Revista Brasileira de Enfermagem

REFERÊNCIA

BORGES, Moema da Silva; SANTOS, Marília Borges Couto; PINHEIRO, Tiago Gomes. Social representations about religion and spirituality. **Revista Brasileira de Enfermagem**, Brasília, v. 68, n. 4, p. 609-616, jul./ago. 2015. Disponível em: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-71672015000400609&lng=en&nrm=iso>. Acesso em: 10 maio 2018. doi: http://dx.doi.org/10.1590/0034-7167.2015680406i.

RESEARCH

Revista Brasileira de Enfermagem
REBEn

Social representations about religion and spirituality

Representações sociais sobre religião e espiritualidade

Representaciones sociales sobre religión y espiritualida

Moema da Silva Borges[I], Marília Borges Couto Santos[I], Tiago Gomes Pinheiro[I]

[I] *Universidade de Brasília, Health Sciences College, Nursing Department. Brasília, Distrito Federal, Brazil.*

How to cite this article:

Borges MS, Santos MBC, Pinheiro TG. Social representations about religion and spirituality. Rev Bras Enferm. 2015;68(4):524-31. DOI: http://dx.doi.org/10.1590/0034-7167.2015680406i

Submission: 11-04-2014 **Approval:** 05-05-2015

ABSTRACT

Objective: to identify the social representations about the concepts of *spirituality* and *religion of* of health teachers. **Method**: exploratory and descriptive study, based on a qualitative approach. 25 subjects participated in it. The following instruments were used to collect data: questionnaire to identify the profile; questionnaire of free association, whose inducing words were *religion* and *spirituality*, and an interview based on the scale FICA (Puchalski, 2006). **Results**: the representations about religion and spirituality, for professors, are forged around the faith in God and it gives them meaning and purpose to deal with the challenges of personal and professional living. **Conclusion**: there are still barriers that need to be overcome with a view to a comprehensive care. For this, it is essential to incorporate spirituality in the process in the curricula of health courses.

Key words: Spirituality; Religion; Religion and Medicine; Healing by Faith.

RESUMO

Objetivo: apreender as representações sociais acerca dos conceitos de *espiritualidade* e *religião de docentes da área da saúde*. **Método:** estudo exploratório e descritivo, com abordagem qualitativa, do qual participaram 25 docentes. Para a coleta de dados foram utilizados os seguintes instrumentos: questionário de identificação do perfil dos participantes; questionário de livre associação, tendo como palavras indutoras *religião* e *espiritualidade,* e um roteiro de entrevista baseado na escala FICA-Profissional de Puchalski. **Resultados:** as representações acerca de religião e espiritualidade, para os docentes, são forjadas em torno da fé em Deus e lhes confere sentido e propósito para lidar com os desafios do viver pessoal e profissional. **Conclusão:** na esfera profissional há barreiras que precisam ser ultrapassadas com vistas a um cuidado integral. Para isso é imprescindível a incorporação da espiritualidade no processo nos currículos dos cursos da área da saúde.

Descritores: Espiritualidade; Religião; Religião e Medicina; Cura Pela Fé.

RESUMEN

Objetivo: identificar las representaciones sociales acerca de los conceptos de *espiritualidad* y *religión* de los profesores de la salud. **Método:** estudio exploratorio y descriptivo, de enfoque cualitativo, con participación de 25 sujetos. Los instrumentos para recoger los datos fueron: cuestionario de identificación de perfil; cuestionario de libre asociación, cuyas palabras inductoras fueron *religión* y *espiritualidad*; y una entrevista basada en la escala FICA (Puchalski, 2006). **Resultados:** las representaciones acerca de la religión y la espiritualidad, para los profesores, se forjan en torno a la fe en Dios y les da sentido y propósito para hacer frente a los desafíos de vida personal y profesional. **Conclusión:** hay barreras que deben superarse con el fin de una atención integral. Para eso, es esencial la incorporación de la espiritualidad en el proceso en los planes de estudio de los cursos de salud.

Palabras clave: Espiritualidad; Religión; La Religión y la Medicina; La Curación por la Fe.

CORRESPONDING AUTHOR **Moema Silva Borges** E-mail: mborges@unb.br

INTRODUCTION

Since the beginning of this century, religious and spiritual involvement are variables that have been gaining importance and recognition as a health indicator in the pursuit of promoting comprehensive care[1-2]. From this perspective, studies show that religious involvement is associated with higher indicators of mental health and well-being[1-2]. The groups of religious people are characterized by a lower abuse of illicit and licit drugs, a lower incidence of suicide, and a lower prevalence of depression, thereby proving that religion has an impact on physical and mental health and works as a protective factor against the development of diseases[3].

Studies by Gallup[4] state that 87% of Brazilians consider religion to be an important aspect of their lives. These data confirm Moreira's study[5] with a focus on religious involvement and its relationship with sociodemographic variables, evidencing 95% of the respondents had a religion, 83% considered religion very important, and 37% attended religious services at least once a week[5]. It can be stated that more than 90% of the population, regardless of their religion, use religiosity and spirituality for the purpose of gaining strength and comfort to face life's adversities, such as disease and death[6], among other purposes.

Beliefs about religion and spirituality can influence the way patients and health care professionals perceive health and disease, and how they interact with others. Koenig[7] states that there are clinical reasons to address religiosity and spirituality in health care, among which are highlighted: many patients are religious and would like to address these issues in health care; religious beliefs affect medical decisions and may hinder adherence to treatment; religions influence health care in the community; many patients have spiritual needs related to the disease that can affect their mental health, and these demands need to be met[7]. "Failure to meet these demands can have significant consequences in terms of quality of life, satisfaction with care and demand of sometimes futile health care services"[8].

The use of the term *spirituality* detached from *religion* is quite recent, and occurred around the sixth and seventh decades of the twentieth century[1]. As a matter of common sense, there is no distinction between these concepts and studies, and they are confusing. Some authors use them interchangeably, whereas others make a clear distinction between them, making *spirituality* a broader concept.

The existing difficulty with the concepts can pose a serious deficiency in the field of study of religiosity or spirituality, because if the terms are not properly and consistently used, this field of research will face serious problems as to its validity and coherence[9].

Give the above, we chose to adopt in this study the concepts based on Koenig and Hufford[1,9], who distinguish *religiosity* as the institutional aspect of spirituality. Religions are institutions organized around the idea of spirit and refer to the belief systems and services that people inherit or adopt, and which they understand to be meant to lead to happiness and satisfaction. The purpose of religion is to provide a structure where one can develop a spiritual awareness. *Spirituality*, on the other hand, refers to a personal relationship with the transcendent, refers to the realm of the spirit (God or gods, souls, angels, demons), something nonphysical, which has been called supernatural. Therefore, *spirituality* refers to a more general term that can also include religion. From this perspective, it represents a core aspect of religion. This kind of argument allows for the statement that there are spiritual people, although they do not follow any religion, or that extrinsically religious people can be especially spiritual[9].

Koenig[1] recommends that, for health care purposes, the concept of *spirituality* is anchored into a broader foundation and includes "religious and non-religious types and is defined by the patients themselves"[1]. For this author, the importance is that the greatest possible number of patients have the opportunity to have their spiritual needs identified and considered, no matter how they understand it[1].

One of the difficulties of incorporating the beliefs about religion and spirituality into patient care has been the fact that most health care professionals do not receive any training on how to deal with the spiritual dimension of health and disease. The overlap of the concepts of religion and spirituality also confirms the difficulties found in developing a practice that meets the spiritual and religious needs by health care professionals, because there is the understanding that they should be handled by priests and religious personnel[10].

Although there is currently a large, diverse and robust body of evidence demonstrating the relevance and impact of approaching beliefs about religion and spirituality in health, the integration of this issue in professional training has met with difficulties. That is because, in the traditional curriculum orientation, spirituality is outside of research and, in general, is not considered scientific knowledge. This fact causes some discomfort to the professionals regarding the issues.

Nevertheless, health care requires a comprehensive and multidimensional approach that necessarily needs to address the culture of people involved in the action. Therefore, given the approach of social representations, both in the theoretical and empirical aspects overlapping with the representation and cultural systems, both of which are forms of knowledge shared by a certain group and which forge their daily practice[11], a question arises: How do faculty in the health care area understand the meanings of religion and spirituality? How do these meanings influence their everyday life? Are these meanings aggregated into professional practice and teaching?

This study aimed to identify the social representations on the concepts of spirituality and religiosity of faculty in courses in the health care area in a public university in the Federal District of Brazil.

METHOD

This was an exploratory, descriptive study, performed from October of 2011 to February of 2012, with 25 faculty working in different courses in the healthcare area and the medical course. The universe of participants was randomly defined and had as inclusion criteri;a being an active faculty member, agreeing to participate, and signing the consent form. Three instruments were used for data collection: a closed-ended questionnaire to identify the sociodemographic profile of the

participants; a questionnaire of free association that presented an inducer word and requested that the participants produced all words, expressions or adjectives that came to their minds from the inducer word, namely, *religion* and *spirituality*; and an interview script based on the Professional FICA-scale[12] which addresses religious and spiritual beliefs of health care professionals in order to identify what the importance and influence of this belief is in their lives. The Professional FICA-scale has been translated to Portuguese, and is appliable to different socio-cultural contexts.

The analysis of the results obtained from the questionnaire of free association was based on descriptive statistics, with the most frequently cited words and meanings attributed to them being identified. For the analysis of the interviews, the Alceste software (Lexical Analysis according to the Context of a Set of Text Excerpts), which quantitatively analyzes textual data according to importance in the statements. We sought to identify significant aspects regarding the concepts of religion and spirituality.

The project was approved by the Ethics Committee of the Health Sciences College and Medical College, protocol number 061/11.

RESULTS

Participant profile

The study participants were 25 faculty, 15 from the Health Sciences College, namely: three each from the nursing, pharmacy, nutrition, dentistry and health management courses, and ten from the medical course. The faculty profile was: 14 (56%) were female and 11 (44%) were male.

Regarding age, five (20%) were aged 25 to 35 years, 11 (44%) were aged 36 and 50, six (24%) were aged 51 to 60 years, and three (12%) were aged 61 to 70. Therefore, 20 (80%) of the respondents were more than 36 years old, characterizing the group consisting of people with a presumed maturity. As for religious affiliation, the subjects reported being: nine (36%) spiritualists [profess the doctrine codified by the French educator Allan Kardec], seven (28%) Catholics, six (24%) spiritual [believe in the existence of the spirit], one (4%) evangelical, one (4%) agnostic [people who believe that supernatural phenomena are inaccessible to understanding by the human mind], and one (4.0%) atheist, [people who do not believe in God or any other higher mind]. As to the time since completing their education, four (16%) graduated 6 - 10 years before, five (20%) graduated 11 - 25 years before, seven (28%) graduated 16 - 25 years before, and nine (36%) graduated more than five years before this research.

Meaning of religion and spirituality from the vision of the faculty

Religion as faith in God

Following the inducer word *religion*, the most frequent words were *faith* (11; 44%), *God* (7, 28%), *belief* (4; 16%) and *peace* (4; 16%).

The words *faith*, *God*, *belief* and *peace* refer to the understanding of religion as a set of beliefs and faith in God that produces peace. Etymologically speaking, the word faith originated from the Greek "*pistia*" indicating the notion of believing and the Latin "*fides*", which refers to an attitude of faithfulness.

The word *faith* was understood by the faculty as the act of believing in the existence of something higher, dismissing factual evidence. God represented this superior being, a greater strength that governs the universe and also the life of each person. Similarly, the meaning assigned to the word *belief* was also understood as the act of believing in a higher power, dismissing factual evidence. In turn, the word *peace* was understood as a feeling of quiet and tranquility, probably as a state of mind achieved by faith and belief in God.

These interpretations approach the religious argument, in which faith is a virtue of the faithful who accept the principles disseminated by their religion as an absolute truth. Having faith in God is believing in his existence and his omniscience. From this perspective, *religion* can be interpreted as a set of formal and stable beliefs and institutionally and culturally relevant practices, aligning with the concept adopted for this study[1,9].

Spirituality and faith and belief in a higher power

Following the inducer word *spirituality*, the most frequent words were *faith* (7, 28%), belief (6, 24%) and force (4, 16%).

Similar to the words following the word *religion*, faculty once again mentioned the words *faith* and *belief*. The understanding of spirituality is based on faith and religious belief, which suggests no differentiation between the concepts of religion and spirituality.

Similar to the representations elaborated from the word *religion*, faculty associated the word *faith* with the act of believing in the existence of something higher, also dismissing factual evidence. *Belief* was interpreted as its traditional religious basis, which involves the use of dogmas connected to an institution. And *strength* was understood as the existence of something transcendent that has power to influence people's lives.

The influence of religious-spiritual beliefs in daily living

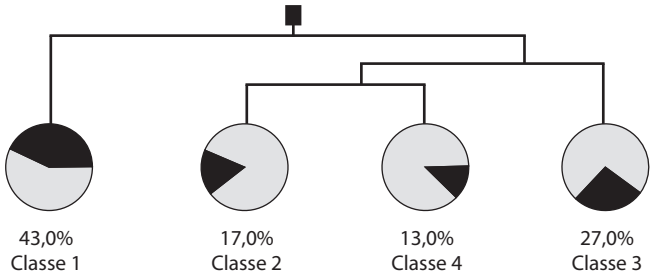

Figure 1 - Dendogram of the *corpus* of social representations about the beliefs about religion and spirituality

To better understand the figure, the dendrogram represents the statistical relationships, in which the strength of the relationship between classes is expressed by the proximity of the content of participants' statements. Class 1, distant from the group formed by the three other classes, suggests that the object representing this class is distinct from the other cluster. Similarly,

the proximity of classes 2 and 4 suggests that their content representation is very close. Thereby, in Figure 1, the existence of two distinct axes can be noted that organized the representation of the study subjects into four classes. The first, consisting of class 1, was named the **Personal dimension of search for sense and meaning** and refers to the personal search for meaning and purpose in life. It consists exclusively of Class 1, called *The community as a guide for living*. The second axis consisted of classes 2, 4 and 3, named, respectively: *R/S Beliefs in the care relationship ME-YOU/professional, R/S Beliefs in the care relationship ME and the Divine,* and *R/S Beliefs as strategies to address challenges in daily life*. This second axis was named **Professional dimension of the search for sense and meaning**. In the second axis, attitudes and moral precepts emerge, as well as the strategies that assist individuals in managing professional difficulties, by giving sense and purpose to everyday work.

Class 1 – The religious community as a guide for living

In this class, the words that were highlighted are the ones with the highest chi-squares, meaning that these were statistically the most frequently mentioned words in the subjects' statements. This evocation denotes the importance of the meanings of these words in the conformity of the classes, thereby they gained prominence in the fragments of the statements. They are: *needing, community, belonging, (I) participate, growing today and always*. The content of the statements indicates that the link of the faculty with their religious and spiritual communities plays an important part and consists of a guide for their values, defining their conduct in the personal dimension of living.

> *I think it's rather important, being part of a community, because it directs us and strengthens us.* (S. 7)

> *Even though today I don't participate that much in this community, it's important to me, I respect it, it's my safe haven, every time I go there I feel good.* (S. 24)

> *I participate in a community and it's extremely important to everyone, I always try to grow in it, I have daily spiritual habits, but I still think I need more to be able to grow.* (S. 5)

Class 2 - R/S Beliefs in the care relationship ME-YOU/ professional

In this class, the statements denote that beliefs about religion and spirituality influence behavior regarding professional practice. In this sense, one can say that although they do not feel totally at ease, because the word *care* also appears here as a synonym of *prudence*, there is an indication of the effort to encase the ME-YOU relationship in the values of the *ethos of human life*, which is common to all religions and aims to foster co-responsibility, helping people provide care as a mutual responsibility[13]. Here the highlighted words were: *professional, influence, care, integrated, person*.

> [...] *sometimes at work we focus more on the technical aspects and set aside circumstances that are related to the people and the outcome itself, and that should be better integrated. I even think I do it a little bit.* (S. 8)

> *They also influence my professional life, because from the moment I believe it, I seek care for my patient in a way that I don't expose him to any harm,* [...] *taking better care.* (S. 3)

> *One can pray a little, to actually be a bit more integrated with the professional life ... But anyway when we take care of each other, we have to be very careful not to express too much and overwhelm, too, because sometimes belief is something dangerous.* (S. 17)

Class 4 - R/S Beliefs in the care relationship - ME and the Divine

In this class, the statements denote that the *ethos* of human life is also based on the relationship with the transcendent, humanizing care actions. "*Indeed, the search for the transcendent contributes to people having a reference beyond themselves and not drowning in individualism and selfishness*"[13]. The fragments of the statements that refer to the idea that *we are all one, the belief in the transcendent, in the spirit that guides human actions, in reincarnation,* invoke an effort around the promotion of the well-being of others. Here the prominent words were: *love, neighbor, spirit, part, (we) are, soul, body, essence*.

> [...] *From the moment you identify with what we really are, with our real essence, our soul, our consciousness, and no longer with the body and the sensations, I call that transcendence.* (S. 16)

> [...] *the physical characteristic guided by a spirit starts to show, and that spirituality has to be crafted so that we can know how to live in society, knowing how to share an elevator, knowing where we should park a car.* (S. 23)

> [...] *I think the detachment from material stuff and in general is charity, in the broad sense of always seeking to work for the benefit of the neighbor* [...]. *It's the love of the neighbor,of God.* (S. 20)

Class 3 - R/S Beliefs as strategies to address challenges in daily life

In this class, discourses emerge revealing that the beliefs about religion and spirituality are used as religious-spiritual coping (RSC). Here the prominent words were: *purpose, stress, belief, (I) think, (I) handle, religion, life, meaning*.

> *I have beliefs, I'm a spiritualist* [...]. *Due to my area, pediatric intensive care, which raises a lot of stress, so my beliefs help me a lot to handle stress and the end of life.* (S. 24)

> [...] *although I'm not very religious, I do have a support and there's a very important meaning in my life, it helps me deal with stress for sure.* [...], *faith that I have on the continuity of life, I believe in reincarnation.* (S. 22)

> *I do have spiritual beliefs. I have my religion, I'm a Christian, I'm a Catholic I believe my faith helps me calm down but gives me a purpose. It helps deal with difficult moments of life, since at certain times… even though we are scientific people* [...]. (S. 18)

DISCUSSION

Almost all respondents had religious beliefs, confirming the results of studies[4-5] about the religious profile of Brazilians. Only one participant declared no belief in God. Regarding professional education, 84% of faculty were more than ten years post-graduation, characterizing them as a group with considerable professional experience. The combination of these two aspects suggests that teachers have the potential to empathize with patients, making an accurate assessment of whether or not the incorporation of religious beliefs in the practice of health care is necessary. Research indicates that the most influential indicator on approach or not approaching spiritual matters by a healthcare professional with patients is not related to the health condition, but the very spirituality of professional[1].

The findings of the free association questionaire indicate that study subjects did not distinguish between the terms, religion and spirituality, overlapping concepts. The comprehension of spirituality of professors does not distinguish the most dynamic character based on personal emotional experience, which characterizes the spirituality process, regardless of the existence of religious beliefs. The meanings of *religion* and *spirituality* were indistinguishable for the studied group.

The vagueness about the terms was frequently referred to in a study on the subject[8]. A literature review aimed to verify the conceptual content of the spirituality topic. The study indicated four central elements within the term, spirituality: transcendence, relationality, center / power / soul, and meaning / purpose[8].

The two axes that emerged in the results suggest a search for meaning and significance in the personal as well as the professional dimension, confirming that the search for meaning and significance is a fundamental human need, which distinguishes the human being from other species. "Human beings are interested in the meaning of things. What is the meaning of this or that? Intelligence extracted sense from this ability, contextualizing and transforming. Men are different from machines and animals because of their awareness of their existence"[14].

Social representations of religious experience carry personal and social dimension. Religious experiences referred not only to immediate attachment or particular experiences of each person, but they were also related to the religious and cultural tradition in which they are integrated[15]. Thus, social representations indicate how to organize mediations between the purposes and ways that faculty use in its work practice, expressing cognitive, ethical and aesthetic meanings.

Aspects emerging from the axes are reaffirmed in the content analysis of each identified class.

The religious community as a guide for living

Involvement in a religious community influences daily life, habits and the relationship of the subject with the world. A common point in religious communities is the inclusion of a basic ethos in its essentials. In this, norms, values, ideals and goals coated by humanity are included, which are competent to connect people for universal validity[13]. These rules are reinforced by church leaders and concretized through social interaction within the religious community[2].

The content statement of faculty members ratified that religious community is where their behavior is suitable, from its specification in the teaching of holiness.

For Bauman[16], words have meaning, but some of them maintain sensations. In his perception, the word community would be one of them. "The community is a warm place, a comfortable and cozy place. It is like a roof under which we are sheltered from heavy rain, as a fireplace in front of which we warmed our hands on a cold day"[16].

It is a fact that research indicates the existence of a significant connection between religion and social support[7]. Participation in a religious community has been associated, not only with an increased number of links and social interactions, but also the best quality of these relationships[1]. Satisfactory levels of religious involvement are positively associated with psychological well-being indicators, such as life satisfaction, happiness, positive affect and high morale[2,7].

The religious community plays two important roles. While protecting the individual, it also plays an important role of enhancing social integration.

Considering that this axis and this class refer to the influence of beliefs about religion and spirituality in the individual life of faculty, and based on the content of representations emerging from this class, it can be deduced that belonging to a religious community provides identity and security to the study subjects.

R/S Beliefs in the care relationship ME-YOU/professional

This class shows the existence of a statement predisposing teachers to integrate sacred teachings into care practice. Based on this intentionality, the displacement of a merely technical view to enhance the other, the patient is able to be transferred to the place for a caring subject rather than remaining the object of clinical interventions, exercising his autonomy. This displacement favors the shared relationship, evoking professional empathy for faculty members.

The principle of autonomy enables the inclusion of YOU - represented by the patient - in decisions regarding therapies to be adopted in the course of their treatment. In this context, the professional attitude is crucial for the patient to become the subject of care.

An empathic ability and compassionate feelings in a relationship are as important as the professional's ability for diagnosing, treating and caring for a patient. In this line of argument, studies have shown that the ability to support patients in their suffering requires health professionals who know how to be compassionate, transmitting dignity according to the family's spiritual needs[12]. So, in relational therapy, the central idea is the recognition, attention and support to be provided for patients during their disease process, aiming for comprehensive care.

Meeting the patient's demands about spiritual approach, and the spiritual needs related to the disease, can affect his mental health. Often, the patient's wishes, beliefs and values play an important role in decision-making for treatment planning. In addition, when a person is hospitalized, he is removed from his religious communities[1], which sometimes means the loss of a important link.

In the statements from the faculty members, it was possible to identify an effort to break with the more technical approach to disease, as well as some concern about approaching the religious and spiritual theme. When approaching this subject with patients, professional barriers include: lack of knowledge, training and time; discomfort with the subject; fear of imposing religious views or offending the patient; the belief that knowledge about religion is not relevant to health care or that is not within one's competence to approach such matters[6]. There is evidence that non-religious professionals can address the spirituality issue in clinical practice as properly as religious ones[2]. Specific training, in addition to having the support of a team also trained to meet the spiritual dimension of human care, must be provided for them to do that.

Because of the technicality and specialized education of faculty and the lack of proper training, the field of beliefs about religion and spirituality in daily practice are found to be difficult to be integrated into comprehensive care. Although health professionals recognize the importance of integrating spirituality into health care, the fact of not knowing how to do that may restrict the integration of these elements in practice[10]. Beliefs about religion and spirituality seem to help faculty members in the performance of their professional activities, based on the exercise of the holy teachings.

From this perspective, the content of this class indicates that the R/S beliefs minimize barriers, favoring empathy in care.

Interpersonal teaching and patient relationship acquire competence, quality and humanity, providing changes in the view and appreciation of others that becomes not only the object of technical operations, and that the patient is also seen as a subject.

R/S Beliefs in the care relationship - ME and the Divine

In the core of all religions, there is an ethos of transcendence, which is able to put a supreme reference beyond the individual and, above all, beyond individualism. The great religions warn researchers that science is not enough, and of the need to be coated with wisdom and enchantment to be capable of facing life's mysteries[13].

At the end of the first half of the twentieth century, scientists began to realize that around 1900, the contemporary scientific revolution began, which in many aspects was confronted with the modern revolution of the 16th and 17th centuries[17]. Max Planck, a physicist, began this process with the first writings on quantum theory, with his great power of questioning and transformation extended to other areas of knowledge. It is speculated that the contemporary scientific revolution would be marking the re-enchantment of science with the mysteries of life. In the words of philosopher Jean Guitton, cited by Regis, under the material universe:

> there is a reality not made of matter, but of mind; a wide thought that after a half century of groping, the new physics began to understand, inviting the dreamers who are to illuminate with fire the night of our dreams[17].

Statements of the faculty, legitimate representatives of the thinking of science in contemporary society, suggest an integration of the holy in the profane actions in daily life. Paraphrasing Scussel[14] "it is not about discussing the existence of God, but of understanding how faculty live from the image they built". In this context, the word faith has a prominent place, frequently evoked, both to represent religion as well as spirituality, in the questionnaire of free association.

For faculty, this faith represents a positive power capable of connecting daily life with the world and the transcendent. Reaffirming that

> what makes a man better, expanding his relationships and quality of life [...], goes through his beliefs, his faith[14] that transcends both rational acts, such as non-rational human life[14].

The content of the statements of the faculty shows that faith allows connection, reconnect ion and integration of the body, soul and spirit in the construction of an ethos of coexistence that provides guidance, from the simplest actions such as *parking a car,* to *trying to work for the benefit of the next one,* demonstrating the love of God. According to religions, "love each other" and "love God", are configured as a single movement.

In this line of argument, loving and caring have been distinguished as a commitment to humanization, and the maximum expression of ethics[18]. "Love means accepting the other within us, there is no socialization without love, and there is no humanization without socialization"[18].

The representation of this class indicates that it is necessary to humanize social relationships. However, it was not explained whether this movement extends to the classroom. In the case of professionals working in education, this humanization should be part of the undergraduate course.

R/S Beliefs as strategies to address challenges in daily life

The term religious/spiritual coping - RSC was used by Pargament[19], who has extensively studied the role of religion in stress-coping strategies. Thus, RSC refers to the use of sacred elements (religious and spiritual) as a way of responding to stressful events faced throughout life. Four assumptions support this concept:

> existence of a threat, damage or challenge; assessment that a person makes about the situation; available resources to deal with stress and responsibility when facing certain experience. The individual's quality of life is directly affected by positive religious/spiritual coping (PRSC) or negative (NRSC) [20].

Thus, the elements of religious and spiritual coping is not always positive, and may also be negative. For example, when a person creates magical thoughts and prays, awaiting a cure that does not happen, disappointment and resentfulness with God may be felt. In this case, it is negative coping.

However, studies show that positive religious coping is used more frequently than negative[1]. This statement was ratified in a RSC assessment study with 45 families of ICU patients, revealing that during the hospitalization process, RSC strategies were more positive than negative[20]. The recognition of religiosity and spirituality as RSC favors identifying the spiritual needs of patients, and enables the professional to plan and provide care in the most comprehensive way possible[21].

In reference only to the professional dimension of university faculty members who teach the health routine, it is quite demanding and characterized by a daily rush. Participation in committees, panels, ad hoc consulting, pressure to publish research and subordination the institutional and governmental rules are in addition to the overload of educational activities, with the need to read for lesson preparation, correct exams, and monitor students in practical classes.

In the context of health care practice teaching, there is still the experience with the disease process, suffering, pain and death. The disease can arouse existential questions for patients, their families, as well as for health professionals. The understanding of why people suffer, die or have to cope with stress is often difficult for faculty to answer.

Representations of this class demonstrate that, compared to the feeling of helplessness when faceing difficulties and pain that can not be softened only through a technical approach, the strength to maintain the required work is founded in the beliefs that, derived from different aspects, help faculty to overcome the immanent plan, supporting and giving sense to the reality in which they are integrated.

FINAL CONSIDERATIONS

The results indicate that, for faculty memers, the representations of religion and spirituality are forged around a faith and belief in God. Faith gives them peace and strength to deal with the challenges of daily life, highlighting the meaning and purpose of life. This view is aligned with the imaginary consensus on the religious theme, as such beliefs constitute a form of approximation to spiritual consciousness and are integrated into the culture.

Considering the concepts adopted in the study, an overlap between the meanings of religion and spirituality in the understanding of the faculty can be identified. However, this conceptual disagreement does not seem relevant, since the study revealed that personal behavior is strongly influenced by these representations, providing the support and necessary faith renewal in the search for meaning and purpose of life. It was possible to learn that, in addition to guiding their personal and professional life, it also provides support to face daily challenges.

The study did not show at what level these representations influence teaching practices. This limitation is recognized, and the need to conduct further studies in order to answer this question is acknowledged.

The search for meaning and purpose in life should be encouraged by professors in promoting comprehensive care, both in patient care, as well as in the learning process of students. In the teaching profession, it is noteworthy that during training, the value of production of meaning and purpose across suffering that often permeates the subjectivity of the patient, must be included as part of therapeutic interventions to be taught in the classroom.

The conclusions indicate that it is necessary to associate the competence of caring for the physical body and spirit, in order to meet the needs of the totality of the human being, and approach humanization of health care. Therefore, the incorporation of spirituality into the undergraduate curricula and the process of teaching - learning in health care, is essential.

REFERENCES

1. Koening H. Medicina, religião e saúde: o encontro da ciência e da espiritualidade. Abreu I, Tradutor. Porto Alegre: L&PM; 2012.
2. Moreira-Almeida A, Stroppa A. Espiritualidade e saúde: o que as evidências mostram?. Revista Debate Psiquiatria. 2012;2:34-41.
3. Tomasso CS, Beltrame IL, Lucchetti G. Knowledge and attitudes of nursing professors and students concerning the interface between spirituality, religiosity and health. Rev Lat Am Enfermagem [Internet]. 2011 Sep-Oct [cited 2013 Aug 02];19(5):1205-13. Available from: http://www.scielo.br/pdf/rlae/v19n5/19.pdf
4. Gallup Worldview. Is religion na important part of your daily life? 2011 [cited 2013 Aug 02]. Available from: http://www.gallup.com/poll/142727/religiosity-highest-world-poorest-nations.aspx
5. Moreira-Almeida A, Pinsky I, Zaleski M, Laranjeira R. Religious involvement and sociodemographic factors: a Brazilian national survey. Rev Psiquiatr Clín [Internet]. 2010 Jan [cited 2015 Apr 02];37(1):12-5. Available from: http://www.scielo.br/pdf/rpc/v37n1/en_a03v37n1.pdf
6. Santos SF, Incontri D. Abordando a espiritualidade na prática clínica: rumo a uma mudança de paradigma. In: Santos FS, Incontri D, organizadores. A arte de cuidar: saúde, espiritualidade e educação. Bragança Paulista: Comenius; 2010. p. 214-30.
7. Koenig HG. Espiritualidade no cuidado com o paciente: por que, como e o quê? 2. ed. São Paulo: FE Editora Jornalista; 2012.
8. Williams JA, Meltzer D, Arora V, Chung G, Curlin FA. Attention to inpatients' religious and spiritual concerns: predictors and association with patient satisfaction. J Gen Intern Med [Internet]. 2011 Nov [cited 2013 Aug 02];26(11):1265-71. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3208457/pdf/11606_2011_Article_1781.pdf
9. Hufford DJ. Visionary spiritual experiences in an enchanted world. Anthropology and Humanism [Internet]. 2010 Nov [cited 2013 Aug 02];35(2):142-58. Available from: http://onlinelibrary.wiley.com/doi/10.1111/j.1548-1409.2010.01063.x/epdf
10. Esperandio MRG. [Theology and the research on Spirituality and Health: a pilot study among health professionals and chaplains]. Horizonte [Internet]. 2014 Jul-Sep [cited 2015 Apr 03];12(35):805-32. Available from: http://periodicos.pucminas.br/index.php/horizonte/article/view/P.2175-5841.2014v12n35p805/7119 Portuguese.

11. Jodelet D. Presença da cultura no campo da saúde. In: Almeida A. Violência, exclusão social e desenvolvimento humano: estudos de representações sociais. Brasília (DF): Editora da UnB; 2006.

12. Puchalski CM. A time for listening and caring: spirituality and the care of the chronically ill and dying. New York: Oxford University Press; 2006.

13. Oliveira JLM. Diálogo entre religião, ciência e ética: desafios e contribuições da psicologia. In: Freitas MH, Paiva GJ, organizadores. Religiosidade e cultura contemporânea: desafios para a psicologia. Brasília (DF): Universa; 2012.

14. Scussel MS. [Self-comprehension and the Divine's representation through a multidisciplinary look]. Protestantismo em Revista [Internet]. 2012 May-Aug [cited 2015 Apr 03];28. Available from: http://periodicos.est.edu.br/index.php/nepp/article/view/227/350 Portuguese.

15. Aletti M. A psicologia diante da religião e da espiritualidade: questões de conteúdo e método. In: Freitas MH, Paiva GJ, organizadores. Religiosidade e cultura contemporânea: desafios para a psicologia. Brasília (DF): Universa; 2012.

16. Bauman Z. Comunidade: a busca da segurança no mundo atual. Rio de janeiro (RJ): Jorge Zahar editor; 2003.

17. Morais R. Deus, a ciência e a educação. In: Incontri D, organizador. Educação e espiritualidade: interfaces e perpectivas. Bragança Paulista (SP): Comenicus; 2010.

18. Maturana H, Zoller G. Amar e brincar: fundamentos esquecidos do humano, do patriarcado à democracia. Mariotti H, Diskin, Tradutor. São Paulo (SP): Pala Athenas; 2004.

19. Pargament KI, Smith BW, Koening HG, Perez L. Patterns of positive and negative religious coping with major life stressors. J Sci Study Relig [Internet]. 1998 Dec [cited 2015 Apr 06];37(4):710-24. Available from: http://www.jstor.org/stable/1388152?seq=1#page_scan_tab_contents

20. Schieder LP, Parejo LS, Puggina AC, Silva MJP. Spirituality of relatives of patients hospitalized in intensive care unit. Acta Paul Enferm [Internet]. 2013 [cited 2015 Apr 06];26(1):71-8. Available from: http://www.scielo.br/pdf/ape/v26n1/en_12.pdf

21. Guerrero GP, Zago MMF, Sawada NO, Pinto MH. [Relationship between spirituality and cancer: patient's perspective]. Rev Bras Enferm [Internet]. 2011 Jan-Feb [cited 2015 Apr 06];64(1):53-9. Available from: http://www.scielo.br/pdf/reben/v64n1/v64n1a08.pdf Portuguese.