

Quality of life, spirituality, religion and personal beliefs of chemical dependents in treatment

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ABSTRACT

This study aimed to identify the scores of quality of life and spirituality/religion and personal beliefs and their relationship to the number of relapses of 180 chemical dependents in recovery. This is a cross-sectional analytical study, whose instruments were sociodemographic questionnaire WHOQOL-Bref and WHOQOL-SRPB. For the analysis, we used descriptive statistics and linear regression ($p < 0.05$) by the SPSS software, version 20.0. The subjects are mainly adults averaging 36 years old, single, with nine to 12 years of schooling, and family income from two to three minimum wages, Catholics and with five or more relapses. On quality of life, Physical domain had the highest score and Environment had the lowest. As for spirituality, Faith facet achieved the highest score and Inner Peace, the lowest. There was an association between the number of relapses and the social Relations domain and Admiration facet. Coping strategies towards drug addiction and relapses are necessary, based on the quality of life and spirituality/religion.

Descriptors: Substance-Related Disorders; Quality of Life; Spirituality.

INTRODUCTION

The World Health Organization (WHO) defines drug as "any substance not produced by the organism that has the property of acting on one or more of its systems, causing changes in its functioning"⁽¹⁾.

Drug use is a comprehensive and age-old practice in different historical contexts. Different populations have used it for therapeutic purposes, in religious rituals, for cultural reasons, for leisure⁽²⁾, as a resource to

address problems and as a means of isolation or socialization⁽¹⁾. Over time the use begun to be related to social problems such as unemployment, violence, criminality and disruptions of family bonds⁽²⁻³⁾.

According to an estimate of the world report on drugs of the United Nations Office on Drugs and Crime (UNODC), 187,000 deaths were related to drug use in 2013. In the same year, about 243 million people, or 5% of the global population between 15 and 64 years old, used illicit drugs⁽⁴⁾. Although illicit drug use between men and women varies from country to country, generally, men use two to three times more than women⁽⁴⁻⁵⁾.

In addition, treatment for drug addiction is prolonged and demands different approaches to detoxification; insertion in therapeutic communities and self-help groups; pharmacological and psychosocial treatment⁽²⁾. In a research on chemical dependents in treatment, 41.4% of them did not finish it⁽⁶⁾, which reinforces the need for monitoring and multidisciplinary team to meet the needs of this public.

It is worth noting that the difficulty of an ideal model of treatment and repeated relapses⁽⁷⁾, may have an inverse relationship with quality of life (QOL), namely, the improvement of QOL may cause fewer relapses. According to WHO, QOL is the "individuals' perception of their position in life and in relation to their goals, expectations, standards and concerns"⁽⁸⁾.

Other variables may influence the treatment and number of relapses, among them stand out religiosity/spirituality and personal beliefs. The term religiosity means how much an individual believes, follows and practices a religion⁽⁹⁻¹⁰⁾. Spirituality is the personal quest to understand issues related to life, values we believe in, and may or may not lead to the development of religious practices. Personal beliefs are any belief or value that the individual supports⁽¹¹⁾.

Thus, working on aspects related to religion and spirituality in chemical dependent treatment programs can be a tool for achieving positive results⁽¹²⁻¹³⁾, as improved QOL and reduction of relapses. In a North American study of 2,847 dependent on different types of drugs, except crack, those with lower spirituality had higher rates of relapses; still, the highest number of remission of drug addiction occurred among individuals with greater spirituality⁽¹⁴⁾.

However, the most complex task when considering any form of treatment in relation to drug addiction is not to make users stop using it, but rather to preserve abstinence and harm reduction⁽¹⁵⁾. A study in Japan found that abstinence was related to cultural factors, such as religion and social, since they influence QOL⁽¹⁶⁾.

Studies that relate relapses, QOL and religiosity and spirituality to drug addiction treatment are still scarce⁽¹²⁻¹³⁾. However, when considering the issue of drugs and relapses as a public health problem, whose treatment can benefit from strategies such as the development of actions towards religiosity/spirituality, a greater understanding of the factors that may influence the relapses is relevant.

Thus, this study aimed to identify and investigate the relationship between QOL scores and spirituality/religion and personal beliefs of chemical dependents in recovery according to the number of relapses.

METHODS

This is a cross-sectional, analytical and exploratory study, with quantitative approach, performed with 180 male chemical dependents in recovery, for treatment in therapeutic clinics for drug addiction, in a city in southeastern Brazil.

The survey was conducted with the total population admitted in all therapeutic clinics associated with the City Council on alcohol and other drugs COMAD/Uberaba/MG/Brazil, with the exception of those who did not meet the inclusion criteria or refused to participate. Eleven clinics were visited, being contacted prior to collection. Only after clarification, approval and scheduling the clinics we held to visit for data collection.

Inclusion criteria for participants in the research were individuals 18 years or older, male and being in recovery in registered therapeutic clinic. Exclusion criteria were not to be in good physiological and mental conditions to respond to the instrument according to the perception of the addict himself.

The participants were addressed on specific days with time and date scheduled in advance with the clinics. The collection period occurred in August and September 2014.

For data collection, we used a sociodemographic, economic questionnaire developed by the researchers, with multiple-choice questions, structured based on national and international scientific literature, addressing sociodemographic and economic variables, and the number of relapses.

To measure QOL, WHOQOL-Bref was used, composed of four domains: physical, psychological, social relationships and environment. The questionnaire contains two general questions about global QOL. The instrument considers the last two weeks experienced by respondents. The World Health Organization has developed it and it was validated in Brazil⁽¹⁷⁾.

Along this instrument, we also used WHOQOL on Spirituality, Religiosity and Personal Beliefs (WHOQOL- SRPB), validated in Brazil⁽¹⁸⁾. It consisted of 32 questions, which include issues related to religiosity, spirituality and personal beliefs, totaling eight facets. The facets address issues as the connection to be or spiritual strength, meaning of life, admiration, wholeness and integration, spiritual strength, inner peace, hope and optimism and faith⁽¹⁸⁻¹⁹⁾.

Microsoft Excel® database performed data collection with the process of double entry and verification of internal consistency of the data. For statistical analysis, the "Statistical Package for Social Sciences" (SPSS) version 20.0 was used, by means of data bivariate analysis, which were presented in the form of absolute (n) and relative (%) frequency distribution, and calculated mean values, standard deviations and minimum and maximum values (measures of range). Linear regression was executed to verify the association between the number of relapses variable and QOL domains and spirituality/religiosity and personal beliefs facets.

The research was approved by the Ethics Committee in Human Research of the Federal University of Triângulo Mineiro, protocol number 814163, respecting the provisions of the Brazilian law for human research.

The interview was carried out only when respondents signed the Free and Clarified Consent Term.

RESULTS

The participants were 180 male subjects in treatment in therapeutic clinics for drug addiction. The age group ranged between 18-71 years, mean of 36.26 ± 11.906 .

Table 1 shows the sociodemographic and economic data, and the number of relapses of chemical dependents in treatment in therapeutic clinics.

In this study, the highest percentage of subjects reported being single (62.2%), live with their parents (38.98%), have between 9-12 years of education (29.4%) and monthly family income of 02-03 minimum wages (27.2%), Table 1.

The highest percentage declared being Catholics (48.3%) and practitioners of the religion (57.2%). Regarding the number of relapses, the majority (52.2%) had relapsed and had between five or more relapses during treatment (18.2%), Table 1.

Regarding the QOL, participants self-rated it as good (40%), and 41.7% reported being satisfied with their health.

Table 2 shows the distribution of QOL scores of chemical dependents in treatment according to the WHOQOL-Bref.

The highest score was for the Physical domain (72.84 ± 17.51), and the lowest for the Environment domain (58.00 ± 17.82), Table 2.

Table 3 shows the scores of the facets that make up the WHOQOL-SRPB instrument on spirituality, religion and personal beliefs, of chemical dependents in recovery in therapeutic clinics.

Faith facet had the highest score (16.32 ± 3.09) and Inner Peace the lowest (14.30 ± 3.07), Table 3.

By associating the number of relapses with the QOL domains, only the Social Relations domain showed a statistically significant association ($t = -2.396$ and $p = 0.019$).

When associating the number of relapses and WHOQOL-SRPB facets, the Admiration facet showed statistically significant association ($t = 2.164$ and $p = 0.033$), while the other facets showed no statistically significant association.

Table 1: Sociodemographic and economic variables and number of relapses of chemical dependents in recovery. Uberaba, MG, Brazil, 2014.

Variables	N	%
Marital Status		
Single	112	62.2
Live in a consensual union	21	11.7
Live in legal union	13	7.2
Separated	30	16.7
Widower	2	1.1
No answer/Ignored	2	1.1
Living arrangement		
Live Alone	53	29.4
Live with parents	69	38.3
Live with partner	24	13.3
Live with friends	3	1.7
Live with other	27	15
No answer/Ignored	4	2.2
Education (in years of study)		
No education	4	2.2
1 - 4	40	22.2
5 - 8	49	27.2
9 - 12	53	29.4
More than 12	28	15.6
No answer/Ignored	6	3.3
Family income (in minimum wage)		
Up to one min wage	31	17.2
From 01 - 02	20	11.1
From 02 - 03	49	27.2
From 03 - 04	32	17.8
From 04 - 05	18	10
More than 05	10	5.6
No answer/Ignored	20	11.1
Religion		
Umbanda	7	3.9
Candomblé	3	1.7
Catholicism	87	48.3
Spiritism	17	9.4
Evangelicalism	43	23.9
No Religion	6	3.3
Other	12	6.7
No answer/Ignored	5	2.8
Practitioner of religion		
Yes	103	57.2
No	62	34.4
Not applicable	8	4.4
No answer/Ignored	7	3.9
Number of relapses		
None	18	10
1	23	12.8
2	13	7.2
3	16	8.9
4	8	4.4
5 or more	34	18.9
No answer/Ignored	68	37.8
Total	180	100

Table 2: QOL domains of chemical dependents in rehabilitation, according to the WHOQOL-Bref. Uberaba, MG, Brazil, 2014.

Domain	Mean	Minimum	Maximum	Standard Deviation
Physical	72.84	10.71	100	17.51
Psychological	66.50	8.33	100	17.15
Social Relations	65.29	8.33	100	21.417
Environment	58.00	9.38	100	17.82

Table 3: Scores of facets spirituality, religion and personal beliefs of chemical dependents in recovery in therapeutic clinics. Uberaba, MG, Brazil, 2014.

Facets	Maximum	Minimum	Mean	Standard Deviation
Connection to be/spiritual strength	20.0	4.0	15.09	3.66
Meaning in life	20.0	4.0	15.73	3.00
Admiration	20.0	4.0	15.25	2.88
Wholeness and Integration	20.0	4.0	14.61	2.96
Spiritual Strength	20.0	4.0	15.64	3.07
Inner Peace	20.0	4.0	14.30	3.07
Hope and Optimism	20.0	4.0	15.23	3.03
Faith	20.0	4.0	16.32	3.09

DISCUSSION

The sociodemographic and economic characteristics of this study differ in comparison with the national literature, are similar in terms of age⁽³⁾, marital status and living arrangements⁽²⁰⁾, and differ as to education and income^(3,6,20).

As for religion, after identifying the stages of motivation in institutionalized alcohol and crack dependents, a study found that 61% of subjects were Catholic⁽¹⁵⁾, a number higher than found in this study. A study, when assessing the degree of religiosity according to individuals in treatment for drug addiction, found that 55% of them consider it to be strong⁽²¹⁾. Religiosity, understood as a key protection mechanism to relapses, assists in the faith promotion; and behavioral changes resulting from the stimulation of healthy lifestyle habits, in turn, allow the improvement of QOL⁽²²⁾. Religion, in this sense, can act as a psychological inhibition factor for drug use⁽¹⁶⁾.

Regarding the number of relapses, a survey that characterized the hospitalization of chemical dependents in a rehabilitation unit in southern Brazil, found that the dropout rate to treatment is 41.4%, and the range of hospitalization/relapses ranged from one to five (89.1%)⁽⁶⁾. The high dropout rate to treatment is perceived by making necessary the adoption of measures to assist in the adherence and maintenance of abstinence⁽⁶⁾. Thus, assistance to chemical dependents should go beyond traditional models, offering psychological, social and health support.

Regarding the assessment of QOL, a study on QOL, self-esteem and self-image of chemical dependents in an institute, in Santa Catarina, also found that 57% self-rated QoL as good⁽²³⁾; it was also found that 38% consider their health similar to others, being satisfied with it⁽²³⁾.

Regarding WHOQOL-Bref domains, in contrast, a study of chemical dependents in recovery identified that the Environment domain was the highest score (65.5)⁽²³⁾. The Physical domain evaluates, among several factors, pain and discomfort, and dependence on medication or treatment difficulties⁽¹³⁾, and this phase is of

great adaptation for the dependent. When identifying the stages of motivation for change in chemical dependents in treatment, a study observed that most of them was in the contemplation stage, in which the individual discovers the possibilities of change⁽¹⁷⁾.

A research that evaluated the QOL of chemical dependents in southern Brazil found that the psychological domain had the lowest score, 58.9⁽²³⁾, which is a divergent result when compared to this study. In the investigation of the factors that increase the desire or intensity of drug use it was found that family problems, idleness, participation in social events, drug-user companies and negative feelings (anger, sadness and anxiety) intensify the use⁽²⁴⁾.

These findings allow the understanding that the environment has an influence on relapse, as keeping the same routine and socializing with the same people who use drugs favors the return to drug use⁽⁷⁾. Proposing strategies to reduce stress and making use of everyday phenomena, the care with feeding, sleep and physical activity, family support and opportunities for employment and/or recreation/leisure may facilitate the withdrawal of drugs^(7,24), and such activities that the multidisciplinary team can stimulate.

When evaluating spirituality with people in treatment for drug addiction, it was found that for the majority of them, having faith in a higher power reduces the personal burden of the challenges of recovery, and attribute success to the recent treatment, being the primary source of hope, trust, strength and peace⁽¹³⁻²¹⁾.

By identifying the risk factors for relapse, a survey found that feelings of frustration, anxiety and anger are the main factors, in addition to altered mood and difficulty in decision making⁽²²⁾, which leads to internal conflicts, thus changing the peace and harmony.

Religiosity, spirituality and personal beliefs reinforce positive emotions and well-being, happiness, optimism, self-esteem and a sense of control over their life. Moreover, by promoting best strategies for dealing with stressful situations, religiosity reduces the probability of symptoms such as depression, anxiety, suicidal tendencies and drug abuse, easing the process of withdrawal and adherence to drug addiction treatment⁽⁹⁾.

By being familiar with religiosity, spirituality and personal beliefs of chemical dependents, health professionals can strengthen coping mechanisms related to treatment, making the welcoming, listening, and integrating the facets of spirituality, religion and personal beliefs with health practices^(10,12,25).

In addition to support and social support to seek withdrawal, it is necessary that the chemical dependent has a network of healthy social relationships and know how to address conflict situations⁽¹⁶⁻²⁴⁾, which are some of the greatest difficulties. The association between the number of relapses and the Social Relations domain has an inverse relation, that is, the lower the number of relapses the higher the score that domain, which assesses personal and intimate relationships and social support⁽¹⁷⁾, which reinforces the importance of these networks in support of this population.

Regarding Admiration facet and its relation to the number of relapses, it is noteworthy that this facet assesses the ability to admire and appreciate things in order to inspire them to live⁽¹⁸⁾. Some of the causes

that justify relapses among chemical dependents are the lack of activity, work, commitment and/or motivation, and this emptiness feeling may reflect the loss of ability to appreciate and seek inspiration to live, which can lead them to seek the drugs as a way to fill⁽⁷⁻¹⁶⁾.

A qualitative research, about discourse on adherence to treatment of chemical dependents, pointed out that the main motivations to continue treatment are: the recognition of the disease, preparation of the team, knowledge of dependents regarding their disease⁽²⁾, and more offers to treatment by health services.

By knowing the factors that support adherence to treatment, nurse can strengthen assistance to this population through coping mechanisms of the disease and encouraging health promotion practices^(3,10). Moreover, professionals should qualify, be encouraged to seek and develop new actions to prevent relapse, involving family and society as partners in the care⁽⁶⁾.

Studies on the necessity of this type of care and their positive perceptions in the treatment of physical and mental disorders are still underappreciated and poorly incorporated into daily practice. Therefore, it is up to the healthcare professional to discern the interventions and strategies to be undertaken, including actions involving spiritual care as part of the comprehensive care model to the chemical dependent^(9,12,25), associated with the conventional treatment.

FINAL REMARKS

History of relapses was present in most chemical dependent respondents, with a predominance of five or more relapses during treatment. There was a statistically significant association between the number of relapses and the social Relations domain of WHOQOL-bref and the facet Admiration of WHOQOL-SRPB.

The provided information will support the work of healthcare professionals, especially nurses, since they have *praxis* for different cycles of life, with holistic vision and commitment to comprehensive care. The investigation of QOL and spirituality, religion and personal beliefs issues may facilitate interpretation, strategies and development of public policies and healthy interventions in the treatment of drug addiction.

The present study has limitations on the cross-sectional profile, which does not establish a causal relationship. Thus, are indispensable new surveys with different methodological designs, since research on the subject tend to focus on clinical population and in specific cultural contexts.

The scarce exploration of literature on the association between QOL, spirituality, religion and personal beliefs for chemical dependents reinforces the need for further investigation of this theme focused on elucidating the mechanisms by which religious and spiritual resources help in the treatment of chemical dependency, improving QOL, and prevention of relapses, in the short, medium and long term.

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REFERENCES

1. Brasil. Ministério da justiça. Secretaria Nacional de Políticas sobre Drogas. Prevenção do uso de drogas: capacitação para conselheiros e lideranças comunitárias (SENAD); 5. ed. Brasília, 2013.
2. Gabatz RIB, Johan M, Terra MG, Padoin SMM, Silva AA, Brum JL. Percepção do usuário sobre a droga em sua vida. Esc. Anna Nery. 2013;17(3):520-5.
3. Capistrano FC, Ferreira ACZ, Silva TL, Kalinke LP, Maftum MA. Perfil sociodemográfico e clínico de dependentes químicos em tratamento: Análise de prontuários. Esc. Anna Nery. 2013;17(2):234-41.
4. United Nations (ONU). United Nations Office on Drugs and Crime (UNODC). World Drug Report United Nations 2015 [Internet]. Vienna: United Nations publication; 2015 [acesso em: 10 fev. 2016]. Disponível em: https://www.unodc.org/documents/wdr2015/World_Drug_Report_2015.pdf.
5. Pasareanu AR, Opsal A, Vederhus JK, Kristensen O, Clausen T. Quality of life improved following in-patient substance use disorder treatment. Health Qual Life Outcomes. 2015;13(35):1-8.
6. Ferreira ACZ, Capistrano FC, Maftum MA, Kalinke LP, Kerchhof ALC. Caracterização de internações de dependentes químicos em uma unidade de reabilitação. Cogitare Enferm. 2012;17(3):444-51.
7. Carvalho FR, Brusamarello T, Guimarães AN, Paes MR, Maftum MA. Causas de recaída e de busca por tratamento referidas por dependentes químicos em uma unidade de reabilitação. Colombia Médica [Internet]. 2011 [acesso em: 02 fev. 2015];42 Suppl. 1:57-62. Disponível em: <http://www.bioline.org.br/pdf?rc11040>.
8. The WHOQOL Group. The World Health Organization quality of life assessment: position paper from the World Health Organization. Soc Sci Med. 1995;41(10):1403-9.
9. Koenig H, King D, Carson VB. Handbook of religion and health. 2. ed. New York: Oxford University Press; 2012.
10. Backes DS, Backes MS, Medeiros HMF, Siqueira DF, Pereira SB, Dalcin CB, Rupolo I. Oficinas de espiritualidade: alternativa de cuidado para o tratamento integral de dependentes químicos. Rev Esc Enferm USP. 2012;46(5):1254-59.
11. World Health Organization. Whoqol and spirituality, religiousness and personal beliefs (SRPB) - report on WHO Consultation. Geneva; 1998. (WHO/ MSA/MHP/98.2, 2-23).
12. Walton-Moss B, Ray EM, Woodruff K. Relationship of Spirituality or Religion to Recovery From Substance Abuse. J Addict Nurs. 2013;24(4):217-26
13. Chambers H. Spirituality and Quaker Approaches to Substance Use and Addiction. Religions. 2015;6(2):385-403.
14. Schoenthaler SJ, Blum K, Braverman ER, Giordano J, Thompson B, Oscar-Berman M, et al. NIDA-Drug Addiction Treatment Outcome Study (DATOS) Relapse as a Function of Spirituality/Religiosity. J Reward Defic Syndr. 2015;1(1):36-45.
15. Sousa PF, Ribeiro LCM, Melo JRF, Maciel SC, Oliveira MX. Dependentes químicos em tratamento: um estudo sobre motivação para a mudança. Temas em Psicol [Internet]. 2013 [acesso em: 02 fev. 2015];21(1):259-68. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1413-389X2013000100018&lng=pt&nrm=iso&tlng=pt.
16. Yoshimasu K. Psychosocial Factors Associated with Substance-Related Disorders; Three Stratified Dimensions. J Addict Res Ther. 2013;S6-006:1-7.
17. Fleck MPA, Louzada S, Xavier M, Vieira G, Santos L, Pinzon V. Aplicação da versão em português do instrumento abreviado de avaliação da qualidade de vida "WHOQOL-bref". Rev Saúde Pública. 2000;34(2):178-83.
18. Panzini RG, Maganha C, Rocha NS, Bandeira DR, Fleck MP. Validação Brasileira do instrumento de qualidade de vida/espiritualidade, religião e crenças pessoais. Rev Saúde Pública. 2011;45(1):153-65.
19. Pedroso B, Gutierrez GL, Picinin CT. Qualidade de vida, espiritualidade, religião e crenças pessoais: análise do instrumento WHOQOL-SRPB. Revista Eletrônica FAFIT/FACIC. 2012;3(1):1-12.
20. Horta RL, HORTA BL, Rosset AP, Horta CL. Perfil dos usuários de crack que buscam atendimento em Centros de Atenção Psicossocial. Cad Saude Publica. 2011;27(11):2263-70.
21. Heinz BA, Disney ER, Epstein DH, Glezen LA, Clark PI, Preston KL. A focus-group study on spirituality and substance abuse Treatment. Subst Use Misuse. 2010;45(1-2):134-53.
22. Silva ML, Guimaraes CF, Salles DB. Fatores de risco e proteção à recaída na percepção de usuários de substâncias psicoativas. Rev Rene. 2014;14(6):1007-15.
23. Silveira C, Meyer C, Souza GR, Ramos MO, Souza MC, Monte FG, Guimarães ACA, Parcias SR. Qualidade de vida, autoestima e autoimagem dos dependentes químicos. Cien Saúde Colet. 2013;18(7):2001-6.
24. Vasters GP, Pillon SC. O uso de drogas por adolescentes e suas percepções sobre adesão e abandono de tratamento especializado. Rev Lat Am Enfermagem. 2011;19(2):1-8.

25. Murakami R, Campos CJG. Religião e saúde mental: desafio de integrar a religiosidade ao cuidado com o paciente. Rev Bras Enferm. 2012;65(2):361-7.