Chapter 5

Family and Community Medicine and Spirituality

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ABSTRACT
Introduction: The association between Medically Unexplained Symptoms (MUS) and depressive and anxious conditions, named Common Mental Disorders (CMD) has been studied, but there are few studies in Brazil. Aims: To estimate prevalence of four MUS (irritable bowel, dyspepsia, chronic fatigue, and dizziness), its relationship with sociodemographic characteristics and co-occurrence with CMD. Method: The sample consists of 764 individuals, a subsample clinically evaluated by physicians, from the population survey 'São Paulo Megacity Mental Health Survey'. Psychiatric diagnoses were obtained through the SCID interview, according to DSM-IV. Information on the presence of MUS were obtained from validated scales in our country. Multivariable logistic regression model was used to study association of MUS and CMD. Results: Half of the sample presented at least one MUS, being more frequent in women, those aged between 35-49 years, 'low average' income and among married people. Chronic fatigue was the most frequent symptom (30.4% in the total sample; 22.9% women; 7.5% men), followed by dyspepsia (26.8%; 19.3% in women and 7.5% in men), vertigo (19.6%; 15% in women and 4.5% in men), and irritable bowel (6%; 4.5% in women and 1.3% in men). There was an association between SEM and depression (RC 3.4; 95% CI, 2.4-4.8) and anxiety (RC 2.2; 95% CI, 1.5-3.0). The likelihood of these common mental disorders increased with increasing numbers of Mus. Conclusion: We confirm the association between MUS and CMD in this sample of the largest Brazilian city, indicating the need of a comprehensive approach in treatment.

Keywords: Common mental disorders, Medically unexplained symptoms, Epidemiology, Somatization, Cross-sectional studies, Irritable bowel syndrome, Dyspepsia, Chronic fatigue, Dizziness, Depression, Anxiety.

1 INTRODUCTION

Religiosity and spirituality has been the object of a growing interest among clinicians and researchers in the health area. There is no scientific consensus regarding the concepts of Religiosity and Spirituality, a fact that leads to implications as non-accurate instruments, the expansion or "reduction" of concepts to other constructs that are not necessarily of religiosity and spirituality, besides clinical aspects that can "confuse" religiosity and spirituality with psychopathological aspects (CURCIO et al., 2019).

Religiosity is the belief and ritualistic practice of a religion, whether in participating in a religious environment or in the act of praying or praying, or of manifesting attitudes that are part of that religious doctrine. Thus, religion is the organized system of beliefs, practices and rituals related to the sacred, but it can also involve rules about guiding conducts of life in a social group. It can be practiced in a community or individually. (ZERBETTO et al., 2016).

Spirituality can be defined as the personal search to understand the meaning of life, its relations with the sacred and the transference, which may or may not lead to the development of religious practices (HAROLD G. KOENIG). Spirituality is a specificof experience and can be included in the clinical context, and it is of great importance that health professionals are able to be able to deal with the patient as a whole.

Spirituality consists of a personal relationship with the transcendent object (God or Higher Power), the metaphysical, in which the person seeks fundamental meanings and purposes of life and which may or may not involve religion. Hundreds of studies have been published investigating the relationship between religious involvement and physical and mental health. Such studies indicate a positive association between religiosity, better health and quality of life. Religiosity has been recognized as an important source of support among people dealing with stressful situations. Thus, several leading health organizations have included recommendations for spirituality assessments as an integral part of adequate patient care. (MOREIRA-ALMEIDA et al., 2010).

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Several studies have shown relationships between greater spirituality, religiosity and better mental health, clinical outcomes, longer survival, general well-being and quality of life. However, in order for scientific research to occur accurately, there needs to be a consensus of meaning regarding the phenomenon to which it is observed (LUCCHETTI et al., 2012).

Religious beliefs have nothing to do with the idea of God or eternal life, but they would say respect to a representation of the world that has, universally, a dual and opposite character. In this sense beliefs, myths and legends, would be " systems of representations" that express the nature of sacred things, their virtues, the powers assigned to them and their relations with things (MONTERO, 2014).

Studies on the development of spirituality and the role of religiosity in coping with difficult situations have increased in recent decades. In the latter part of the 20th century there was a rapid rise in research that examined the relations between religion, spirituality and health, and this trend continued until the first decade of the current century (SILVEIRA et al., 2018).

The debate on a new paradigm in health care aimed at the patient in an integral perspective has been delineated in recent decades, in the context of discussions on the humanization of care (HEFTI et al., 2016)

The term humanization involves a range of meanings and also implies controversies. However, when it comes to dehumanization, the opposite happens. It seems that everyone understands its meaning,

whether in an intuitive way or because they have suffered their consequences in some sphere of their lives (GALLIAN et al., 2013).

Not only do physicians have difficulty with the theme humanization in health, medical schools also present this conflict, notthe medical curriculum is given little attention to reflections on existential issues and non-biological aspects of the human being. Students are alerted to the need to avoid dehumanization, but are not instrumentalized to do so. Knowing how to care for patients in sickness and death requires preparation and, in the absence of this, they use a defense strategy that consists in the denial of their own emotions and protect themselves by ignoring the suffering of others (GALLIAN et al., 2013).

In the health-disease process it is important to consider the individual in its entirety, therefore include its five dimensions: physical, emotional, mental, cultural and spiritual. A broader meaning is established when the objective is comprehensive care for the patient considering, in treatment and rehabilitation, the importance of spirituality and religiosity as a therapeutic resource (GALLIAN et al., 2013).

Therefore, people's spirituality seems to influence how they construct their narratives related to the health-disease process, including strategies for coping with adverse situations. Thus, questions related to spiritualitycan be addressed during meetings between health professionals and the person. Above all, family and community physicians (CFM) who perceive these issues in their practice, how and when they approach them and think they have a fundamental contribution to the clinic (the treatment of the proposed treatment among others.).

Science has been breaking free from old myths, creating new beliefs related to civilization according to the author of Bruce H Lipton's book The Biology of Belief (2007). Scientist and professor at North American universities, known for discussing Epigenetics, which studies the molecular mechanisms by which the environment controls genetic activity, being one of the most active areas of scientific research in general. Epigenetics addresses genome modifications that are inherited by future generations, but do not alter the DNA sequence (MOURA, 2017).

DNA containing genetic instructions that coordinate the development and functioning of all living beings and important structures.

An important structure is the pineal gland, a reddish-gray structure, with an approximate mass of 500 mg (measuring on average 25 by 12 mm in humans), located just above the upper colliculus and behind the stria medullaris, between thalamic bodies, positioned laterally (ROSS,2018).

Anatomically, it is considered part of the epitalamo. It is a small and unique epithalamic structure, located dorsally to the caudal region of the diencephalon. It is derived from neuroectodermal cells and, like the retina, develops from an invagination of the roof of the wall of the third ventricle. It is an endocrine or neuroendocrine gland that regulates body rhythm daily (ROSS,2018).

Also for Ross (2018) is a photosensitive organ and an important timekeeper and regulator of the day/night cycle (circadian rhythm). It obtains information about the cycles of light and darkness from the retina through the retino-hypothalamic tract, which connects in the suprachiasmatic nucleus with the sympathetic neural tracts that follow its path into the pineal gland.

Thus, during the day, the luminous impulses instill the production of the main hormone of the gland, melatonin. Therefore, pineal activity, measured by changes in plasma level of melatonin, increases during darkness and decreases during the light period. In humans, these circadian changes in melatonin secretion play an important role in regulating daily body rhythms (circadians)

Our mind reacts in network, no one thinks or feels alone we establish the tune and connect, and with that our mind goes beyond our thoughts and our emotions. Everything we feel and think reflects in the networked consequences for good or evil, giving us the real importance of our intention: whether our intention is love or hurt, which ultimately determines our harmony and the paths of our destiny (OLIVEIRA, 1998).

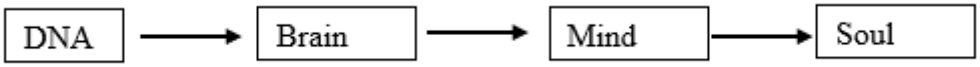
And this whole magnetic network finds an MRI box in our brain, right in the middle of the brain, which is the pineal gland. If the pineal captures an energy that came from the psychosphere and that energy reacts with the limbic system, emotional changes will occur, making us cry and not knowing why. If it reacts in the hypothalamus, alters the thyroid, alters the adrenal, alters the ovaries, reacts in the body as a whole, because the hypothalamus is the one who commands the autonomic nervous system (OLIVEIRA, 1998).

The gland is the link between our organism and the dimensions of space. Therefore, when we speak in pineal we are referring to the mental connections, in interaction between the body world and the spiritual world (OLIVEIRA, 1998).

For Oliveira (1998), the technical physician, centered on biological conception and referenced in diagnostic sophistication, in which the clinic loses space, ends up not finding a logic for that hypertension, for that diabetes, for that cancer, for that disorder oftaking the ide, or establishing a connection of pathologies. This isthe soul reacts to the body with all its connections and the brain has the structure to capture all of this by magnetic pathways. It is the pineal that we have in the middle of the brain, if the pineal captures a tune and goes to the frontal lobe the person may come to have a brilliant idea, or a pessimistic idea, or a negative idea.

As Plato "The soul wishes to fly back home to the world of ideas. She wants to free herself from the prison of the body." Thus, source of energy captured by pineal comes from the spirit and its connections that react there at that point and are distributed in the brain. So the DNA that is the chemistry of the cell command receives the command of the spirit, and this DNA can be impregnated with neuralgic points of the soul and its neuroses that hinder the development of the cell or an organ, thus requiring medication, or transformation into any disease (OLIVEIRA, 1998).

Demonstrating the need to treat the spirit as well as it reacts in DNA forming nuclei of positive or negative energy according to the mental tone of the person. Jorge Andréa (2010) calls nuclei potentiation, so also the brain. In fact Machado de Assis mentioned in Memórias Póstumas de Brás Cubas: "the mind looks over the trapezoid of the brain". That is, the mind that is a product of the soul reacts in the brain, leans over it.



Adapted figure on the Brain Trapezoid (2020).

Therefore the brain is a transducer of the spirit and the pineal gland is in the brain the axis. The energy center, located in the pineal, is where it comes and distributes, when we understand these mechanisms we come to understand the connection between the body and the spirit. And how diseases work in physiology, in the soul and how it interrelates.

There is a coherence, a logic to get to DNA and how we have this connection of the mind. Each person has a perception, a sensitivity and if you do not master their sensitivity, if you do not master their spiritual capacity, "someone" dominates you and if you do not take care of your space "someone" occupies it. Therefore, having dominion over this spiritual territory by the power of your faith by the power of goodness, forgiveness, by the power of your prayers, by the power of your actions, keeps the person with the "closed body". The first spirit you need to receive is yourself!

It is recorded in the will "Now faith is the firm foundation of the things to be expected and the proof of things which are not seen." Hebrews 11:1. So,and you've had the chance to find your mission and thus believe that faith moves mountains. We all have a mission in transcendence and when we occupy that space that is the articulation of good, there is no energy left to get sick. By getting sick (we are not in complete physical, mental and social well-being according to the WHO,1948), we expend energy, so we must channel this energy to do something better. When we put our energy for good we are reamening our diseases, we are achieving the state of health.

When the patient arrives at a consultation or child, be elderly we should ask as a health professional: what is his mission? If you don't know where you want to go, how can you be in the mood to get up? The strength of commitment, this attitude that makes developing a state of healthy euphoria to live and the older a person is, the more magnetism it has, the wider the quota of service to humanity. A person of older age has more magnetic energy, more healing energy, because if the body is degenerating leftover energy, then the older the more healing energy (OLIVEIRA, 2013).

When we talk about age, our brain presents two very special moments of the so-called neuronal pruning (process that occurs within the brain, which results in the reduction of the total number of neurons

and synapses) when you do not use neurons the organism eliminates them: the first moment is at two years of age where the peak of manifestations occurs, the second moment of neuronal pruning is between pre-adolescence and adolescence if that child did not receive with the correct pedagogy the information and if he did not do the necessary exercises of spirituality, through the manifestations of meditation, prayer and the practice of good, when he reaches 12/13 years not having used the nervous circuit that connects with spirituality, the organism sweeps these neurons (OLIVEIRA, 1998).

And then there is a phenomenon similar to that that occurs in animals when they are sick, they will eat the plants that cure that disease, it is one of the research mechanisms of pharmacognosia, animals (NATURE, 2017) with stomach pain look for plants that cure stomach pain. So preteens or teens having lost the connecting neurons go after the plants that put them in a trance and they seek out the drugs.

Today we need to see what we call comorbidity, which is the problem that the patient is living, we must investigate what is the spiritual component, what is the mediumistic part in that diagnosis of schizophrenia, where is the psychic component in the bipolar disorder of that epilepsy, that diabetes, that difficult hypertension to treat, that alcoholism, where is the component. We need to guide the patient to understand and go through spiritual treatments. The patient should be helped to work on his mediumship. We can't help but talk about anthroposophy and neurotheology.

Anthroposophy emerged as a way of observing and understanding the world and man, developed by Rudolf Steiner from 1886 to 1925. It was in 1904 that he came to call this worldview Anthroposophy. Other philosophers already used the term, but designated different conceptions. (ROMANELLI,2015).

The reality described by this worldview is presented in several planes, and the physical world, observed by the human senses, is only one of them, according to Steiner (2019) (passim). In addition to these physical phenomena, this reality encompasses mental and psychic entities and processes that are as possible to be captured as it is possible to capture the surrounding physical reality. Thus, the common observation daily knows only the material plane, according to the levelof consciousness developed by the common man. A more accurate development of human consciousness allows man to perceive other realities besides the material, through the reach of other levels of consciousness. (ROMANELLI,2015) .

In recent years, there has been considerable progress in research that seeks the neurofunctional correlates of the mental states of spirituality, mystical experiences and religious feeling. Among the researchers applied to the area, which has been called Neurotheology (Neurotheology) or Neuroscience of the Spirit (Spiritual Neuroscience), the idea that the results of such studies may have a therapeutic purpose seems quite diffuse: identification of the processes that generate well-being in religious experience should be followed by the elaboration of methods and techniques to induce them, independently of this (CESCON, 2011).

As we can observe there are several proofs in the spiritual field and its physiological interference in fact in people. Thus, the family and community doctor, as the other should be attentive to these issues and

address them in their medical investigations on the diseases, actually observing the patient as a biopsychobeing ssocial.

A proposal of clinical application for the family and community physician can be exemplified by the 3H method, which understands the spiritual experience of the human being as divided into cognitive aspects (head) emotional – experiential (heart) and behavioral (hands). This model is particularly interesting because it helps health professionals to evaluate the strategies of positive coping (Religiosity /Spirituality being a source of comfort or support) or negative (Religiosity/Spirituality increase the burden of suffering of the person). The cognitive aspect stems from philosophical or reflective questions, such as "why is this happening to me" or "what will happen after death?".

The emotional - experiential dimension stems from the process of meaning that the person from to his experience, as a sense of connection and peace or loneliness and despair before his beliefs. The behavioral aspect is manifested by direct actions, such as the choice of life habits (feeding, accepting or not blood transfusion), practice of prayers or religious rituals. With this approach, strategies of support of the person can be identified, as well as thought and feelings that make the experience such as guilt, fear, or perception of punishment within its relationship with the sacred (belief, God or religious institution) (GUSSO,2019). There is no single way to approach spirituality, just as there is no correct way. Often, their approach is done in a natural and quiet way, which depends on the cultural heritages of each doctor. (GUSSO,2019).

However, researchers have created ways to facilitate the approach of spirituality for physicians who still have difficulties with the subject. These instruments serve as a guide for obtaining spiritual history, and the main instruments used are: the questionnaire "FICA" (F - Faith/Belief, I - Importance/Influence, C - Community, A - Action in treatment) and the questionnaire "HOPE" (H – Sources of Hope, significance, comfort, strength, peace, love and social relationship, O - Organized religion, P - spirituality, personal and practice, E – Effects on medical treatment and terminal matters)(GUSSO,2019), ACP Spiritual History (American College of Physicians); CSI-MEMO; and SPIRITual History . Duke University religiosity index "DUREL" (ABUCHAIM,2018).

Table 1 - FICA Questionnaire

F - Faith / belief
Do you consider yourself religious or spiritualized?• Do you have spiritual or religious beliefs that help you deal with problems? If not: what gives you meaning in life?
I - Importance or influence
What importance do you attach to faith or religious beliefs in your life?
Have faith or beliefs influenced you to deal with stress or health problems?
• Do you have any specific beliefs that may affect medical decisions or your treatment?
C - Community
• Are you part of any religious or spiritual community?
• How does she support you?

• Is there a group of people that you "really" love or that is important to you?
• Are communities such as churches, temples, centers, support groups important sources of support?
A - Action on treatment
• How would you like your doctor or health care professional to consider the issue of religiosity/spirituality in your treatment?
• Indicate, refer to any spiritual/religious leader.

Table 2 - HOPE Questionnaire

H – Sources of Hope, significance, comfort, strength, peace, love and social relationships.
What are your sources of hope, strength, comfort, and peace?
What do you cling to in difficult times?
What sustains you and makes you move forward?
O - Organized religion
• Are you part of a religious or spiritual community? Does she help you? How?
What aspects does religion help you in and what doesn't help you much?
P - Personal and practical spirituality
Do you have any spiritual beliefs that are independent of your organized religion?
What aspects of your spirituality or spiritual practice do you think are most useful to your personality?
E - Effects on medical treatment and terminal matters
Have getting sick affect your ability to do things that help you spiritually?
• As a doctor, is there anything I can do to help you access the resources that generally support you?
• Are there any practices or restrictions I should know about your medical treatment? Spiritual history of the ACP
• Is faith (religion/spirituality) important to you in this disease?
Has faith been important to you at other times in your life?
• Do you have someone to talk about religious matters?
• Would you like to deal with religious matters with someone?

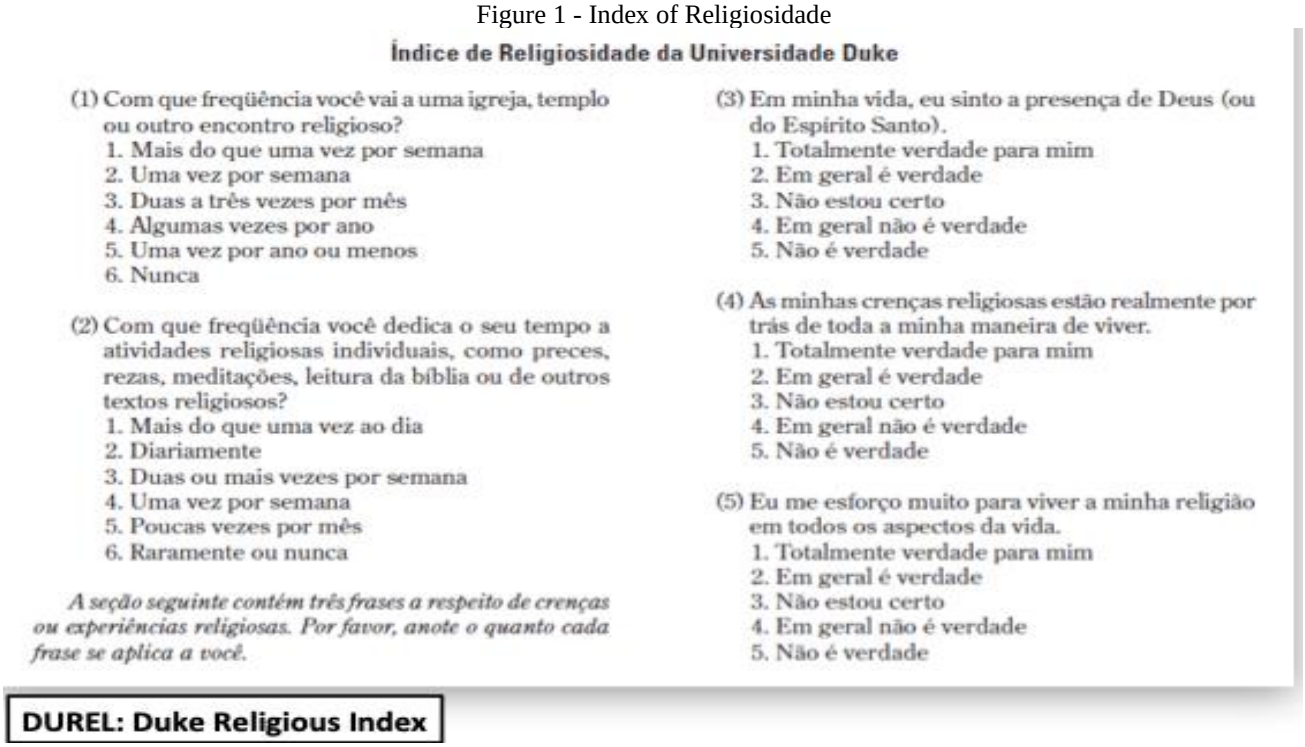
Table 3 - CSI-MEMO

1. Do your religious/spiritual beliefs give you comfort or are they sources of stress?
2. Do you have any kind of spiritual belief that can influence your medical decisions?
3. Are you a member of any spiritual or religious community? Does she help you in any way?
4. Do you have any other spiritual needs that you would like to talk to someone?

Table 4 - SPIRITual History

S—Spiritual Belief System
P—Personal Spirituality
I—Integration and Involvement In a Spiritual Community
R—Ritualized Practices and Restrictions
I—Implications for Medical Care
T—Terminal Events Planning (Advance Directives)

Figure 1 - Index of Religiosidade



Índice de Religiosidade da Universidade Duke

(1) Com que freqüência você vai a uma igreja, templo ou outro encontro religioso?
1. Mais do que uma vez por semana
2. Uma vez por semana
3. Duas a três vezes por mês
4. Algumas vezes por ano
5. Uma vez por ano ou menos
6. Nunca

(2) Com que freqüência você dedica o seu tempo a atividades religiosas individuais, como preces, rezas, meditações, leitura da bíblia ou de outros textos religiosos?
1. Mais do que uma vez ao dia
2. Diariamente
3. Duas ou mais vezes por semana
4. Uma vez por semana
5. Poucas vezes por mês
6. Raramente ou nunca

A seção seguinte contém três frases a respeito de crenças ou experiências religiosas. Por favor, anote o quanto cada frase se aplica a você.

(3) Em minha vida, eu sinto a presença de Deus (ou do Espírito Santo).
1. Totalmente verdade para mim
2. Em geral é verdade
3. Não estou certo
4. Em geral não é verdade
5. Não é verdade

(4) As minhas crenças religiosas estão realmente por trás de toda a minha maneira de viver.
1. Totalmente verdade para mim
2. Em geral é verdade
3. Não estou certo
4. Em geral não é verdade
5. Não é verdade

(5) Eu me esforço muito para viver a minha religião em todos os aspectos da vida.
1. Totalmente verdade para mim
2. Em geral é verdade
3. Não estou certo
4. Em geral não é verdade
5. Não é verdade

DUREL: Duke Religious Index

Source: Moreira - Almeida (2008).

It follows Systematization of the instruments to approach spirituality and religiosity in clinical practice.

Figure 2 - Approach Instrument

Thematic area	**Question**	**Instrumento of origin**	**Subgroup of the question in the Acrostic of instrumentos**
Organized religion (3 questions)	**Do you have any religious affiliations?**	SPIRITual History	S (System of belief)
	How do you name or describe your spiritual belief system?	SPIRITual History	S (System of belief)
	Do you have any spiritual beliefs besides your religion?	HOPE	P (Soal and practical spiritpes)
Meaning of religiosity and/or spirituality for the person (4 questions)	Do you consider yourself religious or spiritualized? If not, **what gives you meaning in life?**	IS	F (Faith / Belief)
	What does your spirituality/religion mean to you?	SPIRITual History	P (Espirit staff)
	How important is your spirituality / religion in daily life?	SPIRITual History	P (Espirit staff)

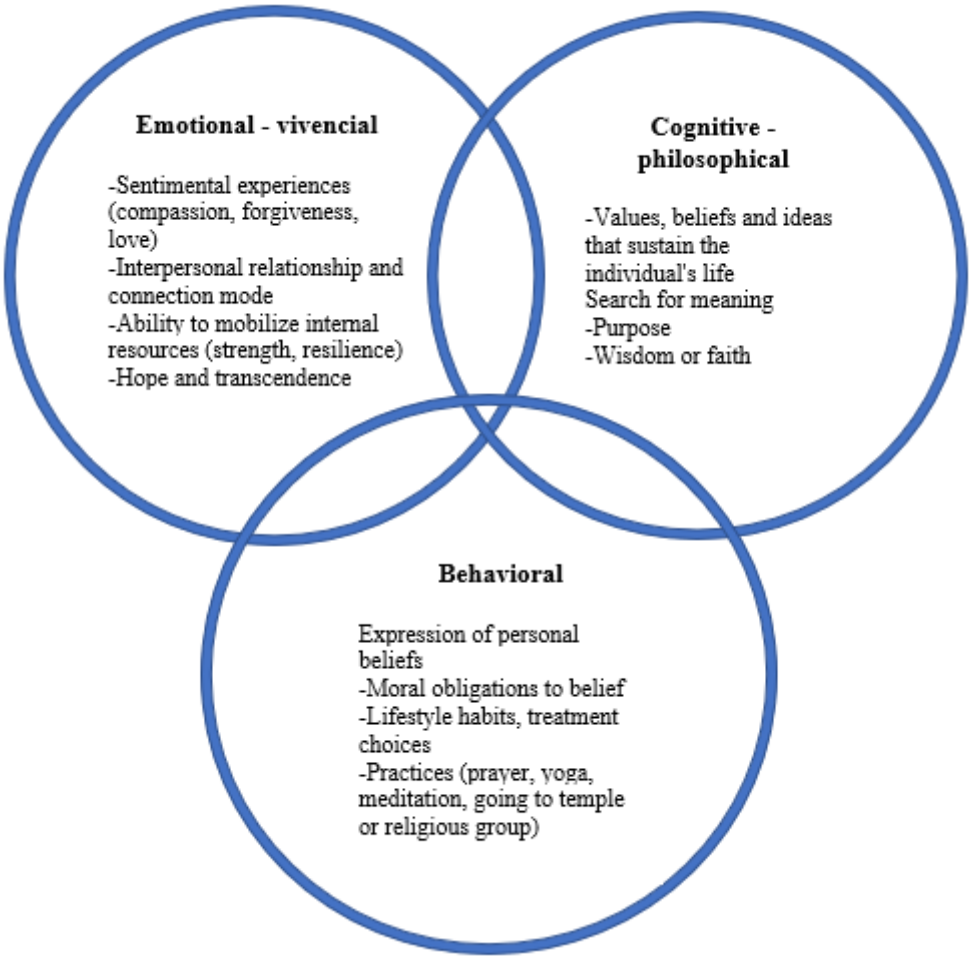
	How important do you attach to faith or religious beliefs in your life?	IS	I (Importância)
Spiritual religious coping (4 questions)	**Do you have spiritual or religious beliefs that help you deal with problems?**	IS	F (Faith / Belief)
	Faith or beliefs have already influenced you to deal with stress or health?	IS	I (Importância)
	What aspects of your spirituality or spiritual practice do you think are most useful to your personality?	HOPE	P (Personal spirit)
	In what ways does religion help you and in which it doesn't help you much?	HOPE	Or (Religion Organized
Spirituality and resilience (5 questions)	**What are your sources of hope, strength, comfort and peace?**	HOPE	H Hope, comfort
	What do you cling to in difficult times?	HOPE	H Hope, comfort
	What sustains you and makes you move on?	HOPE	H Hope, comfort
	Where do you get the strength to deal with this disease?	SPIRITual History	T (Terminal events)
	When you have pain or fear, how do you find comfort?	SPIRITual History	T (Terminal events)
Social support network (11 questions)	Are you part of any religious or spiritual community?	IS	C (Comunidade)
	Does your religious or spiritual community support you? How?	IS	C (Comunidade)
	Communities such as churches, temples, centers, support groups are sources of important support?	IS	C (Comunidade)
	Do you belong to any religious or spiritual group or community?	SPIRITual History	I (Integrate comunidade)
	How do you participate in this group/community? What's your role?	SPIRITual History	I (Integrate comunited with)
	Are you part of a religious or spiritual community? Does she help you? How?	HOPE	Or (Organized religion

	What is the importance of this group to you?	SPIRITual History	I (Integrating de)
	Is this group a source of support for you? In what sense?	SPIRITual History	I (Integrate comunited with)
	Does this group give you or would you give any support on matters related to your health?	SPIRITual History	I (Integrating de)
	Is there a group of people who do you "really" love it or that is important to you?	IS	C (Comunidade)
	Refer, refer to any spiritual leader /	IS	A (Action
	religious.		in tto)
Practices and lifestyle (6 questions)	**Do you have specific practices performed as part of your religious or spiritual life (e.g., prayer, meditation, service)?**	SPIRITual History	A (Rituals, practices and restrictions)
	Are there practices or activities that the lifestyle of your religion encourages or prohibits? How do you accept that?	SPIRITual History	A (Rituals, practices and restrictions)
	What is the meaning of these practices or restrictions for you?	SPIRITual History	A (Rituals, practices and restrictions)
	What religious or spiritual practices would you like to have available in the hospital or at home?	SPIRITual History	T (Terminal events)
	What practices would you plan at the time of death, or after death?	SPIRITual History	T (Terminal events)
	In your beliefs, there is some practice or restriction on your medical treatment that I should know?	HOPE	E (Notto Effects)
Relationship of religiosity/spirituality and with the therapeutic project (7 questions)	**Do you have any specific beliefs that may affect medical decisions or your treatment?**	IS	I (Importor Influence)
	When planning your care near the end of life, such as religion and spirituality influence their decisions?	SPIRITual History	T (Terminal events)
	There are particular aspects of your treatment that you would like to dispense with or suspend because of your faith?	SPIRITual History	T (Terminal events)
	Has getting sick affect your ability to do things that help you spiritually?	HOPE	E (Effects on tto)

	Would you like to discuss religious or spiritual implications in the care of your health?	SPIRITual History	I Medical implications
	Would you like to discuss the religious or spiritual implications of health care?	SPIRITual History	I Medical implications
	There are other specific elements of medical care that you refuse by religious/spiritual motifs?	SPIRITual History	R (Rituals, practices and restrictions)
Impact of religiosity/spirituality on the doctor-patient relationship (4 questions)	**What knowledge or understanding of this do you think would strengthen our doctor-patient relationship?**	SPIRITual History	A (Rituals, practices and restrictions)
	How would you like your doctor or health care professional to consider the issue of religiosity / spirituality in your treatment?	IS	A (Action in tto)
	What aspects of your religion/spirituality would you like me to consider in your care?	SPIRITual History	I Medical implications
	As a doctor, there's something I can do to help you access the resources that usually support you?	HOPE	E (Effects on tto)
Total: 8 areas 44 questions	Selected Questions FICA: 5 HOPE Selected Questions: 6 Selected SPIRITual Questions: 5		

Source: OLIVEIRA (2018).

Figure 3 - 3H model for spirituality evaluation



Source: GUSSO (2019).

Patient-centered spiritual history has the potential tocover disease and illness spectos and can also make the experience more meaningful for the patient and healthcare professional. Thus, medical intervention helps the patient mobilize internal resources and participate in a shared decision-making process. The use of the patient-centered approach to the spiritual approach can be an appropriate strategy and an interesting perspective for a better clinical outcome (OLIVEIRA,2018).

Thus, it is a task for all health professionals with emphasis on family and community physicians, to incorporate the available evidence on the subject. But it is also a task to expand its development especially in the research of interventions and the curricular place of spirituality and health. The residency programs of the specialty and the master's and doctorates of primary health and collective health care can be opened to proposals for studies in this field and contribute to the criticism, deepening and applicability of knowledge already available. It is important to highlight the need for these developments to contemplate the concrete reality of the country, because people and their spirituality are immersed in the contradictory, excluding and conflicting social soil of Brazil (GUSSO,2019).

The principles of primary care and family and community medicine focus on the person. For example in primary care one of the basic principles is the principle of integrality, it means seeing the person as a whole, for all that he is, without prejudiced exclusions, we cannot fail to approach the psychological

aspects of the person because it constitutes it. We cannot but worry about the social and economic situation that the person is living, because it also underlies even the potential of it to implement therapeutic measures, and we cannot help but worry about something that it values very much that is its religiosity and its spirituality.

Of course some people don't consciously appreciate it, but that doesn't mean it's unimportant, all people are equally important. So if someone doesn't actually cultivate that side it should also be fully respected. We conclude that the role of the professional, of the family doctor, is to make room for the person, if desired, to place himself on these aspects (above). And so corroborating the principle of integrality, for the need to see the person as a whole, and not only because they have beliefs, not only because they value their belief, but because also, it uses them in relation to the care of their health. Most people pray for health, most people ask the other person to pray for their health, sometimes they also put themselves in collective practices, community practices of faith and prayer, cults, which put them in a situation even to receive support from others for their care, and thus tune their own self with transcendence acquiring peace and this also influences their health.

So it's clear the need to see it as a whole. And if primary care brings this principle of integrality of such relevance, family and community medicine as a medical specialty in the same way proposes to use the clinical method centered on the person, so that we know how the person experiences his health or disease situation. She experiences being an integral person, also with beliefs and expectations then it is conatural, primary care and family and community medicine, in the figure of the doctor, the approach of religiosity and spirituality, really observingthe patient as a biopsycho s social being.

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