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RESEARCH

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Sociodemographic Characterization, Academic Formation and Both Religion and Spirituality Indexes from Health Professors

Caracterização Sociodemográfica, Formação Acadêmica e Índices de Religião e Espiritualidade de Docentes da Saúde

Caracterización Sociodemográfica, Formación Académica e Índices de Religión y Espiritualidad de Docentes de la Salud

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ABSTRACT

Objective: The study's goal has been to characterize the professors from the health field on sociodemographic aspects, academic formation and both religion and spirituality indexes. **Methods:** It is a descriptive-exploratory study with a quantitative approach, which was carried out with 34 health professors from a Higher Education Institution, in *Teresina* city, *Piauí* State, Brazil, from December/2015 to May/2016. Questionnaires were applied with sociodemographic variables and academic training, in addition to three scales of both religion and spirituality. The data was handled in the SPSS® software. **Results:** It was evidenced the predominance of women, age group of 45 years old on average, married, catholic, with an average of 18 years of professional performance and specializations in different areas. It was also observed a strong influence of both spiritual and religious factors related to the beliefs, spiritual and daily well-being of the professors inserted in academic practices. **Conclusion:** The influence of religious, spiritual and spiritual well-being corroborates the need for reflections with regards to the new methodological proposals in Higher Education Institutions, then considering the professors' performance towards health students within the academic practice framework.

Descriptors: Religion, Spirituality, Professors, Health, Higher Education.

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RESUMO

Objetivo: Caracterizar os docentes da área da saúde sobre aspectos sociodemográficos, formação acadêmica e índices de religião e espiritualidade. **Métodos:** Estudo quantitativo, realizado com 34 docentes da saúde de uma Instituição de Ensino Superior, em Teresina, Brasil, de dezembro/2015 a maio/2016. Foram aplicados questionários com variáveis sociodemográficas e de formação acadêmica, além de três escalas de religião e espiritualidade. Os dados foram processados no software SPSS. **Resultados:** Evidenciou-se o predomínio do sexo feminino, com média de 45 anos, casados, católicos, com média de 18 anos de formação e especializações em áreas diversas. Observou-se forte influência dos fatores espirituais e religiosos nas crenças, bem-estar espiritual e cotidiano dos docentes inseridos em práticas acadêmicas. **Conclusão:** A influência de aspectos religiosos, espirituais e bem-estar espiritual corrobora para a necessidade de reflexões sobre novas propostas metodológicas no Ensino Superior para atuação da prática acadêmica de docentes para os estudantes da saúde.

Descritores: Religião, Espiritualidade, Docentes, Saúde, Educação Superior.

RESUMEN

Objetivo: Caracterizar a los docentes del área de la salud sobre aspectos sociodemográficos, formación académica e índices de religión y espiritualidad. **Métodos:** Estudio cuantitativo, realizado con 34 docentes de la salud de una Institución de Enseñanza Superior, en Teresina, Brasil, de diciembre/2015 a mayo/2016. Se aplicaron cuestionarios con variables sociodemográficas y de formación académica, además de tres escalas de religión y espiritualidad. Los datos se procesaron en el software SPSS. **Resultados:** Se evidenció el predominio del sexo femenino, con promedio de 45 años, casados, católicos, con promedio de 18 años de formación y especializaciones en áreas diversas. Se observó una fuerte influencia de los factores espirituales y religiosos en las creencias, el bienestar espiritual y cotidiano de los docentes insertados en prácticas académicas. **Conclusión:** La influencia de aspectos religiosos, espirituales y bienestar espiritual corrobora para la necesidad de reflexiones sobre nuevas propuestas metodológicas en la Enseñanza Superior para la actuación de la práctica académica de docentes para los estudiantes de la salud.

Descriptores: Religión, Espiritualidad, Docentes, Salud, Educación Superior.

INTRODUCTION

Religiosity and spirituality are the main components of an individual's culture, and religiosity is one of the forms of expression of spirituality.[1,2] Religion involves beliefs, practices and rituals related to the transcendent, which is God; and religiosity is the collective experience shared or practiced. Nevertheless, spirituality is an abstract, subjective, complex, non-institutional term whose definition varies among people, philosophies, cultures, and refers to the multidimensional human experience.[3-5] The use of the term detached religion is fairly recent and would have occurred around the 60s and 70s of the twentieth century, thus the triad mind, body and spirit was underestimated and poorly explored by researchers and health professionals for a long time.[6,7]

Studies recognize spirituality to be related to how people seek the meaning of life, and which was generally considered to be separate from religion; however, Muslims, for instance, perceive their spirituality as being inseparable from their religion.[5] Spirituality can be used as a coping and support strategy for critical situations in people's lives, as it can increase the sense of purpose and meaning of life, with this, it is verified that higher levels of spirituality were associated with greater resistance to stress, less anxiety, and a more optimistic orientation of life among individuals.[1,4,7-10]

Nowadays, spiritual care is considered an essential part of the overall treatment planned to improve the quality of life of patients and their families.[5] Spirituality is the essence of human beings and plays a vital role among people. Thus, addressing the spiritual dimension in care and professional care makes a considerable difference in the physical and psychosocial outcome of the human being, whereas there is no way to support health improvements only in rational arguments and institutional measures. In this sense, spirituality must find its place in humanized care.[11-13]

Prayer is one of the most commonly used means of dealing with a particularly disturbing event or condition, especially when it is related to the individual's health.[2] Studies suggest that providing spiritual assistance could help patients to improve their physical comfort, decrease anxiety levels, and increase their hope for the future, since, the care to be integral requires beyond technical-scientific knowledge, sensitivity to the perception of all the needs of the patient, including the spiritual.[5,6]

Spirituality is also defined as the search for understanding and meaning in life that may or may not be related to religion, religious rituals, and community rituals.[14,15] Common religious beliefs that bring people to their church provide a context in which people can connect with others on health issues. Studies show that networking that takes place in church contexts enhances social bonds and creates an extended family. It is this sense of having a "church family" that directly affects psychological and physical health, and well-being; therefore, spirituality is essential in the training of health professionals.[2,16]

The assessment of spiritual needs is usually not made and spiritual care is often neglected. The role of spiritual health care is accepted by health professionals, and this recognition of a patient's spiritual needs is formally expressed through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Accreditation Committee for Rehabilitation Facilities; nevertheless, health professionals have difficulty understanding the articulation between spirituality and health, as well as incorporating the spiritual dimension in their professional activities.[4,11]

Few health professionals routinely screen spiritual history to identify patients' beliefs, values, or spiritual needs.[17] According to recent research, 59% of British medical schools and 90% of US medical schools have courses or content about spirituality and health. Nonetheless, there is little research about teaching in medical schools in other countries, such as those in Latin America.[18] A multicenter

study of 3,600 students from Brazilian medical schools concluded that there is a gap between students' attitudes and expectations about inclusion of spirituality and religiosity in their training and clinical practice.[16]

In a study performed with health professionals in a referral hospital in palliative care, 94.8% of the evaluated professionals believe that the topic "Health and Spirituality" should be part of the regular curricula of health teaching; however, half of the professionals reported that during their university education, their professors rarely discussed or presented this theme, and 36.2% of them said that they had never presented such an approach; thus, the patients' religiosity and spirituality are generally not approached by health professionals in daily practice.[13,19]

There is a lack of information about spirituality, compared to the interest of many students and professors, and it is necessary to implement instruments that make it possible to prepare the students to perform this approach with their patients, in order to contemplate, in the best possible way, a more integrative therapy.[20] The education of students in this field is one of the most important items for their future careers, and developing a sensitivity to spirituality in students can provide the right path to provide spiritual care for patients.[11]

Given the aforementioned, it is relevant to disseminate scientifically the sociodemographic characteristics and indexes of religion and spirituality of health professors, considering the importance of content sharing in the academic environment, based on the benefits of holistic focused assistance in spiritual/religious aspects as factors of health protection. Hence, this study had the objective to characterize the professors from the health area on sociodemographic aspects, academic formation, and both religion and spirituality indexes.

METHODS

It is a descriptive-exploratory study with a quantitative approach, which was carried out with health professors from a Higher Education Institution (HEI), in *Teresina* city, *Piauí* State, Brazil.

Thirty-four professors from the HEI, in which the following inclusion criterion was established, were enrolled in the study: to be hired as lecturer of the courses related to health (Medicine, Nursing, Dentistry, Physiotherapy, Biomedicine, Nutrition, Speech-Language Pathology and Physical Education) during the period data collection. Professors that were on medical leave, leave or vacation were excluded.

Data collection was performed from December 2015 to May 2016, through the application of a questionnaire with objective items that included sociodemographic variables (gender, age, origin, skin color/race, marital status, number of household members, family income, occupation and religion) and variables related to the academic formation (graduation time, subject and postgraduate workload, specialization, masters and doctorate, besides the time of completion).

It was also used the application of the Duke Religious Index (DUREL) scale, developed in the United States and validated in Brazil.[21,22] This scale has five items and three dimensions: Organizational Religiosity (OR), Non-Organizational Religiosity (NOR) and Intrinsic Religiosity (IR). The first two items address OR and NOR based on epidemiological studies conducted in the United States, related to indicators of physical, mental health and social support. The other items refer to IR.[23] The Scale of Spirituality Assessment in Health Contexts was also used, which consisted of five items. This scale evaluates two spiritual dimensions, as follows: a vertical dimension, associated with the practice of religion, denominated beliefs; and a horizontal, existentialist, denominated hope/optimism.[24] Conclusively, the Spiritual Well-Being (SWB) Scale was developed. The United States and validated in Brazil, making a total of 20 items.[25,26] SWB is originally divided into two dimensions, as follows: Religious Well-Being (RWB) and Existential Well-Being (EWB), each of which consists of 10 items, on a 6-point Likert scale.[26]

The results of the application of the DUREL Scale of Religiosity and the Scale for Assessment of Spirituality in Health Contexts were interpreted from the levels of response indicated by the professors participating in this study. The analysis of the SWB scale was performed according to the levels of response (frequencies) and from the scores generated in the dimensions and overall. For this, negative items were reversed so that the highest value (6=totally agree) was always associated with a higher level of spiritual well-being. For the RWB dimension, the following items were inverted: 1, 5, 9 and 13; for the EWB dimension was inverted: 2, 6, 12, 16 and 18.

Data on the application of the instruments were entered into databases, double typed in Microsoft Excel®, in order to validate for identification of possible typing errors. They were processed in IBM® SPSS® software, version 21.0, calculations of descriptive statistics, such as: average, standard deviation, minimum and maximum, as well as absolute (n) and relative (%) frequencies.

It should be emphasized that the inclusion of the participants in the research was carried out according to the principles of the Resolution No. 466 of December 12th, 2012, from the National Health Council, taking into account the ethical precepts and respecting the freedom and autonomy of the participants involved.[27] All the participants were clarified about the purpose and the methods of the research and signed the Free and Informed Consent Term. The study was approved by the Research Ethics Committee from the *Centro Universitário UNINOVAFAPI*, under *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Apprecia-

tion] No. 49386815.0.0000.5210 and Legal Opinion No. 1.294.349, on October 23rd, 2015.

RESULTS AND DISCUSSION

Considering the analysis of the responses of the 34 professors who participated in the study, obtained through the application of the data collection instruments, in agreement with the proposed objective, it was possible to represent the sociodemographic characteristics of the health professors according to the following variables: gender, age, origin, skin color/race, marital status, number of household members, family income, occupation and religion (**Table 1**).

Table 1 - Professors' sociodemographic data (n=34). *Teresina* city, *Piauí* State, Brazil, 2017

Variable	A	SD	n	%
Gender				
Female			26	76.5
Male			8	23.5
Age	45.2	9.0		
Up to 45 years old			15	44.1
More than 45 years old			19	55.9
Origin				
Teresina city			18	53.0
Other cities from the *Piauí* State			8	23.5
Other States			8	23.5
Skin color/race				
White			16	47.1
Black			2	5.9
Yellow			1	2.9
Brown			15	44.0
Marital status				
Single			6	17.6
Married			22	64.8
Divorced			5	14.7
Common-law marriage			1	2.9
Number of household members				
Up to 2 people			7	20.7
3 to 5 people			20	58.8
6 to 8 people			6	17.6
9 people or more			1	2.9
Family income				
3 to 4 MW			1	2.9
5 to 6 MW			2	5.9
7 to 8 MW			6	17.6
> 8 MW			25	73.6
Occupation				
Public servant			12	35.3
Hired			22	64.7
Religion				
Catholicism			30	88.2
Evangelicals			2	5.9
Spiritualism			2	5.9
Total			34	100.0

Legenda: M: média; DP: desvio padrão; SM: salário mínimo (R$ 880,00, vigência 01/1/2016)

A greater frequency of female gender (76.5%) was observed in this study, as was in another study done in Jordan, where more than half of the participants were female. The gender made a difference in the participants' perceptions of spirituality and spiritual care. They had satisfactory levels of spiritual awareness and spiritual assistance. According to the author, the predominance of the female sex was correlated with a greater perception about the understanding of spiritual assistance.[5]

The majority of the participants were older than 45 years old (55.9%), which may influence their responses to the research questions, due to the influence of the spiritual aspects on older people, cultural characteristic of Brazil, a country with great diversity of beliefs and variety of beliefs.[4] Religiosity and cognitive orientation towards spirituality seem to be more strongly and significantly related to age and gender; the differences observed as a function of culture assume that the interaction effects between the three variables should be examined.[28]

Seeing the marital status, it was observed that most of the professors were married (66.7%), which is in spite of the fact that a large part of the professors had or would be building their own family, which can lead them to have another vision of religion as well as spirituality. Adults who are already parents have indicated that religiosity played a central role in their lives as a social space that influenced their views of the world and health attitudes; in which spirituality was specifically seen as a positive influence on health, and a contributor to protective outcomes.[2] For more experienced adults, the most common source of social support is family members and members of religious organizations.[3]

Concerning the religion of the participants, there was a prevalence of the Catholic religion (88.9%), corroborating with data from other studies that show the predominance of the Catholic religion among the participants. A study carried out with professors of the nursing and medical course at a *Universidade de São Paulo*, who verified that 90% of professors answered that they profess some religion; the religions cited by the professors were the following: Catholicism (50%), Spiritualism (30%) and Evangelicals (16%).[29] According to a study carried out in a hospital in *Pernambuco* State, a hospital of reference in palliative care, 48.3% claimed to be Catholic, 20.7% had no religious affiliation, but believed in God; 13.8% said they were Spiritists.[13] These data confirm the strong influence of Catholicism in Brazil.

Furthermore, it was verified an average of 18 years of professional performance, with specializations in several areas. It was also evidenced that 73.5% of the participants did not have specialization in chronic conditions and 73.5% reported having MSc/PhD degree (**Table 2**).

Table 2 - Characteristics of professors training (n=34). Teresina city, Piauí State, Brazil, 2017

Variable	A	SD	n	%
Professional performance	18.8	7.9		
Up to 18 years			18	52.9
More than 18 years			16	47.1
Hours of specialization*	746.1	786.1		
360 hours (minimum)			9	40.9
More than 360 hours			13	59.1
Specialization in chronic diseases				
Yes			9	26.5
No			25	73.5
Hours of specialization in CD†	1,224.0	939.7		
360 hours (minimum)			2	40.0
More than 360 hours			3	60.0
Other specializations‡				
Teaching in Higher Education			4	21.1
Public Health			2	10.5
Hospital Administration			1	5.3
Obstetric Nursing			1	5.3

Family Health			1	5.3
Mental Health			1	5.3
Higher Education			1	5.3
Parenteral and Enteral Nutrition			1	5.3
Exercise Physiology			2	10.5
Pediatrics			1	5.3
Geriatrics			1	5.3
Bioethics			1	5.3
Medical Informatics			1	5.3
Medical Clinic			1	5.3
Hours of other specializations§	559.6	593.7		
360 hours (minimum)			5	38.5
More than 360 hours			8	61.5
Master/doctorate				
Yes			25	73.5
No			9	26.5
Master/doctorate research area‖				
Family Health			5	22.7
Biology			1	4.5
Public Health Surveillance			1	4.5
Physical Activity and Health			1	4.5
Health Sciences			4	18.2
Public Policy			1	4.5
Microbiology			1	4.5
Collective Health			2	9.1
Science and Information			1	4.5
Pharmacology			1	4.5
Environment			1	4.5
Biomedical Engineering			2	9.1
Human Anatomy			1	4.5
Conclusion time of the master/doctorate‖	5.7	5.4		
Up to 3 years			11	47.8
More than 3 years			12	52.2
Total			18	100.0

Legend: A: average; SD: standard deviation; CD: chronic diseases; *Considering those that informed (n=22); †: n=5; ‡: n=19; §: n=13; ‖: n=22

Research developed with health professors showed that 84% of the professors had more than 10 years of professional performance, which is characterized as a group with considerable professional experience; similar to the professors in this study.[7]

It was observed that most of the professionals in this study had extensive professional experience in the health area, however, they stated that they did not have proximity to the approach of religion and spirituality in their teaching practices, which could result in fragility for the assistance to patients.

Although practitioners considered the approach to spirituality and religiosity of patients to be relevant, and felt empowered to do so, only a minority reported feeling prepared for it. The lack of training and the ability of professionals to identify users' demands, as well as the fear of influencing patients' beliefs, constitute barriers that make it difficult to approach religiosity/spirituality in care.[13] A survey with the participation of 1,144 physicians in the United States, found that only 10% said they frequently questioned questions of religiosity and spirituality to patients.[17]

Concerning the religiosity index, the professors' answers expressed some relationship with God and/or religious beliefs, considering that 29.4% attended church or some religious meeting a few times a year, followed by 20.6% of two to three times a month. It was also found that 58.8% expressed religious beliefs behind all the way of life, 47.1% showed an effort to live the religion in all aspects of life and 35.3% showed dedication to individual religious activities daily (**Table 3**).

Table 3 - Frequency distribution of the DUREL Scale responses according to the professors' answers (n=34). *Teresina* city, *Piauí* State, Brazil, 2017

Item	Measure level n (%)					
	>1/week	1/week	2-3/month	some/year	≤1/year	Never
Go to church, temple or other religious meeting	9 (26.5)	6 (17.6)	7 (20.6)	10 (29.4)	-	2 (5.9)
	>1/day	daily	≤2/week	1/week	some/ month	R/N
Dedication to individual religious activities	7 (20.6)	12 (35.3)	4 (11.8)	5 (14.6)	4 (11.8)	2 (5.9)
		TT	GT	NS	GNT	NT
I feel the presence of God (or the Holy Spirit)		28 (82.4)	3 (8.8)	3 (8.8)	-	-
Religious beliefs are behind my way of living		20 (58.8)	10 (29.5)	1 (2.9)	2 (5.9)	1 (2.9)
I strive to live my religion in all aspects of life		16 (47.1)	12 (35.2)	2 (5.9)	2 (5.9)	2 (5.9)

Legend: R/N: rarely or never; TT: totally true; GT: in general it is true; NS: I'm not sure; GNT: in general it is not true; NT: Not true

A study showed that attending church can promote comfort, relief, and well-being, just as internalizing religious beliefs and values can contribute to self-control.[30] Another survey conducted with directors of Brazilian medical schools revealed that Brazil is a highly spiritual country, where 83% of the population consider religion to be very important in their lives, 37% attend religious services at least once a week and 95% report an affiliation with a religious denomination.[18]

Observing the spirituality index, the majority (70.6%) reported being fully in agreement with the strength of faith and spiritual/religious beliefs in their lives and with hope and optimism for difficult times and for the future (**Table 4**).

Table 4 - Frequency distribution of the responses related to the Spirituality Assessment Scale in Health Contexts according to the professors' assessment (n=34). *Teresina* city, *Piauí* State, Brazil, 2017

Item	Measure level n (%)			
	NS	PA	CB	TA
My spiritual/religious beliefs give meaning to my life	3 (8.8)	4 (11.8)	6 (17.6)	21 (61.8)
My faith and beliefs give me strength in difficult times	-	3 (8.8)	7 (20.6)	24 (70.6)
I see the future with hope	-	5 (14.7)	8 (23.5)	21 (61.8)
I feel that my life has changed for the better	1 (2.9)	2 (5.9)	12 (35.3)	19 (55.9)
I learned to value small things in life.	1 (2.9)	1 (2.9)	3 (8.8)	29 (85.3)

In a survey conducted with professional nurses, the results showed that religious beliefs provide strength, tranquility, and faith to face life's issues; then, endorsing the results of this study.[6]

Spirituality is a natural aspect of human functioning that refers to a special class of experiences, beliefs, attitudes, and behaviors. The experiences themselves are characterized as modes of consciousness that alter the functions and expressions of personality and impact the way in which we perceive and understand ourselves, others and reality as a whole.[28] Therefore, spirituality is considered as something superior which gives meaning to inexplicable things, rules life and commands the universe.[4]

Regarding the results of spiritual well-being, all the professors disagreed with the statement "I do not really appreciate life", and most of them (94.2%) totally disagreed on "Life does not make much sense" and totally agreed in "I believe that

there is some real purpose for my life", demonstrating that the majority practiced their spirituality based not only on the specific religion but on everyday elements of life, with beliefs, optimism, encouragement and experiences and faith in God (**Table 5**).

Table 5 - Frequency distribution of the responses related to the Spiritual Well-Being Scale according to the professors' assessment. *Teresina* city, *Piauí* State, Brazil, 2017

Item	Measure level n (%)					
	TD	PD	DA	AD	PA	TA
Religious well-being						
I do not find much satisfaction in personal prayer with God	25 (73.5)	2 (5.9)	3 (8.8)	-	1 (2.9)	3 (8.9)
I believe that God loves me and cares for me	-	1 (2.9)	-	1 (2.9)	3 (8.8)	29 (85.4
I believe that God is impersonal and is not interested in my everyday situations	24 (70.6)	2 (5.9)	-	2 (5.9)	3 (8.8)	3 (8.8)
I have a significant personal relationship with God	-	1 (2.9)	1 (2.9)	4 (11.8)	4 (11.8)	24 (70.6
I do not receive much personal strength and support from my God	27 (79.5)	2 (5.9)	1 (2.9)	2 (5.9)	1 (2.9)	1 (2.9)
I believe that God cares about my problems	-	2 (5.9)	-	4 (11.8)	2 (5.9)	26 (76.4
I do not have a satisfactory personal relationship with God	27 (79.5)	3 (8.9)	1 (2.9)	1 (2.9)	1 (2.9)	1 (2.9)
My relationship with God helps me not to feel alone	1 (2.9)	1 (2.9)	-	1 (2.9)	6 (17.7)	25 (73.6
I feel fully fulfilled when I am in close communion with God	-	1 (2.9)	-	2 (5.9)	5 (14.7)	26 (76.5
My relationship with God contributes to my sense of well-being	-	-	-	-	4 (11.8)	30 (88.2
Existential well-being						
I do not know who I am, where I came from or where I'm going	26 (76.5)	4 (11.8)	1 (2.9)	-	2 (5.9)	1 (2.9)
I feel that life is a positive experience. I feel restless about my future	1 (2.9)	-	-	1 (2.9)	3 (8.8)	29 (85.4
I feel restless about my future	13 (38.3)	2 (5.9)	3 (8.8)	3 (8.8)	10 (29.4)	3 (8.8)
I feel quite fulfilled and satisfied with life	-	-	-	4 (11.8)	11 (32.4)	19 (55.8
I have a feeling of well-being about the direction my life is going	-	-	-	4 (11.8)	9 (26.5)	21 (61.7
I do not like life very much	34 (100)	-	-	-	-	-
I feel good about my future	1 (2.9)	-	-	2 (5.9)	12 (35.3)	19 (55.9
I feel that life is full of conflict and unhappiness	13 (38.2)	5 (14.7)	2 (5.9)	5 (14.7)	7 (20.6)	2 (5.9)
Life does not make much sense	32 (94.2)	-	1 (2.9)	-	1 (2.9)	-
I believe that there is some real purpose for my life	-	-	-	1 (2.9)	1 (2.9)	32 (94.2

Legend: TD: totally disagree; PD: partially disagree; DA: more disagree than agree; AD: more agree than disagree; PA: partially agree; TA: totally agree

Research has revealed that 87% of Brazilians consider religion as an important aspect of their lives and that more than 90% of the population, regardless of the religion they profess, uses religiosity and spirituality with the object of strength and comfort in the face of life's adversities; associating spirituality with the belief in a being superior to the human being and believing that having a good relationship either with God or superior being, independent of the religion practiced by the individual, favors the understanding of human suffering.[1,4,7]

Still on spiritual well-being, the following table shows that the dimensions of religious well-being and existential well--being are in agreement, insofar as these aspects encompass the spiritual characteristics of human subjectivity; knowing that the individual is composed of religious and existential aspects that relate to each other, resulting in the composition of spirituality, based on individual values, beliefs, and feelings. For this analysis, it was observed that religious well-being showed an average of 54.8, while existential well-being showed an average of 49.1 (**Table 6**).

Tabela 6 - Escores das dimensões e global da Escala de Bem-Estar Espiritual conforme avaliação dos docentes (n=34). Teresina/PI, Brasil, 2017

Dimension	A	SD	Min	Max
Religious well-being	54.8	6.4	29.0	60.0
Existential well-being	49.4	3.9	42.0	55.0
Spiritual well-being (global)	**104.1**	**8.5**	**77.0**	**115.0**

Legend: A: average; SD: standard deviation; Min: minimum value; Max: maximum value.

In this sense, through the concept of self-transcendence, spirituality was incorporated into a biopsychosocial model of temperament and character. The great advantage is that spirituality allows its inclusion within naturalistic science in a way that does not expressly require the use of religious and theological ideas, but at the same time does not completely deny the use of such ideas and systems of thought for interpretation of spiritual phenomena. It also opens up the possibility of exploring and investigating practices such as prayer, meditation, and contemplation as vehicles to facilitate the activation of spirituality in a way that is not restricted to the limits of either doctrinal or institutional religiosity.[28]

The appreciation of the approach of spirituality and religiosity in clinical practice is a major necessity, as well as the fostering of spaces for discussion about the role of religion and spirituality among professors and students since the beginning of formation, which may contribute for effective health care.[16]

CONCLUSIONS

Herein, it was possible to characterize professors linked to teaching in several health courses regarding the sociodemographic aspects and related to academic formation, showing indexes of religion and spirituality in the context of a HEI and allowing reflections on the extent and repercussion of the theme in the academic environment.

The results indicate the importance of the influence of both religion and spirituality on the biopsychosocial health of an individual, which expresses the need for a closer approximation of health professors with this theme in higher education systems, so that it can be passed on to the health students through the undergraduate courses the relevance of providing care centered on a holistic and efficient approach, aiming a comprehensive and humanistic care to the patient and their families, respecting any intrinsic factors of each human being.

Concerning the study's limitations, the fact of conducting the research in a single HEI, with peculiarities of the investigated professors and local political aspects, stands out. Nonetheless, this research makes it possible to offer a contribution to the scientific community, in that it indicates the relevance in considering religious and spiritual aspects for the knowledge and practice in the care with the individual.

This study emphasizes the incentive to carry out other specific research related to the theme, so that, based on kno-

wledge about religion and spirituality of health professors, it is possible to reflect on new methodological proposals for the performance of academic practice from professors to students, aiming the religious and spiritual well-being of all people involved.

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