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Religiousness/Spirituality and their practical manifestations among health professionals that provide care to children

Religiosidade e espiritualidade de profissionais de saúde que cuidam de crianças e suas expressões práticas

Religiosidad y espiritualidad de los profesionales de la salud que atienden a niños y sus expresiones prácticas

Thamires Goulart Lambranho de Azevedo[I]; *Márcia de Assunção Ferreira*[I]

[I]*Universidade Federal do Rio de Janeiro. Rio de Janeiro, RJ, Brazil*

ABSTRACT
Objective: to know the personal knowledge and practices regarding religiousness and spirituality implemented by physicians and Nursing teams working in the care of end-of-life children. **Method:** a qualitative and descriptive study conducted between April and July 2024by means of semi-structured interviews with 30 participants. The lexical analysis of the text materials was performed with the aid of the Alceste software, as well as descriptive statistics about the participants' profile. The research was approved by an Ethics Committee. **Results:** the sample was mostly comprised by women with more than 20 years of experience and graduate studies; the majority considered themselves spiritualized and believed in divinities, with Kardecists, Catholics and Evangelicals standing out. Gaps were identified in how the concepts of spirituality and religiousness are understood, as well as in the way in which the practices are reflected in the routines through prayers, meditation and contact with nature. **Final considerations:** religiousness and spirituality comfort, support and influence the care provided. It is necessary to implement training programs and to enable spaces that integrate these dimensions into the professional practice.
Descriptors: Spirituality; Religion; Social Representation; Child; Health Personnel.

RESUMO
Objetivo: conhecer os saberes e práticas pessoais sobre religiosidade e espiritualidade de médicos e equipe de enfermagem atuantes no cuidado de crianças em processo de terminalidade. **Método:** estudo qualitativo, descritivo, com 30 participantes, realizado entre abril e julho de 2024, por entrevista semiestruturada. A análise dos textos foi lexical, pelo Alceste, e estatística descritiva sobre o perfil. Aprovou-se a pesquisa em Comitê de Ética. **Resultados:** a maioria foi de mulheres, com mais de 20 anos de experiência e pós-graduação. A maioria se considera espiritualizada e acredita em divindades, com destaque para kardecistas, católicos e evangélicos. Identificaram-se lacunas na compreensão dos conceitos de religiosidade e espiritualidade e como as práticas se refletem no cotidiano, com orações, meditação e contato com a natureza. **Considerações finais:** a religiosidade e espiritualidade confortam, apoiam e influenciam o cuidado. Há necessidade de formação e espaços que integrem essas dimensões na prática profissional.
Descritores: Espiritualidade; Religião; Representação Social; Criança; Pessoal de Saúde.

RESUMEN
Objetivo: identificar los conocimientos y las prácticas personales sobre religiosidad y espiritualidad de médicos y equipos de enfermería que trabajan en el cuidado de niños en fase terminal. **Método:** estudio cualitativo, descriptivo, con 30 participantes, realizado entre abril y julio de 2024, mediante entrevistas semiestructuradas. Se realizó análisis léxico de los textos mediante *el software Alceste*, así como estadística descriptiva de los perfiles de los participantes. La investigación fue aprobada por el Comité de Ética. **Resultados:** la muestra fue compuesta mayormente por mujeres, con más de 20 años de experiencia y posgrados, advirtiéndose que gran parte se consideraba espiritual y creía en deidades, especialmente kardecistas, católicas y evangélicas. Se identificaron lagunas en la comprensión de los conceptos de religiosidad y espiritualidad y en cómo estas prácticas se reflejan en la vida diaria, como la oración, la meditación y el contacto con la naturaleza. **Consideraciones finales:** la religiosidad y la espiritualidad confortan, apoyan e influyen en el cuidado. Se observa la necesidad de formación y de habilitar espacios que integren estas dimensiones en la práctica profesional.
Descriptores: Espiritualidad; Religión; Representación Social; Niño; Personal de Salud.

INTRODUCTION

When the World Health Organization included spirituality in the definition of health in 1998, research studies targeted at understanding its impacts on the population life conditions were driven[1]. A number of studies have shown the relationship between spirituality, religiousness and disease coping, highlighting their influence on health promotion and on rehabilitation processes[2].

Corresponding author: Thamires Goulart Lambranho de Azevedo. E-mail: thamires.goulart96@gmail.com
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Religiousness and Spirituality (R/S) are different concepts and important challenges arise when addressing them, especially in health, taking into account their social and cultural implications[3]. Religiousness refers to how religion-associated values and practices are experienced, with the possibility of manifesting itself intrinsically (at the personal level), such as through prayers and reading religious materials, or extrinsically (at the collective level) by taking part in cults, mass and religious meetings. In turn, spirituality is a broader concept related to beliefs and practices that may or may not involve faith in supernatural states or entities. However, its definition is essentially subjective and personal[4].

Religiousness and spirituality are widely acknowledged as fundamental health care dimensions and can exert an influence on the perceptions about experiences in health, illness, treatment and cure processes in terms of the physical, emotional or mental dimensions, even with diverse influence on care, be it related to self-care or to professional decisions[5]. In this sense, religiousness and spirituality are important objects to be studied in the health field.

Despite this relevance, the initiatives ensuring their effective incorporation into academic curricula such as in Nursing ones are still scarce, limiting the approach to these aspects in professional training[6]. Given this, it becomes essential to research about religiousness and spirituality along with health professionals that provide care to children, seeking to understand what they know about such topics and how they apply them in their personal actions. This refers to the necessary relationship between knowledge and practice.

Such considerations related to the set of perceptions, knowledge, practices and behaviors that people incorporate based on R/S allow them to formalize them as Social Representation (SR) phenomena, as they reflect collective constructions that convey beliefs, values, opinions and behaviors inherent to specific groups, in line with the way in which Moscovici[7] and Jodelet[8,9] conceive the elaboration of meanings about reality, shared in interactions, rooted in cultures and in given historical contexts.

In the context of caring for end-of-life children, there are still few studies analyzing the influence exerted by spirituality and religiousness in the performance of the professionals serving them. This scenario reveals restricted interest among the scientific community in understanding the mechanisms underlying this relationship in Palliative Care situations[2].

In this sense, the study objective was to know the personal knowledge and practices regarding religiousness and spirituality implemented by physicians and Nursing teams working in the care of end-of-life children, with a view to contributing to reflections that expand the debate about how these aspects are integrated into health care.

THEORETICAL FRAMEWORK

The way in which health and disease processes are understood undergo constant changes, and the World Health Organization (WHO) adopts a dynamic view that integrates the biological, psychological, social and spiritual dimensions. Although factors such as religiousness and spirituality are fundamental for living conditions, they have been neglected in health practices for a long time. However, these aspects have lately gained increasing focus and were progressively more incorporated into the care provided, with emphasis on their practical relevance[6].

With a Kartesian approach, the biomedical model centers its attention on systems and organs, with the main focus aimed at the biological aspects of a disease, leading to a fragmented view of the human body. In this model, nosological diagnoses and physical treatments are highlighted and the complexity inherent to human beings as a whole oftentimes becomes secondary. This limited view impairs the patients' broader understanding and leads to fragmented care centered on the pathologies, reason why it has been questioned, opening room to implementing another model (the biopsychosocial one) with a more encompassing view characterized by an integrative perspective[10-12].

This movement characterized by debates about the biomedical and biopsychosocial paradigms has intensified in the last few decades due to the expansion of the health conception that has called for the incorporation of a more integrated approach, which not only encompasses the biological aspects but also the psychological, social and spiritual ones. In 1998, the WHO expanded its multi-dimensional concept of health, acknowledging the spiritual dimension as a quality life component along with the physical, psychological and social aspects[10].

Consequently, the R/S integration has been increasingly explored as a way to enrich care practices and face diseases. An expression of this interest is manifested in the diversity of instruments and scales to incorporate R/S care, some of them to assist in communicating and exploring spiritual beliefs, favoring more humanized care[13].

In Brazil, interest in this topic has increased in the last few years driven by the religious diversity inherent to the country and by the health professionals' commitment towards a holistic approach that encompasses the biopsychosocial and spiritual aspects[10,11,14].

Research Article
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In this research, the knowledge and practices were explored through SRs, which gather individual representations that functionally and socially link the object represented in a given population, easing its communication and actions[15]. They correspond to thought processes in which people internalize symbolic objects that influence their practices[16].

In the professional context, these representations do not exclusively arise from academic training; they are shaped throughout life by means of social experiences and interactions[12]. Thus, understanding these constructions allows analyzing how health professionals integrate both technical-scientific knowledge and the wisdom acquired in their life experiences.

This study adopted a procedural approach with the purpose of understanding the SRs of a given group, examining them through their discourse and behaviors in relation to the object researched and, therefore, meeting the research objective by identifying the way in which knowledge about the phenomena under study is constructed and how it guides the care practices. This implies analyzing how the participants' thoughts evolve in SR studies. Consequently, it is sought to explore who has the knowledge, from which social place they are speaking, which process contribute to their construction and the effects generated by this wisdom on the professional practice[8].

METHOD

This is a qualitative study of a descriptive nature that seeks to understand the complexity involving the diverse knowledge and practices about religiousness and spirituality in health professionals' routines. This approach allows exploring the experiences underwent, providing an in-depth analysis of the phenomenon under study. The research is grounded on the Theory of Social Representations (TSR) to achieve this end[7], adopting a procedural approach[8] to investigate how these concepts are constructed, shared and applied in the professional practice.

It was conducted at three pediatric sectors from a federal public institution located in Rio de Janeiro, namely: Pediatric Intensive Care Unit (PICU); Pediatric Nursing (PN); and Intermediate Care Unit (InCU). Altogether, these sectors serve patients aged from 29 days to 18 incomplete years old. Each unit has specific structures and teams, targeted at the care of children with different clinical complexity levels, including intensive, semi-intensive and low-/medium-complexity care.

The group of participants was comprised by nurses, physicians and nursing technicians assigned to the sectors selected, in both shifts (day and night) and providing direct and continuous care to pediatric patients. The professionals included were all those reported in the group of participants working for at least one year in these sectors and providing direct care to pediatric patients. The exclusion criteria considered were as follows: residents, professionals on holiday or on medical leave during the data collection period, and those not providing direct care to the children hospitalized in the sectors researched. The professionals that met the criteria were invited and there were no withdrawals after they gave their consent to participate.

A total of 30 professionals met the criteria and were considered as participants. The qualitative sample was intentionally selected and not based on probability. In order to recruit the participants, the researcher visited the sectors selected with the objectives of making her first contact with the health professionals, presenting the research, clarifying doubts and providing relevant information about the study.

In studies on the size of qualitative samples, the recommendations is to conduct approximately 30 interviews as a guide for researchers; however, safety in relation to the results should be guided considering the objectives, the theoretical stance and the analytical structure that will be applied in the research. In this sense, data saturation also serves as a framework for achieving greater density in the assertions based on the data produced[17,18].

During these visits, the professionals were invited to take part in the research and, once they had accepted, they provided their phone numbers to schedule the interviews at appropriate times. The participants' recruitment process was ended by means of a pre-analysis of the contents as each interview was conducted. When concluding that the research empirical framework had been outlined by applying the data saturation criterion[14], recruitment was ended with 30 professionals: 10 from each professional category.

The data were collected between April and July 2024 by means of semi-structured interviews. The instrument applied was organized in two parts: the first one consisted in objective questions to outline the participants' socioprofessional and demographic profiles, such as profession, time since graduation, age, sex/gender, specialization and having addressed the topic in undergraduate studies and religion. In turn, the second part consisted of a semi-structured script with open questions related to general knowledge about what religiousness and spirituality are and what they thought about these topics; and how they apply and/or put religiousness and spirituality into practice in their personal life. The interviews were conducted by the lead author (a nurse specialized in Pediatrics), who was also in charge of transcribing the testimonies. The second author took part in the process to devise the instruments, in the *corpus* review and in data treatment in the software.

Research Article
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It is noted that a pilot test was applied to three professionals (one from each category), who met the inclusion criteria defined for this study but were not included in the qualitative sample design. It was not necessary to make any adjustment to the instruments after the test. The interviews lasted between 20 and 40 minutes and were voice-recorded in an electronic device. The audios from the interviews were recorded and subsequently transcribed by the researchers.

The sociodemographic data were organized in Excel 2007 and analyzed by means of simple and percentage descriptive statistics. The interviews were transcribed and subjected to lexicographic and lexicometric analysis with the aid of the Alceste® software (version 2012), based on a single *corpus* structured following the program's own rules.

The research protocol was approved by a Research Ethics Committee as per the ethical guidelines established for research studies with human beings. Data collection was initiated immediately after due authorization from the participants, who signed a Free and Informed Consent Form.

The participants' identity was preserved by using codes, namely: Nursing Technician (NT); Physician (Ph); Nurse (Nur); Female Gender (F); Male Gender (M); in turn, as for religion; Atheist (A); Agnostic (Ag); Catholic (C), Evangelical (E), Umbandist (U); Candomblist (Ca), Kardecist (K) and No Specific Religion (NSR), all followed by a number corresponding to the order in which each interview was conducted (from 1 to 30).

RESULTS

The sample was comprised by 30 health professionals and had predominance of the female gender, with 86.7%. As for the participants' age groups, predominance of subjects aged 40-49 years old (30%) was observed, followed by 30-39 (23%); in turn, 20-29 years old accounted for 13%, with 50-59 and 60 years old or more totaled 17% each. Predominance of participants with more than 20 years since graduation was noticed, representing 50% of the sample; it is noted that the range of less than five years recorded 7%, whereas 6-10 and 11-15 years were equal at 17% each and 16-19 years totaled 10%. As for the “graduate studies/specialization” variable, there was predominance of those having attended these training levels, representing 86.7% of the sample, with only 13.3% of the participants having no graduate studies or specialization.

Greater predominance of Theists (in other words, individuals that believed in at least one God) was also observed, corresponding to 83.3% of the sample; in turn, Atheism was stated by 10% and Agnostics represented 7%. According to religious designations, most of the participants were Kardecists (30% of the sample), followed by Catholics (23.3%) and Evangelicals (20%). The participants professing no religion totaled 20% of the sample; in turn, Candomblists and Umbandists accounted for 6.7%, the lowest percentage in this population.

As for the “presence of spirituality” variable, there was predominance of health professionals that considered themselves spiritualized (representing 90% of the sample) with only 10% of non-spiritualized participants.

In relation to the “having addressed the R/S theme in professional training” variable, there was predominance of professionals that did not have the topic addressed in their training (corresponding to 76.7% of the sample), followed by only 23.3% of participants that did have it addressed.

The *corpus* processed in the Alceste® software consisted of 30 Initial Context Units (ICUs) and seven variables. The total number of forms contained in the *corpus* was 81,917, with 5,187 different forms analyzed and 1,027 forms for analysis after due reduction. The mean number of words analyzed by Elementary Context Units (ECUs) was 18.18.

Leverage of the *corpus* in the software was 75%, subdividing the texts into 1,417 ECUs distributed in two blocks with four lexical classes. This study focuses on lexical classes 3 and 4, where the diverse knowledge and practices related to Religiousness/Spirituality (R/S) are identified, as well as their reflections in health professionals' routines. Table 1 consists of classes 3 and 4, which include words with similar meanings; however, the classes are separated from one another because there are also differences that should be considered. In Class 3 retention corresponded to 9% of the *corpus*, with 128 ECUs and 102 words suitable for analysis; in turn, Class 4 retained 14% of the *corpus*: 194 ECUs and 116 words suitable for analysis. Class 3 reveals the professionals' conceptions regarding R/S, as well as the existing gaps in how these phenomena are understood. In turn, Class 4 evidenced how the practices linked to R/S are made a reality in the professionals' personal experiences.

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Table 1: Descending Hierarchical Classification dendogram, based on the interviews with Medicine and Nursing professionals from a hospital specialized in Pediatrics (n=30). Rio de Janeiro, RJ, Brazil, 2024.

Lexical Class 3 Professionals' conceptions		Lexical Class 4 Personal practices	
Form	**Phi**	**Form**	**Phi**
differenc+	0.33	I'd_like_to	0.35
spiritualiz+	0.29	relat+	0.30
dogma	0.27	frequent+	0.27
care_p+	0.28	routine	0.26
exist+	0.27	practic+	0.23
specif+	0.25	pray+	0.22
necessary	0.25	Makes	0.22
foll+	0.25	I'd_l+	0.22
vis+	0.22	Day	0.22
Ritual	0.22	fac+	0.21
norms	0.20	Church	0.21
nature	0.20	than+	0.20
superior_for+	0.20	accord+	0.20
religiousness	0.20	Habit	0.19
Force	0.20	Read	0.18
religi+	0.19	hav+	0.18
consider+	0.19	I'm_going_to	0.17
concept	0.18	protection	0.17
spirituali+	0.18	bles+	0.16
care_p+	0.18	christ+	0.15
broa+	0.18	religi+	0.15
Believe	0.18	bibl+	0.15
Larger	0.18	slee+	0.15
involv+	0.18	Cult	0.15
divin+	0.18	pra+	0.15
superior	0.17	play_a_r+	0.15
connec+	0.16	worsh+	0.14

Class 3: Manifestations of the professionals' knowledge about R/S: Gaps in how these phenomena are understood

Lexical Class 3 includes 9% of all the ECUs that comprise the analysis *corpus* and consists of 128 reduced forms of words found in full. The analysis of the words associated with Class 3 evidenced the professionals' knowledge about religiousness and spirituality, as well as what the participants understand regarding differences between these terms. In addition to that, it was also possible to evidence the health professionals' comprehension gaps regarding these themes, as a large part of them did not study them during their professional training courses.

The contents where the words are included are better understood in the following ECUs:

> *The difference between spirituality and religiousness, although many people and even some of my professional peers mistake them, is absolute in the sense that I consider spirituality, the fact of you noticing that people exist beyond their physical body, that they have a different psychological manifestation and religiousness would be to imprison that inside a philosophical view.(Ph, M, K-2)*
>
> *For you to see that religion is actually a sect, whichever it is. I've already been a Buddhist, Kardecist and Umbandist myself; I've already frequented several types of religions and now I see that it's everything a sect-like view. It even looks like soccer and its organized fan groups that enter into conflict, as I see it. (Ph, M, K-2)*
>
> *I believe there are differences between religiousness and spirituality. I believe that spirituality is not necessarily linked to any religious practice. I know many people, even people that believe in divinities, they believe in saints and they don't necessarily have any defined religion, but they believe in some force superior to the human one. (Nur, F, E-28)*
>
> *Spirituality is how you connect with the universe, not necessarily through mediation by some institution or other. I believe it's that. For me, spirituality practices or manifestations is you believing there's some larger force that rules the universe (Ph, F, K-29)*
>
> *And spirituality is but another way to be, to believe in some force, some power, some energy that you can find in nature, in the sea, in the Sun. (NT, F, C-5)*

Research Article
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> *I think there's a difference between religiousness and spirituality. Religiousness is when you really believe in and profess some religious doctrine, following all its norms and rituals. Spirituality is believing in something beyond what you can see, beyond what you can touch. It's believing in something that's above human existence. (Nur, F, K-7)*
>
> *Spirituality is having that sensation of a larger energy that drives you. I think it's that, I think I can't explain much more than this. In turn, for me religiousness practices or manifestations is you praying what is prayed in the religion you profess; for example: I'm a Kardecist, we pray for charity in the first place. (Ph, F, K-23)*
>
> *Spirituality is when a person believes that there's another plane in addition to ours. It's believing in some superior power, in forces beyond human ones. And religiousness is when a person has faith in that religion, only the one they believe in. When they follow the beliefs and rules of a given religious doctrine. (NT, F, NSR-20)*

Class 4: How R/S practices manifest themselves in health professionals' routines

Lexical Class 4 includes 14% of all the ECUs that comprise the analysis *corpus* and consists of 166 reduced forms of words found in full. The analysis of the words associated with Class 4 deals with the way in which R/S practices manifest themselves in health professionals' routines.

The contents where the words are included are better understood in the following ECUs:

> *Then I'm always using my scapular, it's already a part of me. In relation to religion, what I do is pray all day, mainly before going to bed, I'm always thanking God for good things too, for deliverance, those things. I like listening to some Catholic Church music that soothes me. (Nur, F, C-22)*
>
> *I take part in Spiritualism study groups, I attend a Spiritualist center, I do Evangelical cults at home, those things. I'd like to do more in relation to religion, no doubt, because I believe this helps me in my life here on Earth, also to evolve spiritually and as a human being. (Nur, F, K)*
>
> *You profess your faith where you feel comfortable. And you're going to pray, you're going to do your prayers and thank. Religion plays a role in everything in my life. (NT, M, C-15)*
>
> *As for religion, I have the habit of praying. I pray all day, manly before going out of my house I make the sign of the Cross and ask for my path to be illuminated by my spiritual friends and that they also shed some light on my professional practice. (Ph, F, K-29)*
>
> *I think that spirituality practices or manifestations is having a thanking and praying routine, the fact of thanking for yet another day of life, thanking for nature, for the air we breathe. I have that at least. I have that praying and thanking daily routine. It's a moment when I connect with God, with my Guardian Angel too, I believe a lot in that. (Nur, F, K-1)*
>
> *I'd like to do more in relation to religion, mainly being more positive. Because with everyday issues, emotional stress, you sometimes end up forgetting to thank God, to thank for your food, your job, your health. (NT, F, E-21)*
>
> *And there are also everyday actions in relation to religion, such as doing a prayer, reading the bible, going to mass. Religion is my support, my faith and, even if I'm distanced, I believe a lot in God. It's what prevents me from going crazy when facing some problems, difficulties, joy too. (Nur, F, C-22)*
>
> *In relation to spirituality, I meditate, I have a lot of contact with nature. I like to be surrounded by trees, I like to be in contact with the sea, with the Sun, with waterfalls. And with religiousness itself too. I practice spirituality along with religiousness. My religious practices are linked to spirituality. (Nur, F, K-7)*
>
> *I don't do anything so transcendental that helps me live better with myself and others. I have habits I consider healthy, trying to have good social relations, sleeping well, practicing physical activity periodically, having leisure moments, contact with nature, rest moments. (Ph, F, A-18)*

DISCUSSION

Although there is no scientific consensus to specifically clarify what religiousness and spirituality are given the subjective nature of the topic, some authors propose a differentiation for didactic and research purposes. The concepts of spirituality, religiousness and religion should be analyzed individually in theoretical terms[19,20].

However, in the practical actions and experiences observed in health settings and other social contexts, it is noticed that these three phenomena are inter-related and mutually integrated, becoming a challenge for researchers to reach consensus about the specific meaning of each concept and their inter-relations. In addition to that, a single definition might be restrictive, as these phenomena are complex and multi-dimensional[10].

A fact to be considered is that most of the participants are Theists; in other words, they are individuals that believe in the existence of at least one divinity or supernatural being that exert an influence on the world and on human life. Theism includes a broad range of beliefs, from faith in a single God (Monotheism) to believing in several ones, which is called Polytheism[20].

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Although many people who believe in divinities do have some religious designation, not all Theists are formally identified with a given organized religion: they may have personal beliefs without necessarily following any specific religious structure. However, it is important to know about this profile because beliefs, religions and spirituality manifestations can exert an influence on the way in which health professionals and family members face issues related to grief, distress and acceptance of death, for example[13].

SRs link ideas and experiences; and life events show the practical dimension of those SRs[21]. The specificity of the idea and the functional value of the concept can be seen through the objectivation and anchorage processes, allowing understanding people's actions and those of their groups when facing these phenomena[7,8]. In this sense, the way in which the distinction between spirituality and religion emerges significantly in the representations is identified in the results, when the former is understood by awareness regarding existence beyond the physical body, as a psychological perception that transcends the material world.

On the other hand, religiousness is objectivized and anchored in the idea of prison for some interviewees, when the perception about the transcendent is placed into a specific philosophical structure where norms, rituals and doctrines limit the freedom of spiritual experiences. The prison image conveys that religion reduces spiritual experiences to conformism with a pre-determined view where the answers are already defined, which may seem restrictive for a person seeking a freer and more personal spiritual connection.

Historically, R/S have always been connected with Nursing, but they lost relevance as Positivism advanced. This interest was renewed from the 1960s onwards with the development of holistic theories. Modern Nursing has been increasingly oriented towards care humanization, distancing itself from the traditional biomedical model. This movement has increased the frequency of R/S-related issues in care practices[6].

The number of studies on R/S has increased significantly. However, as can be identified in the ECUs highlighted, R/S are still diffuse terms frequently mistaken by health professionals because, although related, they represent different concepts. Religiousness refers to practicing and adhering to a specific religion, manifested trough activities such as taking part in religious rituals, attending temples or praying as per the precepts of that religion. In general, it involves adopting beliefs, values and practices formalized and shared by a community of followers[11].

On the other hand, spirituality has a broader and subjective connotation. It is associated with an individual search for meaning, purpose and connection with something transcendental or superior, which is not necessarily linked to a specific religion. In summary, religiousness tends to be more institutionalized and collective, whereas spirituality is a more intimate and personal experience that can manifest itself either within or outside a religious context. This distinction allows people to feel spiritualized without necessarily professing a specific religion, as well as religious individuals that experience their spirituality in the context of their faith[11].

Therefore, it is identified that the health professionals' knowledge about religiousness and spirituality is similar to common sense wisdom about how R/S are usually understood in a fluid and interchangeable way, also with no large distinctions in their practical expressions. This leads to reflecting that they understand, experience and practice them that way in their personal contexts, as they should also do in professional contexts.

Combined with lack of opportunities for continuous learning and development, the absence of structured strategies to integrate religiousness and spirituality into the care process leads to a significant gap in reified understanding about these phenomena among health professionals. Spirituality and religiousness play a fundamental role in many patients' lives, influencing their attitudes in relation to health, diseases and treatments. However, without specific training addressing these aspects in an integrated and in-depth way, the professionals may feel unprepared to deal with spiritual and religious issues that arise in the care context[10,11] and to face the phenomenon in their professional performance, only resorting to the arsenal they have gathered through their personal practices.

A number of studies evidence that most students acknowledge the importance of spiritual approaches in care; however, they oftentimes seek references about the topic within religion itself. This practice can be inadequate because it unconsciously tends to impose personal beliefs on the patients' treatments, which may impair the impartiality and holistic approach required in health care. Each patient has unique religious and spiritual beliefs and values and, when transferring their own convictions, the professionals run the risk of neglecting the patients' religious or spiritual diversity, impairing care quality and respect for their choices[11,22].

Despite consensus among health professionals about the importance of incorporating R/S in the care practice, this approach still faces a number of challenges in Brazil. The difficulty lies in the fact that, although these competences are acknowledged as essential for more humanized and effective care, there is still no clear consensus about how to incorporate and structure them in the curricula of health courses, and even more so on how to apply them in everyday clinical practices[23].

Research Article
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A review study indicates that there are limitations in the humanized care provided by nurses to end-of-life children, as they not only need to offer psychosocial support to them and their families but also have to deal with their own emotions[24]. In addition, in the specificity inherent to pediatric cancer, the difficulty integrating spirituality in Nursing care is made evident by devaluation of the topic or inability to identify the children's spiritual needs and those of their families, as a result of insufficient knowledge[25].

The care to be provided in pediatric end-of-life situations requires delicate communication skills, empathy and emotional support for the families, abilities that go beyond the traditional technical competences. The absence of a teaching model that addresses R/S and the resistance to implement changes in the curricula can be factors hindering comprehensive training of health professionals, turning R/S application (especially in difficult contexts such end-of-life) into a challenging task for many professionals[11]. In addition, without proper training, the probability of not treating these human dimensions or even of omitting them is high, not leading to the humanized assistance necessary for comprehensive care.

The complexity inherent to the concepts of religion, religiousness and spirituality frequently creates divergences as for their scientific validity and relevance for the area, which emerges as an obstacle to including the topic in health training courses[6]. However, it is important to note that adopting a single definition for these phenomena can restrict both the scope of research studies and the subjective experience of these aspects[6], as well as the application possibilities in the care provided to these individuals.

Absence of theoretical deepening in training can make professionals develop a predominantly technical and biomedical view regarding R/S in the clinical practice, neglecting fundamental aspects inherent to the patients' experience. This can give rise to discomfort and unpreparedness to deal with patients and families whose beliefs exert a direct influence on the way in which they face their health, diseases, life and death[20]. In addition to that, inadequate training on R/S can lead to cultural insensitivity. Professionals lacking formal academic training in the scope of religiousness and spirituality applied to health and care can inadvertently disrespect or ignore the patients' beliefs and those of their family members, generating discomfort, ineffective communication and even ethical conflicts.

In this context, it is important to know the SRs regarding religiousness and spirituality among the health professionals working in care in pediatric end-of-life situations because these representations guide decisions and attitudes, justifying people's stances towards specific phenomena[9]. Thus, the way in which each professional understands religiousness/spirituality and how they will apply it to their practice (in case they are faced with a situation that calls for that) will be largely shaped by their personal beliefs and experiences in relation to them.

This variability in approaches to these themes due to the religiousness and spirituality SRs reflects the complexity inherent to end-of-life care for children, the working context of the research participants. This is why developing training in R/S may consider the professionals' personal experiences and life events to promote self-understanding regarding their practices, as well as about the gaps in reified comprehension of these phenomena. Collectively, this may be a way of assisting in devising more coherent and empathetic practices in the professional field. This way, the professionals would be better prepared to offer comprehensive and qualified care with due technical and scientific support, in terms of the patients' religious and spiritual dimensions and those of their families, even in challenging contexts.

For the participants included in this research, religiousness is a belief component that offers support and allows people to find meaning in everyday events, helping them to stay strong in their purposes and believe in something superior. It goes beyond religious practices or simply professing a given religion. It is about a lifestyle and a way of interpreting everyday life, involving specific dogmas, rituals, practices and costumes.

The participants' representations reveal that the concept of religiousness is quite broad and that there is no defined consensus about it. What prevails is the idea that religiousness is linked to aspects such as doctrine, faith, some specific religion, believing in at least one superior being or force, practices and religious dogmas and rituals, which can be manifested in different ways.

As for spirituality, the participants stated that this concept is related to each person's inner essence, to their connection to profound aspects inherent to it and to elements from nature such as the sea, the Sun and the trees. It is a way of living, believing in positive and negative energies; it is radiating good vibrations and trusting that there is something above men that offers answers and guidelines for life. Although it can encompass religiousness, not all people that experience spirituality follow or profess religious practices.

When asked about their strategies to promote personal and inter-personal well-being, the participants that do not identify themselves as spiritualized individuals mentioned habits such as proper sleep, practicing physical activities in the open air and maintaining good social relations. However, they did not relate these aspects to the concept of spirituality.

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The R/S object mobilizes experiences in the participants, sheltered in their beliefs and thoughts about existential issues, which shapes the formation of individual representations. However, common thoughts and actions are also identified, which may provide hints about sharing representations towards social representations. It is noticed that there is a more conceptual thought regarding what constitutes spirituality, with few variations in the answers and where connection with something superior without any need for a specific religion stands out. However, fluidity between Religiousness and Spirituality is also noticed, which points to a theory-practice and knowledge-actions gap, which can be attributed to scarce access to reified information in R/S teaching during professional training and in participation in scientific events related to the topic[23].

These considerations indicate that incorporating knowledge about the R/S object into the cultural contexts where the research participants live (especially that of professional training in the health field) urges them to converge certain ideas and practices about R/S in clinical contexts. Consequently, it is possible to apprehend R/S SRs that translate the relationships established by individual representations in the social and functional fields where a given phenomenon takes place, which in the case of this research is the care provided to end-of-life children, allowing for an inter-subjective understanding of the members from this professional group based on similar practical experiences[15].

As already addressed, when applying the TSR in studies on psychosocial objects, objectivation and anchoring stand out as sociocognitive processes[7,9] that make an abstract idea gain shape as a concrete and close image, with more familiarity than what was previously known, understood and acceptable. In the ECU from ICU 2, certain approximation between religions and the idea of soccer teams with their fans is noticed, in a sect-like conception related to religions understood as intolerant groups with excessive attachment to their own point of view. When addressing religion from this understanding, the idea of dispute is brought to the center of the stage, acceptable as a soccer match where both sides always go into the field to win and not exactly to accept each other in peaceful harmony. The issue of conflicts between sports fans is also considered, which would be between their followers or practitioners in the case of religions.

It is interesting to note this process because if common sense knowledge about religiousness/religion is diffused and anchored in dispute fields, assistance/care practices may be inhibited when the religions professed by the families and the professionals are different, sheltered in antagonistic conceptions about the birth-life-death process, for example. This is why it is so important to address the R/S topic in professional training since, in addition to introducing formal knowledge about the topic, it sensitizes the professionals towards the different understanding trends about the birth-life-death processes.

The fact that this theme is absent from the curricular components of Higher Education course in the health area highlights the importance of investing in graduate programs and continued training options in the work environment as permanent education modalities, in order to meet people's need with a more encompassing approach targeted at care integrality[23].

A qualitative study conducted with 38 nurses working in Palliative Care sectors from a public hospital showed that lack of formal training related to care aimed at the patients' spiritual dimension impairs implementing comprehensive assistance, with this education modality pointed out as a good strategy to minimize this deficit in training[26].

This issue regarding lack of formal training is also evidenced in continental China, where the specialized personnel to provide spiritual care to the patients is scarce. Nevertheless, a research study conducted with physicians, nurses and social workers active in pediatric Palliative Care showed that, although not formally organized, spiritual support is provided individually in the services but that education and training strategies are necessary to create the culture inherent to this care and to better structure the work done[27].

R/S practices manifest themselves in several ways in health professionals' routines, mainly in their personal ones. Religiousness and spirituality are widely acknowledged as essential aspects of human subjectivity, contributing to organizing life and to constructing meanings for people. In addition to that, they also exert an influence on physical, mental, cultural and spiritual well-being in an integrated way. R/S-related issues promote a dialog between science and faith in the health care context, not only valuing the life and history of each children treated but also the personal experience of each health professional in their life outside the work environment[23].

R/S among the health professionals working with end-of-life children are extremely relevant factors, supporting everyday performance of their activities and contributing to the quality of the care offered. Putting R/S into practice renders the professionals more attentive to the patients' needs, allowing for a broader and humanized care model. In addition to that, when spirituality and spiritual support are strongly present in a multi-disciplinary team, the spiritual and religious needs presented by the patients' families (which are vulnerable given the closeness of death) are also met. In

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other words, the professionals' beliefs are a determining factor in the way in which they will provide care to the patients and their family members[28].

However, the literature on this topic is limited, as most studies on spirituality and religiousness in end-of-life situations are mainly focused on the patients as analysis object. R/S are essential to help the professionals face the loss of patients, in addition to strengthening their everyday well-being, allowing them to integrate spiritual and religious practices into their personal life[28].

R/S in the health professionals' routine play a significant role both in their personal well-being and in their professional practice. These elements work as emotional support, resilience and meaning sources, helping them face the everyday challenges and stress inherent to their role. Spiritual or religious practices can provide reflection and inner strengthening moments, which helps professionals to deal with pain, losses and the complexity inherent to the cases they treat[29,30].

In addition to that, personal beliefs can promote greater openness to listening to the patients' life experiences and genuine respect for them, which eases establishing a relationship marked by trust and mutual respect. The professionals that integrate their beliefs into the practice can oftentimes offer additional support, especially at moments marked by distress or in end-of-life situations, helping patients and family members to find comfort and meaning.

On the other hand, the influence of the professionals' R/S demands some ethical balance so that their personal beliefs do not outdo the patients' needs and beliefs. In a diverse health environment, the challenge lies in offering compassionate and respectful care regardless of the cultural or religious differences between each professional and patient, always respecting each person's autonomy and singularities and those of their family[5].

Understanding the patients' religious and spiritual dimensions can help health professionals improve care quality, respect the families' beliefs and provide more suitable emotional support, promoting a more holistic and sensitive approach in pediatric end-of-life situations.

Study limitations

The study limitation is methodological, as it was conducted in a single hospital institution from the city of Rio de Janeiro targeted at assistance, teaching, research and technological development. Expanding research to other fields would enhance the results and, consequently, the contributions to the Health and Pediatric Nursing areas.

FINAL CONSIDERATIONS

Among health professionals caring for end-of-life children, the spirituality and religiousness SRs are permeated by multiple meanings, knowledge and practices, arising from their personal experiences and life events and with fluidity between the concepts. This hints to potential individual representations about the object represented. Nevertheless, similar testimonies asserting that R/S are sources of comfort, guidance and emotional support for health professionals are identified, establishing a connection with the transcendent and promoting safety and confidence, especially at moments marked by adversity. The R/S manifestations include practices such as prayers, participating in religious celebrations, reading the bible, thanking the universe, meditation, connection with nature and goodness actions.

Although some professionals do not identify themselves as professing a specific religion, many of them state having spiritual beliefs that exert a positive influence on their world view and inter-personal relations. Although the professionals do have their own conceptions about R/S (arising from SRs), these conceptions still lack sufficient philosophical and scientific deepening to be applied to the technical-professional field. Especially in the pediatric end-of-life context, it is essential to recognize and integrate these human dimensions in the care practice so as to provide more sensitive, welcoming and comprehensive care.

In order to overcome the challenges inherent to the R/S approach in the professional practice, it is necessary to include these topics in training, in a structured way. In addition to that, institutional spaces for critical reflection and to share experiences on the theme must be promoted. Such scenario points to the need to invest in permanent education strategies that promote developing relational competences and qualified listening, capable of welcoming diverse religiousness and spirituality manifestations found in care settings and respecting the singularities of patients, family members and professionals alike. The systematic incorporation of these topics into training processes represents a fundamental step to strengthening a humanized and comprehensive approach, committed to care complexity and to acknowledging subjectivity as a constitutive element of health care.

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REFERENCES

1. Rossato L, Sena BTS, Nascimento LC, Scorsolini-Comin F. Religiosity/spirituality (R/S) in professional practice in pediatric oncology: resource or protocol? Cienc Psicol. 2022 [cited 2025 Jan 05]; 16(2):e2324. DOI: https://doi.org/10.22235/cp.v16i2.2324.
2. Thiengo PCS, Gomes AMT, Mercês MCC, Couto PLS, França LCM, Silva AN. Spirituality and Religiosity in health care: an integrative review. Cogitare Enferm. 2019 [cited 2025 Jan 05]; 24:e58692. DOI: http://dx.doi.org/10.5380/ce.v24i0.58692.
3. Gomes AMT, Silva CM, Brandão JL, Couto PLS, Mercês MC, Araújo MAC et al. Spirituality and religiosity for umbandist and candomblecist women: social representation and health implications. Ciênc. saúde coletiva. 2023 [cited 2025 Jan 10]; 28(9):2721-31. DOI: http://dx.doi.org/10.1590/1413-81232023289.20172022EN.
4. Cunha VF, Almeida AA, Pillon SC, Fontaine AMG, Scorsolini-Comin F. Religiosity/spirituality in nursing practice: an integrative review. Rev Psicol Saude. 2022 [cited 2025 Feb 04]; 14(2):131–50. DOI: https://doi.org/10.20435/pssa.v14i2.1287.
5. Koenig HG. Spirituality in patient care: why, how, when, and what. West Conshohocken: Templeton Press; 2013.
6. Scorsolini-Comin F, Pillon SC, organizadores. Enfermagem psiquiátrica: como ensinamos? Ribeirão Preto: Centro de Apoio Editorial da EERP-USP. 2023 [cited 2025 Feb 04]; 180 p. 2022. Available from: https://www.livrosabertos.abcd.usp.br/portaldelivrosUSP/catalog/book/1450.
7. Moscovici S. A psicanálise sua imagem e seu público. Petrópolis (RJ): Vozes; 2012.
8. Jodelet D. Ciências sociais e representações: estudo dos fenômenos representativos e processos sociais, do local ao global. Soc Estado. 2018 [cited 2025 Jan 21]; 33(2):423-42. DOI: https://doi.org/10.1590/s0102-699220183302007.
9. Jodelet D. Representações Sociais: um domínio em expansão. In: Jodelet D, organizadora. Representações Sociais. Rio de Janeiro: Ed UERJ; 2001.
10. Rossato L, et al. Religiosity/spirituality from the perspective of nursing students: group experience report. Rev Saude Desenvolv Humano. 2021 [cited 2025 Feb 02]; 9(2):6879. DOI: https://doi.org/10.18316/sdh.v9i2.6879.
11. Marinho PRS, Silva JP. Religiosity/spirituality in the health professional training process: experience report. Rev Psicol Divers Saude. 2024 [cited 2025 Mar 20]; 13:e5206. DOI: http://dx.doi.org/10.17267/2317-3394rpds.2024.e5206.
12. Almeida PJR, Caldeira FID, Gomes C. Do modelo biomédico ao modelo biopsicossocial: a formação de profissionais da saúde no Brasil. REBESDE. 2022 [cited 2025 Jul 31];3(2):e-017. DOI: http://dx.doi.org/10.33872/rebesde.v3n2.e017.
13. Bezerra JN, Evangelista CB, Cruz RAO, Ferreira FA. Instrumentos que avaliam a espiritualidade de pacientes em cuidados paliativos: revisão integrativa da literatura. Rev Interscientia. 2019 [cited 2025 Jan 15]; 7(2):160-73. DOI: https://doi.org/10.26843/interscientia.v7i2.930.
14. Forti S, Serbena CA, Scaduto AA. Spirituality/religiousity measurement and health in Brazil: a systematic review. Cienc Saude Colet. 2020 [cited 2025 Jan 15]; 25(4):1463–74. DOI: https://doi.org/10.1590/1413-81232020254.21672018.
15. Lahlou S. Social Representations and Individual Representations: What is the difference? And why are individual representations similar? RUDN Journal of Psychology and Pedagogics. 2021 [cited 2025 Apr 12];18(2):315-31. DOI: http://dx.doi.org/10.22363/2313-1683-2021-18-2-315-331.
16. Morera JAC, Padilha MI, Silva DGV, Sapag J. Theoretical and methodological aspects of social representations. Texto Contexto Enferm. 2015 [cited 2025 Feb 02]; 24(4):1157–65. DOI: https://doi.org/10.1590/0104-0707201500003440014.
17. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant. 2018 [cited 2023 Nov 10]; 52(4):1893-907. DOI: https://doi.org/10.1007/s11135-017-0574-8.
18. Rego A, Cunha MP, Meyer Junior. V. Quantos participantes são necessários para um estudo qualitativo? Linhas práticas de orientação. Rev. de Gest. dos Países de Líng. Port. 2019 [cited 2025 Jul 23]; 17(2):43-57. DOI: https://doi.org/10.12660/rgplp.v17n2.2018.78224.
19. Raddatz JS, Motta RF, Alminhana LO. Religiosidade/espiritualidade na prática clínica: círculo vicioso entre demanda e ausência de treinamento. Psico-USF. 2019 [cited 2025 Feb 15]; 24(4):699–709. DOI: https://doi.org/10.1590/1413-82712019240408.
20. Koenig HG, King DE, Carson VB. Handbook of religion and health. 2nd ed. Oxford: Oxford University Press; 2012.
21. Santos EAS, Campos PHF. As representações sociais como teoria e como prática. Frag. 2022 [cited 2025 Mar 19]; 32(2):181-90. DOI: https://doi.org/10.18224/frag.v32i2.12267.
22. Esperandio MRG, Souza YQ, Nadalin O, Hefti R. Spirituality in clinical practice: the perspective of brazilian medical students. J Relig Health. 2021 [cited 2025 Mar 18]; 60(3):2154–69. DOI: https://10.1007/s10943-020-01141-1.
23. Silva Filho JA, et al. Religiosity and spirituality in mental health: nurses' training, knowledge and practices. Rev Bras Enferm. 2022 [cited 2025 Apr 10]; 75:e20200345. DOI: https://doi.org/10.1590/0034-7167-2020-0345.
24. Primo PV, Santos AL, Santana BBSB, Soares KS, Matos GOS, Souza MC. Humanização do cuidado de enfermagem em crianças em estado terminal: práticas e desafios. REASE. 2025 [cited 2025 Ago 6]; 11(3):1704-1714. DOI: https://doi.org/10.51891/rease.v11i3.18434.
25. Silva JEG, Maciel IS, Pontes GO, França JRFS, Buck ECS, Dias TKC. Rev. A espiritualidade no cuidado paliativo de enfermagem à criança com câncer: revisão integrativa. Ciênc. Saúde Nova Esperança. 2024 [cited 2025 Ago 6]; 22(3):401-12. DOI: https://doi.org/10.17695/rcsne.vol22.n3.p401-412.
26. Oliveira LAF, Oliveira AL, Ferreira MA. Nurses' training and teaching-learning strategies on the theme of spirituality. Esc Anna Nery. 2021 [cited 2025 Apr 10]; 25(5):e20210062. DOI: https://doi.org/10.1590/2177-9465-EAN-2021-0062.
27. Cheng L, Cai S, Zhou X, Zhai X. In Every Detail: Spiritual care in pediatric palliative care perceived by healthcare providers. J Pain Symptom Manage. 2024 [cited 2025 Ago 6]; 67(2):167-72. DOI: https://doi.org/10.1016/j.jpainsymman.2023.11.005.

DOI: https://doi.org/10.12957/reuerj.2025.91397

28. Arrieira ICO, Thofehrn MB, Porto AR, Moura PMM, Martins CL, Jacondino MB. Spirituality in palliative care: experiences of an interdisciplinary team. Rev Esc Enferm USP. 2018 [cited 2025 Apr 14]; 52:e03392. DOI: https://doi.org/10.1590/S1980-220X2017007403312.
29. Andrade BRV, Cunha JXP, Biondo CS. The resilience of nurses in caring for children who experience terminality. Rev Enferm UFSM. 2020 [cited 2025 Apr 13]; 10:e88. DOI: http://dx.doi.org/10.5902/2179769240348.
30. Garcia VS, Riveros ER. Experiência de enfermeiros pediátricos intensivos na morte de uma criança: experiências, lesão, aspectos bioéticos. Cienc Doente. 2013 [cited 2025 Apr 09]; 19(2):111–24. DOI: http://dx.doi.org/10.4067/S0717-95532013000200011.

Author contributions

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Use of artificial intelligence tools

Authors declare that no artificial intelligence tools were used in the composition of the manuscript "*Religiousness/Spirituality and their practical manifestations among health professionals that provide care to children*".