the subject were: fear of imposing their own beliefs; lack of time; and fear of hurting patients' feelings.

During their studies, nursing students are never, or hardly ever, driven to study the topic. Generally, support for the development of spiritual help is neglected.[8,9] A study[26] analyzed the representations of life sciences professors about religiosity and spirituality and concluded that their personal conduct is influenced by these representations, and they must include, in addition to physical care, the skills for spiritual care. To do so, the topic of spirituality must be included in the curricular content of undergraduate courses.

Education must prepare nurses to consider human beings in their biological, emotional, and spiritual aspects.[13] Spirituality within health institutions refers, first and foremost, to respect for life. This means considering human beings in their entirety, respecting and addressing all aspects: physical; intellectual; emotional; and spiritual, creating a corporate culture based on principles, creating ethics and universal and spiritual values to enlighten decisions, strategies, policies, and all relationships within the organization. Spirituality can help us disseminate and take responsibility in all aspects of life, in which the professional is not the only one.[29]

The contribution of this study is to appreciate and emphasize the importance of systematization of nursing care as a professional practice and to show all aspects nurses must pay attention to. Comprehensive care in clinical practice includes close relationship, dedication, and identification of patients' needs, including the spiritual ones. The record of a nursing diagnosis is extremely relevant to both the continuation of care and the profession, because it allows for the identification of all aspects observed and those actually performed by nurses.

CONCLUSIONS

Almost all of the participating nurses in this study reported that they believe in God or in a superior force. Most of them were Catholics and were committed to spiritual practices, especially private. With regard to the association of spirituality with personal characteristics, most of them were separated or divorced, umbandists, women, and aged 41 or over. The sector of activity did not interfere in their spirituality.

The spirituality of nurses did not interfere in their record of the diagnosis of "spiritual suffering"; however, it interfered in the nurses' regard of spiritual aspects, because there was a significant association with willingness to talk about spirituality with patients with seven out of the eight factors of the evaluation instrument, and most individuals reported that they have requested or suggested spiritual help.

Therefore, not recording spiritual help as a nursing care service probably reflects a biomedical model that is consolidated, and that is attached to physiology-based diagnoses, taboos, and preconceptions that surround the topic.

The conclusions of this study clarify many questions, and further studies are necessary to assess how spiritual help actually takes place in nurses' practice. The findings of this study highlight the importance of a coherent care service. In addition, the need to develop skills and perception among nurses as strategies to improve clinical thinking with regard to more subjective aspects such as spirituality becomes clear.

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