Religiosity and mental health as aspects of comprehensiveness in care

Religiosidade e saúde mental como aspecto da integralidade no cuidado

Religiosidad y salud mental como aspectos de la atención integral

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ABSTRACT

Objective: to understand how religiosity can influence the health of individuals diagnosed with mental disorders, based on comprehensive care. **Methods:** this is an integrative literature review, with the inclusion of articles in Portuguese, English and Spanish, between 2010 and 2018. **Results:** the critical analysis and qualitative synthesis of the 24 selected studies were categorized into two subtopics: The influence of religiosity in promoting comprehensive mental health care; Mental health versus religiosity: influencing conditions for effective access to comprehensive care. **Final considerations:** a positive influence of religiosity was identified in the lives of individuals diagnosed with mental disorders; however, evidence shows that health teams do not feel comfortable and prepared to work with religiosity as an expression of spirituality. This being one of the dimensional aspects of health, it can be inferred, on the results, the existence of this gap in the comprehensive care approach.

Descriptors: Religion; Mental Health; Mental Disorders; Comprehensive Health Care; Holistic Health.

RESUMO

Objetivo: compreender como a religiosidade pode influenciar a saúde dos indivíduos diagnosticados com transtornos mentais, com base no cuidado integral. **Métodos:** trata-se de uma revisão integrativa de literatura, com inclusão de artigos em português, inglês e espanhol, no período entre 2010 e 2018. **Resultados:** a análise crítica e síntese qualitativa dos 24 estudos selecionados foram categorizados em dois subtópicos: *A influência da religiosidade na promoção do cuidado integral em saúde mental*; *Saúde mental versus religiosidade: condicionantes influenciadores para efetivação do acesso ao cuidado integral*. **Considerações finais:** identificou-se uma influência positiva da religiosidade na vida dos indivíduos diagnosticados com transtornos mentais, no entanto as evidências demonstram que as equipes de saúde não se sentem confortáveis e preparados para trabalhar a religiosidade como expressão da espiritualidade. Sendo este um dos aspectos dimensionais de saúde, pode-se inferir, sobre os resultados, a existência desta lacuna na abordagem integral do cuidado.

Descritores: Religião; Saúde Mental; Transtornos Mentais; Assistência Integral à Saúde; Integralidade em Saúde.

RESUMEN

Objetivo: comprender cómo la religiosidad puede influir en la salud de las personas diagnosticadas con trastornos mentales, a partir de una atención integral. **Métodos:** se trata de una revisión bibliográfica integradora, que incluye artículos en portugués, inglés y español, entre 2010 y 2018. **Resultados:** el análisis crítico y la síntesis cualitativa de los 24 estudios seleccionados se categorizaron en dos subtemas: La influencia de la religiosidad en la promoción de la atención integral de la salud mental; Salud mental versus religiosidad: influyendo en las condiciones para el acceso efectivo a la atención integral. **Consideraciones finales:** se identificó una influencia positiva de la religiosidad en la vida de las personas diagnosticadas con trastornos mentales, sin embargo la evidencia muestra que los equipos de salud no se sienten cómodos y preparados para trabajar con la religiosidad como expresión de la espiritualidad. Siendo este uno de los aspectos dimensionales de la salud, es posible inferir de los resultados la existencia de esta brecha en el enfoque de atención integral.

Descriptores: Religión; Salud Mental; Transtornos Mentales; Atención Integral de Salud; Integralidad en Salud.

https://doi.org/10.1590/0034-7167-2020-1011   Rev Bras Enferm. 2022;75(1):e20201011   1 of 11

INTRODUCTION

First of all, it should be noted that, although the words spirituality and religiosity are often used interchangeably, they have different meanings. Spirituality can be understood as the search for understanding the meaning of everyday situations and the relationships they establish with the sacred/transcendental[1], i.e., it consists of a personal relationship with God/Higher Power with the metaphysical, in that the person searches for fundamental meanings of life, which may or may not be related to some religion[1-2].

In an interview about the meaning of life, the Buddhist Lama Michel Rinpoche discusses spirituality as a necessity, something we need to make sense of our existence, understanding each being as unique and subjective, constituted not only of a body, but of an internal reality as important as the external, both interconnected and in sync. In this perspective, spirituality is the inner process of transformation and religion is the method that someone creates to reach this process of transformation. The religious institutions are in charge of creating conditions to keep alive this method adopted by the religion[2].

According to Salgado[3], for example, "spirituality is broader and more open than religion, since spirituality implies the universal and religion, the particular, the individual". Religion emerges, then, as an organized system of beliefs, practices and symbols designed to facilitate the approach to the sacred, but it can also involve rules on life conduct guided by a community[1]. For this reason, religiosity can offer guidelines for man's behavior, interfering with suicidal thoughts, influencing self-destructive tendencies and stimulating strategies for coping with daily adversities[4].

In Brazil, according to the 2010 Demographic Census, religious affiliation is made up of people who declare themselves to be mainly Catholic (64.9%), evangelical (22.2%), spiritualists (2.0%) and Jehovah's witnesses (0.4%). In the state of Amazonas, there are only changes among Jehovah's witnesses (20.6%) who are in greater numbers than people who declare themselves to be spiritualists (14.8%).

With the advent of postmodernity, religion undergoes significant transformations. Postmodern individuals start to relate to religion and exercise their religiosity in a renewed way. Despite all the assumptions that with the technical-scientific development, arising from modernity, there would be no more room for religion, God and mythological or mystical explanations. However, it remains and individuals appear to be increasingly religious[5].

These changes are observed and manifest in the course of human history. But the intellectual evidence typical of modernity, according to French sociologist Michel Maffesoli[6], does not allow us to locate what is evident. For this, it is necessary to know how to descend to the sources of the underground and being-together, i.e., the sharing of collective passions and emotions, hence the need to know how to put into practice a more qualitative approach if we want to be connected with behavior of postmodern society.

It is no longer the simple social dominated by the rational, with political and economic expression, but another way of being together, in which the imaginary, the dreamlike, the playful, precisely, occupy a primordial place. Therefore, we cannot deny the importance of spiritual power, nor the strong return of culture, the prevalence of the immaterial, much less the presence of the invisible in an indivisible way[6].

In postmodern times, religious and spiritual involvement appears as a variable that has been gaining relevance and recognition, mainly as a health indicator for the pursuit of promoting more comprehensive care[7]. Until the 20th century, religion had a negative view of health, being more often considered as a possible cause of neurosis. This situation started to change in the 21st century, when the relationship with religion started to be seen as a positive factor in health, especially for mental health[1].

Currently, it is already known about religious involvement as a positive factor for health. Comparative studies reveal that there is a relationship between beliefs, religious practices and physical health, in which individuals with greater religiosity have a lower prevalence of coronary heart disease, hypertension, less blood pressure levels, lower prevalence of infectious diseases, less complications in the post-surgery and lower mortality rate[1], in addition to being directly related to indicators of psychological well-being, such as satisfaction with life, happiness, high positive and moral affection and better physical and mental health[4]. The feelings of belonging, connection and identity, when experienced and experienced by religious practitioners, provide positive coping in stressful situations[7].

According to data from the World Health Organization (WHO), mental disorders (major depression, schizophrenia, bipolar disorders, alcohol use disorders and obsessive-compulsive disorder) already represent five of the top ten causes of disability worldwide[8]. In this scenario, the World Psychiatric Association (WPA) itself states that, in the field of health, religious practices, as well as spirituality, have significant implications for prevalence, diagnosis, treatment, clinical outcomes and disease prevention.

It is important to note that, given the current pandemic scenario for the new coronavirus (SARS-CoV-2), there were significant impacts on the economy, politics, religion, public health and mental health of the whole society. This pandemic influenced the lifestyle and social dynamics, "further favoring the unbalanced and persistent emotions of sadness, anger, guilt, panic, fear, insecurity, which paralyzed the movement of life", bringing temporary and long-term effects[9].

From this context, present in the new scenario of postmodern society, it is clear that mental health care and factors related to well-being are a topic that is more relevant than ever. It is also worth emphasizing its importance, when considering the spiritual dimension to have become since 1999 by the WHO, a multidimensional conceptual indication for quality of life, in which the physical, psychological, social and spiritual domains guide the technical-scientific production of the different areas of knowledge that make up the sciences, especially health.

Therefore, when it comes to mental health care, it is important to keep in mind the guarantee of assistance based on individuals' needs, without focusing only on their illness, but in the quest to promote health in all its physical, spiritual, emotional, social, family dimensions, in addition to ensuring that patients have individualized care[10]. Thus, health care for people diagnosed with mental disorders is centered on valuing life, its comprehensiveness and subjectivity.

It is also known that beliefs about religion and spirituality influence the way patients and healthcare professionals perceive being healthy and getting sick, in addition to influencing the relationship between themselves and with others[10-11]. This need arises from the need to expand the discussion and reflection on the relationship between religiosity as an expression of the spiritual dimension of the

human being and mental health care. Spirituality, as mentioned, is an important and inseparable dimension of the human, as important as the biological, psychological and social dimensions, which can be demonstrated by the values, beliefs, behaviors and emotions[7].

There are also clinical reasons for addressing religiosity in health practice, among which the following stand out: many patients are religious and want to be able to discuss the topic; religious beliefs can influence medical decisions and end up creating barriers to treatment adherence; religions influence health care in the community; many patients have spiritual needs that can affect their mental health[1]. These clinical reasons need to be met and provide support for the practice of comprehensive care.

Brazil is a recognized religious country, which brings religion as a topic of interest to the Brazilian, crosses culture, is present in everyday life and influences their beliefs, behavior and world-view[12]. In addition to the growing importance dedicated to the relationship between health, spirituality and religiosity, healthcare professionals need to be prepared to identify and recognize the role that spirituality and religious beliefs play in improving quality of life of individuals diagnosed with mental disorders.

From this context, religiosity and its close relationship with spirituality are valued as important contributions to clinical care and health promotion, and it is essential that teaching, research and assistance activities be incorporated into academic curricula[13]. Thus, they can contribute to a therapeutic direction aimed at coping with the disease and awakening healthy potentials in individuals with an emphasis on a comprehensive approach to care.

OBJECTIVE

To understand how religiosity can influence the health of individuals diagnosed with mental disorders, based on comprehensive care.

METHODS

This is an integrative literature review, structured in six distinct stages: 1) elaboration of research question; 2) definition of databases and criteria for inclusion and exclusion of studies; 3) definition of information to be extracted from the selected studies; 4) assessment of studies included in the review; 5) interpretation of results; 6) presentation of knowledge review/synthesis[14].

The study was guided by a protocol developed by the researchers. The research question was prepared according to the strategy Population, Interest and Context (PICo)[15]. Thus, the following structure was considered: P - population diagnosed with mental disorders; I - influence of religiosity; Co - attention to mental health. Thus, the following guiding question was elaborated: how can religiosity influence the health of individuals diagnosed with mental disorders based on comprehensive care?

The bibliographic survey was carried out in November 2018 through virtual access to the databases: Latin American and Caribbean Literature in Health Sciences (LILACS) and Nursing Library (BDENF) through consultation with the Virtual Health Library (VHL); Medical Literature Analysis and Retrieval System Online (MEDLINE), accessed through the PubMed portal; Cumulative Index to Nursing and Allied Health Literature (CINAHL), via Main

Collection (Thomson Reuters). Moreover, a manual search was also used by reading the references of included primary studies.

Articles in Portuguese, English and Spanish, available in full, from 2010 to 2018 were included, and editorials, theses, dissertations, integrative review articles were excluded, those already selected in the search in another database and that did not answer the research question. The inclusion criteria were defined, in 2018, in the occurrence of participation in the Institutional Program for Scientific Initiation Scholarships (PIBIC). Thus, the period of 8 years prior to search was defined, taking into account the deadline for submitting results to this program.

For the search in the databases, descriptors selected in the Health Sciences Descriptors (DeCS) and their English equivalents in the Medical Subject Headings (MeSH) and CINAHL Titles were selected, as well as uncontrolled descriptors, established according to synonyms of the controlled.

To systematize the information collected, the advanced search form was used, respecting the peculiarities and distinct characteristics of each database. The descriptors were combined with the Boolean operator OR, within each set of terms in PICo strategy, and then crossed with the Boolean operator AND. Four search strategies were developed in each database, as identified in Charts 1 and 2.

Chart 1 - Search strategies carried out on LILACS* and BDENF** databases, 2018

Search strategy	Selected descriptors		Pre-selection of databases	
	Controlled descriptors	Uncontrolled descriptors	LILACS	BDENF
1	"*Religião*" OR *Religião*	(*Crenças Religiosas*) OR *Oração* OR (*Ética Religiosa*)	187	153
2	("*Saúde Mental*") OR (*Saúde Mental*)	(*Áreas de Saúde Mental*) OR (*Higiene Mental*)	5,001	1,099
3	("*Transtornos Mentais*") OR (*Transtornos Mentais*)	(*Diagnóstico Psiquiátrico*) OR (*Transtorno do Comportamento*) OR (*Transtornos Mentais Graves*) OR (*Doença Mental*) OR *Insanidade*	290	126
4	1 AND 2 AND 3		7	4

*Latin American and Caribbean Literature in Health Sciences; **Nursing Library.*

The search was carried out by two independent researchers, simultaneously, who standardized the sequence of use of descriptors and crosses in each database and then compared the results obtained. To guarantee the broad search, the papers, in their entirety, were accessed through the periodical portal of the Coordination for the Improvement of Higher Education Personnel (CAPES - *Coordenação de Aperfeiçoamento de Pessoal de Nível Superior*), in an area with Internet Protocol (IP) recognized at *Universidade Federal do Amazonas* (UFAM).

The studies found were imported into a single folder, in order to sort and identify duplicates on different bases. The exportation of articles prioritized health databases (MEDLINE/PubMed and LILACS), followed by specific nursing (CINAHL and BDENF).

For extraction and synthesis of information from the studies selected for analysis, an instrument was used as a script to record the articles that were developed by the authors using the spreadsheet editor Microsoft Excel, version 2010. The following information was

extracted: study title, study authors, journal, year of publication, study design, study objective and outcome of the main results identified.

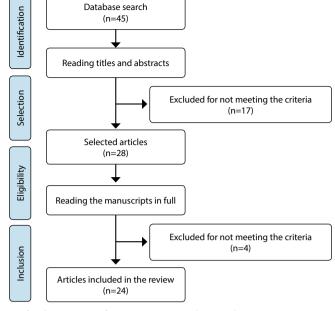**Chart 2 -** Search strategies carried out on MEDLINE* and CINAHL** databases, 2018

Search strategy	Selected descriptors		Pre-selection of databases	
	Controlled descriptors	Uncontrolled descriptors	MEDLINE	CINAHL
1	"Religion" OR Religion	Religions OR (Beliefs, Religious) OR (Religious Beliefs) OR (Religious Ethics) OR (Ethic, Religious) OR Prayer OR Prayers	67,816	19,419
2	("Mental Health") OR (Mental Health)	(Health, Mental) OR (Mental Hygiene) OR (Hygiene, Mental)	413,264	116,323
3	("Mental Disorders") OR (Mental Disorders)	(Disorder, Mental) OR (Disorders, Mental) OR (Mental Disorder) OR (Diagnosis, Psychiatric) OR (Psychiatric Diagnosis) OR (Behavior Disorders) OR (Disorders, Behavior) OR (Mental Disorders, Severe) OR (Disorder, Severe Mental) OR (Disorders, Severe Mental) OR (Mental Disorder, Severe) OR (Severe Mental Disorder) OR (Severe Mental Disorders)	515,497	75,218
4	1 AND 2 AND 3		11	23

*Medical Literature Analysis and Retrieval System Online; **Cumulative Index to Nursing and Allied Health Literature.

The level of evidence was determined according to this classification[16]: level I - meta-analysis of controlled and randomized studies; level II - experimental study; level III - quasi-experimental study; level IV - descriptive/non-experimental study or with a qualitative approach; level V - case or experience report; level VI - consensus and expert opinion.

Forty-five publications were identified, of which, after applying the inclusion and exclusion criteria, 24 articles were selected for the sample of this review. No other studies were included after the manual search process. For the selection of publications, the Preferred Reporting Items for Systematic Reviews and Meta-Analyzes (PRISMA) recommendations were followed, as shown in Figure 1.

* Preferred Reporting Items for Systematic Reviews and Meta-Analyzes.
Figure 1 - Methodological flowchart according to the PRISMA* model, 2018

Critical analysis and qualitative synthesis of selected studies were carried out in a descriptive manner and categorized into two subtopics: The influence of religiosity in promoting comprehensive mental health care; Mental health versus religiosity: influencing conditions for effective access to comprehensive care.

As it is an integrative literature review, the research analyzed secondary and publicly available data. Therefore, it was not submitted to an Institutional Review Board. However, total attention was obtained in the exercise of maintaining the original ideas of the authors of publications used in the development of this study.

RESULTS

In this review, 24 articles were selected, of which 70.8% were identified in the CINAHL database, 16.7% in MEDLINE, 8.3% in LILACS and 4.2% in BDENF, as identified in Chart 3. Of these, 66.7% were published in interdisciplinary health journals, 20.8% in nursing journals and 12.5% in journals from other health areas (psychology and medicine). Only 12.5% of these included articles were written in Portuguese, the rest in English.

Regarding study design, 54.2% are cross-sectional studies, 16.6% are qualitative research, 12.5% are descriptive studies, 8.3% are quantitative research, 4.2% are ethnographic research and 4, 2% are cohort studies. As for the level of evidence, 95.8% of publications were classified as level IV and 4.2% as level III.

Chart 3 - Articles selected from the database search, 2018

Title	Year Country	Outlining	Outcome
Bem-estar psicológico de jovens de 18 a 24 anos: fatores associados[17]	2012 Brazil	Quantitative study	- Those who reported some type of religious practice were 5% more likely to report psychological well-being; - People with mental disorders are less likely to indicate psychological well-being.
Religiosidade e os transtornos mentais comuns em adultos[18]	2017 Brazil	Cross-sectional study	- Women showed greater religious involvement than men; - According to sex, women had a higher prevalence of common mental disorders, they were not significantly associated with religiosity.

To be continued

Chart 3 (concluded)

Title	Year Country	Outlining	Outcome
The Spiritism as therapy in the health care in the epilepsy[19]	2016 Brazil	Qualitative study	- Spirituality practices are associated with lower rates of suicide, less anxiety and depression and greater well-being in people with epilepsy; - Patients with bipolar disorder, religiosity and positive religious coping strategies were associated with fewer symptoms of depression.
Contributions from ethics and research that guide integrating religion into psychotherapy[20]	2011 USA	Qualitative study	- Psychologists' codes of ethics agree that respect for clients' self-determination and decision-making are obligations; - Belief in a loving God can be beneficial, while belief in a vengeful, harmful God.
Religiosity and decreased risk of substance use disorders: is the effect mediated by social support or mental health status?[21]	2010 USA	Cross-sectional study	- Measures of religious participation and religious beliefs were significantly associated with a lower likelihood of abuse/dependence among those with alcohol use; - Religiosity was associated with greater social support and positively associated with any drink.
Understanding spirituality from the perspective of patients with mental disorders: contributions to nursing care[22]	2016 Brazil	Qualitative study	- Religious elements have been associated with health strengthening; - For the interviewees, it was clear that the Psychosocial Care Center (CAPS - *Centro de Atenção Psicossocial*) is not a place that encourages spirituality; - Higher levels of religious and spiritual involvement are positively associated with indicators of psychological well-being.
The faith of the psychiatrist[23]	2011 England	Qualitative study	- There is evidence that psychiatrists are less likely to identify with a particular tradition of faith and to believe in God than their patients; - Psychiatrists do not consider themselves less spiritual than their patients.
Ministers' perceptions of church based programs to provide depression care for African Americans[24]	2013 USA	Cross-sectional study	- Women and young people were cited as a high-risk group for being depressed; - Depression can be more stigmatized in the religious community, hampering the prominent role of ministers in care.
Mental and Physical Health and Spiritual Healing: An Evaluation of Complementary Religious Therapies Provided by Spiritist Centers in the City of São Paulo, Brazil[25]	2016 Brazil	Cross-Sectional Study	- Directors of spiritist centers interviewed are sought mainly for depression (11.8%), cancer (11.3%) and 8.7% for diseases in general; - In the question of when a person is advised to seek medical help, 87% said 'always', with several observations that spiritual treatment is not a substitute for medical treatment.
Conceptualizing mental health in the United Arab Emirates: the perspective of traditional healers[26].	2015 United Arab Emirates	Qualitative study	- All healers reported that women were more likely to seek their services; - Healers were positive about the idea of integrating mental health care services, suggesting that their interventions had no adverse effect and were generally helpful and comforting.
The role of religious advisors in mental health care in the World Mental Health surveys[27]	2017 USA; Brazil; Bulgaria; China; Colombia; Italy; Spain; Iraq; Germany; Japan; Lebanon; Mexico; Northern Ireland; Portugal; Romania; Nigeria; Ukraine	Epidemiological study	- In low-income countries, the use of religious counselors was greater among respondents with more serious disorders; - Among those who used some service, women and young people were more likely to seek help from religious counselors.
Religious discrimination and common mental disorders in England: a nationally representative population-based study[28]	2015 England	Quantitative study	- 11-fold increase in the prevalence of discrimination against people who did not follow Christianity in relation to Christians; - Increase in the prevalence of all mental disorders in people who have suffered some form of discrimination.
Caracterização clínica e sociodemográfica dos usuários de um centro de atenção psicossocial (CAPS)[29]	2011 Brazil	Quantitative study	- 64.8% of caregivers are defined by blood ties, with mothers being 29.7%; - 87.4% of users live in locations outside the neighborhood where the service is implemented.
Listening to disembodied voices: anthropological and psychiatric challenges[30]	2014 India	Ethnographic study	- Most caregivers were women from the third group of pilgrims who cared for a son or daughter with schizophrenia; - Most pilgrims support the idea that staying in the Sanctuary has a calming effect on anyone affected by madness.
The diagnostic and statistical manual: sacred text for a secular community?[31]	2014 USA	Qualitative study	- Even if DSM is not considered a prophetic text (like the Bible), it works as a historical text written for a specific people (mental healthcare professionals) and their culture, at a specific point in history.

Chart 3 (concluded)

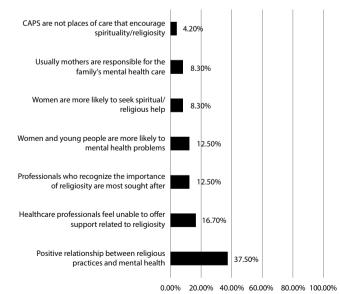| Title	Year Country	Outlining	Outcome
Ethnic density and risk of mental ill health - The case of religious Sectarianism in Northern Ireland: A population data linkage study[32]	2017 United Kingdom	Ethnographic study	- Increased Catholic population density, especially in underserved areas, was associated with greater chances of reporting mental health problems; - In the Protestant population, there was a decrease in the likelihood of self-reported mental health difficulties as the Protestant population density increases.
Religion, spirituality, and mental health of US military veterans: Results from the National Health and Resilience in Veterans Study[33]	2017 USA	Cross-Sectional Study.	- The chances of having post-traumatic stress disorder throughout life, major depression and alcohol use disorder were 54%, 50% and 34% lower, respectively, in the high R/E versus low R/E group; - Compared to the moderate R/E group, the high R/E group scored higher on measures of mental health (vitality, mental health, emotional functioning) and general health.
Parent Spirituality, Grief, and Mental Health at 1 and 3 Months After Their Infant's/Child's Death in an Intensive Care Unit[34]	2016 USA	Longitudinal study	- Spiritual strategies and activities helped fathers cope with grief and helped bereaved mothers to maintain their mental health and personal growth.
Religion-Based Emotional Social Support Mediates the Relationship between Intrinsic Religiosity and Mental Health[35]	2014 USA	Cross-sectional study	- Intrinsic religiosity was significantly negatively associated with hopelessness, depression and suicidal behaviors, while extrinsic religiosity was not; - Emotional support was significantly negatively associated with each of the mental health variables.
Psychiatric disease incidence among Danish Seventh-day Adventists and Baptists[36]	2013 Denmark	Cohort study	Increased incidence rates: - General affective disorders in women and decreased in men; - Unipolar disorders for both Adventist and Baptist people; - Bipolar disorders only among Seventh-day Adventists.
Religion, health beliefs and the use of mental health services by the elderly[37]	2011 Singapore	Cross-sectional study	- Elderly people with religious affiliations had higher rates of mental health problems; - Elderly people interviewed without religious affiliation reported the lowest rate of mental health problems and the highest rate of demand for treatment.
Religion, spirituality, and mental health: current controversies and future directions[38]	2012 England	Qualitative study	- In adolescence, religious involvement has salutary effects on subjective well-being, and religious adolescents experience less symptoms of anxiety and depression.
The effects of mental illness on families within faith communities[39]	2012 USA	Cross-sectional study	- Individuals in the DEP group (depression/emotional problems) were younger, more likely to be female and less likely to marry when compared to the CON (Control) group; - Help with depression and mental illness was the second priority for families in the DEP group, while it ranked 42nd on the list of requests for families in the CON group.
African American Men and Women's Attitude Toward Mental Illness, Perceptions of Stigma, and Preferred Coping Behaviors[40]	2013 USA	Cross-sectional study	- Younger and middle-aged men and women, compared to older men and women, significantly preferred the use of professional help, informal support and religious coping.

Figure 2 - Result of evidence on the influence of religiosity for comprehensive care in individuals diagnosed with mental disorders identified in this methodological scope, 2019

Of the 24 articles analyzed in this review, the diagram below represents the results obtained that show the powers and limits on the influence of religiosity for comprehensive care in individuals diagnosed with mental disorders.

DISCUSSION

The influence of religiosity in promoting comprehensive mental health care

This integrative review revealed that religious influence has long been associated with a better quality of life, however the most recent discussion is how religiosity can exert such influence. In fact, studies that affirm a positive association between religion and mental health were identified, revealing that individuals who attend meetings of religious groups have a 5% higher probability of reporting psychological well-being[17]. Consequently, non-religious individuals, classified as having low or moderate spiritual well-being, are twice as likely to have mental disorders and about seven times more likely to have a diagnosis of alcohol abuse or dependence[18].

In an article on the impact of faith, religiosity and spirituality as complementary and supporting treatments for epilepsy, the authors concluded that spirituality practices are associated with lower rates of suicide, anxiety and depression[19]. It was also identified that religious involvement may be associated with improved physical health, longevity, lower rates of suicide, less use of nicotine, alcohol and other drugs, in addition to influencing the decrease in divorce and delinquency rates[20-21].

As already revealed, psychological well-being indicators, such as life satisfaction, happiness, positive affection and high morale, were associated factors identified in reports that showed higher levels of religious and spiritual involvement[22]. Such reports meant that God and the Saints help, alleviate and partially cure mental illness, symbolize faith as an improvement in their lives and believe that God gives them strength, courage to carry out their daily activities and provides solutions to their difficulties, indicating a supportive thinking, in which a protective factor may also reside in their lives.

Evidence indicates that people, when they are ill, physically or mentally, are prone to becoming more religious. In other words, religion ends up being used as a strategy to transmute/overcome situations of suffering. In this way, religious beliefs are used to help deal with the stress caused by mental illness and improve their condition over time. It became evident that the sick seek God through prayers, religious rituals, support and comfort from members of their religious communities, with a focus on conduct of prayer and reading the Bible. This, in turn, develops in patients the ability to express their concerns, express anger and frustration, in addition to being a factor that helps them learn to deal with their feelings and emotions[18].

It is evident, therefore, that personal beliefs and values influence the construction of logical and rational thinking beyond individuals' imagination and, consequently, in decision-making as a health user. However, what has been identified is that these conditions are often not discussed among professional users and are not taken into account during the construction of a therapeutic plan[23].

In a study of patients diagnosed with non-affective psychosis in England, 92% reported spirituality as an important aspect of their lives and 66% considered it subjectively important to deal with their disease, but only 40% reported talking about religion with their physician[23]. In a study conducted in the United States, 75% of respondents pointed out that their religious beliefs directly influenced decision making during treatment[21]. From this context, it is perceived the importance of considering and valuing psycho-spiritual needs and religiosity as an influencing factor in improving quality of life of individuals with mental disorders, directing health care planning to better cope with the disease and the awakening of healthy potentials in individuals.

It is essential that the responsible healthcare professional addresses these issues with patients and family, understanding them as protagonists of treatment. While healthcare professionals are qualified to know the dimension of individuals' spirituality and religiosity, they will become increasingly able to perceive the influence of this dimension on health and illness. Improving its decision-making process in the care of the self and the other, it improves the methodological research designs in correspondence, expansion and permeability. For this path of possibility, the imagined results can promote a more assertive and positive care towards being healthy.

Mental health versus religiosity: influencing conditions for effective access to comprehensive care

The perception of a single and subjective being still seems to be a step to be reached, surrounded by obstacles, such as understanding of health as a complete physical, social and mental well-being, without excluding the spiritual needs that may eventually be presented by patients. It was identified, in one of the studies, that the participants with mental disorder identified that CAPS is not a place that stimulates spirituality, even though they affirm that the religious elements provide balance to live with their limitations[22]. This information highlights a challenge faced by mental health services in providing spiritual support and a care plan that addresses these shortcomings/needs for comprehensive care.

One explanation for this problem and other problems is the lack of training during training to deal with the spiritual needs of each patient[20]. Three quarters of social workers approached in a survey reported that they had no content on religion/spirituality during graduation, and minimum levels of exposure to religious issues in training were reported by psychiatrists and psychologists[20].

Many nurses, in addition to other healthcare professionals, do not consistently provide spiritual care, because they do not feel comfortable and prepared due to lack of knowledge for such a context[19], and the physician himself is often unaware of the involvement or religious belief of their patients[23]. Consequently, religious institutions are no longer considered possible partners in the continuity and effectiveness of patient treatment[18].

It is possible, in this way, to infer from the professionals' reports that there are gaps in the curricula on the themes of religion and spirituality common to the interdisciplinary team, which assists patients with mental illness. In addition to content, there are also limitations regarding the use of methodologies that allow the future professional to experience spirituality itself, in order to (re) know it and value it in being cared for.

This discussion refers to reflection addressed by Professor Mauro Ivan Salgado[3], from the Faculty of Medicine of *Universidade Federal de Minas Gerais*, in 2006, in which he affirms that physicians linked to spiritual issues tend to be better professionals, as they understand that the a more balanced subject in his own dimensions is more likely to better understand the pain and suffering of the other and, consequently, will be more attentive to himself and his patients. In this way, humanization, acceptance and comprehensive care will be involved in their medical practice.

Still on this path of personal experimentation, Lama Michel Ripunch states that the first step in the spiritual path is to love yourself and the second step is to love your neighbor. Self-love is considered to cultivate and respect what is good for us and to abandon what is bad for us. Thus, consequently, loving your neighbor is desiring the happiness of your neighbor, regardless of where, how, with whom and doing something so that the other is happy, free from their own suffering[2].

Suffering is also linked to the perception of unmet human needs. It is worth mentioning, in this investigative scenario, the importance of effective communication by healthcare professionals in seeking to understand the real needs of each person, including their own, avoiding entanglements that interfere with the care provided and therapeutic planning. Studies have also revealed that devout Christian individuals prefer to discuss their personal-social problems with people who are also Christians, lest others challenge their beliefs[20].

On the other hand, religious institutions themselves face similar difficulties. Research in the United Studies, which analyzes the ministers' perception of depression, points out that some of them do not feel prepared to deal with severe cases of depression manifested by their faithful, for fear of making the case even more serious, claiming not to know about mental illnesses[24].

The referred fact generates a series of speculations, since such difficulties in dealing with both needs seem to cause discomfort in both assistance, both in the religious and in the clinic, related to the unpreparedness, both of the health team in face of spiritual and religious issues of the assisted as well as providers of religious support, who do not know how to deal with mental illnesses, especially due to lack of knowledge about them.

Another path of possibilities for the exercise of comprehensive and integrated health care in all its dimensions is the complementary practices associated with conventional medical treatment. It is known that, in integrative and complementary practices, is a challenging proposal for health care integrated with spiritual aspects. These therapeutic practices stimulate the body's natural self-healing mechanisms through its association with the open, the sacred[3].

In a study that interrogates spiritualists, 87% of the interviewees inferred that medical help is always advised and emphasized that spiritual treatment is not a substitute for physicians[25]. Another study, carried out with healers, revealed that they were positive about the idea of integrating mental health care services, suggesting that their complementary methods for the treatment of these diseases had no adverse effects[26]. This perception reinforces the benefits, or, at least, the non-harm in the integration of care, as well as a lack of interest in substituting them.

In contrast, interviews with religious ministers suggested that, in the church community, depression may be more stigmatized because it represents, for some parishioners, a break in the relationship with God and a failure in the concept of being a "good Christian", the which can make it difficult to seek medical treatment for fear of suffering some type of judgment in the community of which they are members[24]. This context is worrying, since a multicenter study carried out by the World Health Organization, with 101,258 participants, indicated that, in low-income countries, 20.9% sought religious counselors for the most serious mental disorders, being women and young people more likely to seek religious help[27].

From this perspective, religion, more specifically the discrimination suffered within a religious group, ends up becoming an aggravating factor in the mental health chart or even a contributor to the emergence of comorbidities. This problem was emphasized in a study carried out in England, which found a two-fold increase in the risk of common mental disorders among people who reported experience of religious discrimination[28].

Another issue that should be addressed is the role of mothers in providing care to patients diagnosed with some type of disorder. A study reveals that 64.8% of caregivers are defined by blood ties, with 29.7% of cases by mothers[29]. In ethnographic research, the result is equivalent, the majority of caregivers were women caring for a son or daughter diagnosed with schizophrenia[30]. Regarding caregiving mothers, a study conducted in the United States showed that mothers who perform spiritual/religious activities after the death of their child were assessed with lesser symptoms of grief and symptoms such as depression and post-traumatic stress[31].

Such findings bring up a reflection about the support provided to these patients and how it is efficient in treatment, with an emphasis on biopsychosocio-spiritual care and the evolution of these individuals, as well as the support provided to family members, to deal with the disease and the challenges it produces in their daily lives, especially mothers.

Based on the scope of studies analyzed, it is clear that both health services and religious institutions and Higher Education Institutions (HEIs) did not demonstrate a significant scientific impact of care, related to the religiosity and spirituality of people affected by diseases and or mental disorders. Perhaps, due to lack of knowledge, as was reported in many identified references, the evidence is justified to have, in most studies, a level IV classification for this methodological scope. This means that, although we have recognized the need for spiritual expression, the research analyzed here is not yet demonstrating, by degree of evidence, the influence of the spiritual dimension of care so that health care becomes comprehensive.

Study limitations

With regard to limitations in the development of this writing, data collection time restriction between 2010 and 2018 is pointed out, in order to comply with PIBIC notice; these are perceived limits and can motivate further research.

Contributions to health, nursing, and public health

Nursing has been expanding the concept of care beyond the health-disease polarity. Therefore, the view of care permeates and depends on the view of being human, and it is essential to approach this tonic to understand health and care as comprehensive care. The relationship between mental health and religiosity/spirituality is still poorly studied. It is common, in clinical practice, to attend to cases involving suicide attempts, alcoholism or drug abuse, patients report that family members comment: "This is a lack of God in your heart", "This is a demon that is in you". The international disease code, our well-known ICD-10, presents the code F 44.3 to define trance and possession status. However, how many times have we witnessed this diagnosis being prescribed? How to prescribe something little discussed in the academy? Or, how can we provide an effective assistance plan about which we are not aware?

In view of this scenario, seeking all respect arising from understanding, individual choices, lifestyle and human dimensions, we suggest expanding this knowledge so that we can provide

more effective care. We believe in the possibility of reformulating teaching both in its content and in methodologies that enable students to experience more of the academic life everyday, intertwined with their multidimensional life, which goes far beyond cognition. The distance created by the current model causes a false understanding that patients are there (what he needs), and professionals (super hero), here. This is how an abyss is created. Studying the spiritual dimension and religious practices can add a more permeable view that we all live in the daily life and the vulnerability is for everyone, in all dimensions of the human being, whether professionals, therapists or patients.

Our contribution goes in the intention of expanding the understanding of the human being in its material, subtle and secret aspects. Mental health has many aspects that are still secret from us, favoring that stigmas and preconceptions are still experienced in the 21st century. However, in new times (post-COVID), new possibilities are needed to work with the different dimensions of the human, especially those that are more subtle.

FINAL CONSIDERATIONS

In this integrative review, a positive influence of religiosity practices in the lives of individuals diagnosed with mental disorders was identified; however, the evidence demonstrates that health teams do not feel comfortable and prepared to address these issues and, thus, make comprehensive care effective in all its dimensions.

Studies reveal that religious individuals are more likely to report well-being and, consequently, better quality of life. Furthermore, there are greater chances of presenting lesser chances of developing some type of addiction, i.e., individuals stop smoking and makes use of alcohol due to lifestyle adopted by some religious groups, which ends up causing positive impacts in physical health and decreasing the levels of comorbidities.

The search for some type of relief for suffering, the search for some relief for the despair that takes place in the life of those who are sick, whether physically or emotionally, were perceived as striking reasons for individuals to become more religious and to adopt practices such as prayer, reading, such as the Bible, even spiritual practices that offer emotional comfort and stress reduction.

As it is a subject that encompasses individuals' subjectivity, the difficulty that specialists have in addressing them and inserting them in a broad and personalized therapeutic plan seemed unanimous. Therefore, in order to honor the duty as healthcare professionals to help alleviate suffering, offer quality health care and implement a comprehensive approach to care, the search for knowledge about the religious and spiritual aspect is essential.

For this, it is necessary to recognize religiosity as the choice of a way to work on the spiritual dimension of the human being, even though it is not the only one. In this perspective, it is interesting that healthcare professionals develop skills in themselves to know cognitively and experience in themselves spirituality and the meaning of life. Additionally, it is concluded that it is essential that interaction between workers of religious institutions and health workers is stimulated, so that, integrated, in the differences and in the care that each one carries out, wisdom disappears to deal with people's mental distress. Thus, we believe in boosting this power that is already present in contemporary society, in the fertile soil of everyday life, ready as a seed to blossom in a beauty that inspires care and that care is comprehensive.

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