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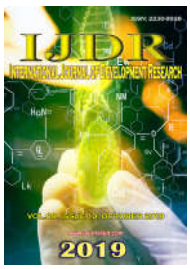

RESEARCH ARTICLE OPEN ACCESS

TRANSPERSONAL CARE AND NURSES' PERCEPTION OF SPIRITUAL ASSISTANCE TO ELDERLY PATIENTS IN PALLIATIVE CARE

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ABSTRACT

Objective: to understand the perception of nurses about spiritual care for elderly patients in palliative care. **Methods:** a descriptive study with a qualitative approach, carried out with 27 care nurses at the University Hospital of Brasilia in 2018. The interviews were conducted through a semi-structured script and submitted to content analysis. The technique of structuring the discourse of the collective subject was carried out. **Results:** it was possible to construct five discourses of the collective subject and grouped into two categories called 1) Spiritual care offered by the nurses, and 2) Factors favorable and unfavorable to the offer of spiritual care for elderly patients. From the central nuclei present in the reports, respondents consider spiritual assistance and family participation in palliative care important. However, they attribute the role of intervening in spirituality mainly to religious volunteers and the family. **Conclusion:** the study shows that even in the face of difficulties in providing spiritual care, family support, moments of listening and the execution of activities that motivate inner peace are significant for a greater response of the spiritualityelderly patients.

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INTRODUCTION

Aging is a natural process that characterizes a stage of human life. With technological advances, decreased mortality rates due to improved sanitary conditions, and decreased fertility rates due to the possibility of birth control, Brazil is in the process of reversing the age pyramid thus demonstrating the increase in population aging. However, aging is also one of the risk factors for the development of chronic diseases, including cancer.With the development of the ability to think rationally and logically, there was also a need to try to understand the meaning of life and death, especially for individuals outside the therapeutic possibilities of cure, as they need differentiated care from those seeking curativist treatment (Cervelin, 2014). Palliative care consists of a care modality granted to the patient and his family in the face of a disease or clinical condition that impairs the continuity of life. These interventions are provided by a multidisciplinary team who observe the patient in their physical, social, psychological and spiritual aspects, with the purpose of improving the quality of life, prevention and identification of diseases, as well as relieving suffering and pain, permeated by effective communication. In this sense, this

practice is essential when clinical and therapeutic cure interventions are not effective (Morais, 2018). In 2015, Brazil was ranked 42nd in the Quality of Death Index ranking where palliative care provided by eighty countries was assessed through analysis of health professional reports, presence of national policies and investments aimed at palliative care (Kelly, 2018). Although Brazil presents a growth in relation to the index published in previous years, and has legislation that guarantees the right of access of citizens to this type of therapy, the country still has difficulties in implementing the quality of care (Luiz, 2018). The terms spirituality and religiosity for many have the same meaning, but are distinct processes. Spirituality corresponds to a unique knowledge of each individual who seeks explanations that go beyond their understanding of the existential process. It has an essential role in the process of care and treatment of diseases, as it is not based exclusively on religion, but on principles related to its own values, and can thus be included in the various stages and contexts. In contrast, religiosity refers to a practice based on belief that brings the lender closer to specific deities. This, in turn, governs a collective behavior and way of life; in this sense they can be shared between people of the same religion (Cervelin, 2014; Gomes, 2014; Arrieira, 2017; Tonin, 2017 and Savieto, 2016).

Transpersonal Care advocates the promotion of a spiritual approach to the care process. Nursing should not be based on the traditional biomedical model, which focuses only on the cure of diseases through a series of established protocols, but attributes spirituality as an important aspect in integral patient care. In addition to including a spiritual dimension in care, Watson explains that through the nurse's interaction with the patient, we can explore their emotions and subjectivity and analyze their relationship in the care process (Santos, 2016).
Palliative care is becoming increasingly present in nursing interventions to elderly patients at the end of life, and it is necessary to understand the nurses' perception, the importance and the meaning that spirituality has in care. Since these professionals spend more time with patients and family members during hospitalization, they often perceive their particularities more easily. In this sense, grasping their perception is indispensable to broaden the debates on this theme. Faced with so many challenges involving the spiritual dimension in palliative care, this study is based on the following guiding question: How do nurses perceive the importance of spiritual assistance to elderly patients in palliative care? Thus, the study aims to apprehend nurses' perceptions about spiritual assistance to elderly patients in palliative care.

MATERIALS AND METHODS

This study corresponds to a descriptive research with qualitative approach. To better understand the thoughts of the subject, group or collectivity, one should explore their ideas through qualitative knowledge, which aims to evaluate quality subjectively (Wadams, 2018). The research was carried out with assisting nurses from the University Hospital of Brasilia (HUB) from July to November 2018. To choose the sample, the study included professional nurses who worked in the Medical Clinic sector at the HUB for a minimum period. 1 year, since this time was established so that the experiences with palliative care of these professionals were sufficient to achieve the research objectives. Nurses who were on vacation or leave during the data collection period and those who did not perform care activities, that is, worked only in administrative functions, were excluded. The sample consisted of 27 nurses, to whom the researchers clarified all doubts regarding the purposes of this study. Subsequently, the data were collected through semi-structured interview interviews, recorded through audio recording in a private place, affirming the right of data confidentiality. The interviews were transcribed in their entirety and analyzed following the technique of content analysis, where the ideas are described as a union of different methodologies whose function is to examine various forms of arguments, with the purpose of observing all the data obtained, be they verbal or nonverbal [(11)].
The content analysis technique made it possible to emerge two categories named 1) Spiritual care offered by the nurses, and 2) Factors favorable and unfavorable to the offer of spiritual care.Through the analysis of the participants' speech extracts it was possible to identify the central nuclei found in the reports, and this allowed the formation of Collective Subject Discourses (CSD). In this sense, the main approaches and meanings of spiritual care organized in order to apply Jean Watson's Theory of Transpersonal Care were prioritized.The technique of structuring the Collective Subject Discourse (CSD) takes up social representations, linking individual and collective interpretations, that is, grouping particular ideas with similar logic to construct a discourse that expresses the concept of the point of view. collective view (Lefevre, 2014). Thus, there is no individual identification of the research participants, since the statements present a collective idea.
This study was approved by the Research Ethics Committee of the Faculty of Ceilândia - FCE of the University of Brasilia - UnB under opinion No. 2,642,997.

RESULTS

Study participants were 27 nurses who work in direct assistance in palliative care to elderly patients out of therapeutic possibilities of cure. Among these, 20 participants (74%) were female and 7 participants (26%) male. When asked about the time of nursing education, 10 participants (37%) had less than 5 years of training, 10 (37%) between 5 and 10 years of training, and 7 participants (26%) had more than 10 years of training. Regarding the time of working with palliative care, all 27 (100%) were younger than 5 years and 14 participants (51.5%) reported having done at least 1 training focused on palliative care and terminal life.

Spiritual care offered by care nurses: Faced with a nursing, often based on biomedical models and focused only on curing the disease, it is necessary an approach that fully values the patient, treating each individual according to their different specificities and needs, as observed in the CSD 1.

CSD 1 - Care is not just about giving that nursing care. All of this involves psychological, spiritual, religious aspects, because everyone is different, each has their own belief. We have to know how to respect the opinion of the individual. The spiritual part is very important. Knowing that this life we take nothing. So, we give that pain control work, psychological work, comfort, in general, so that it gets even better in the acceptance phase of its own death, especially that elderly patient. But more important than technique, than technical

procedures, I think it is this more humanistic approach, thus, to see the patient as a being, who thinks, with needs, who has his religion, who has his beliefs and their values.

Through discourse, we found that participants consider that addressing spiritual aspects improves the acceptance of elderly patients in palliative care in the process of finitude of life. In addition to securing the opinions of individuals and maintaining respect for their religious beliefs, practitioners prioritize pain relief. Many times, due to the large number of patients, work overload and excessive technical procedures, they are limited to promoting biological care and relegating care in the other dimensions to a secondary level, not providing adequate spiritual support to patient, family and the nursing team. In DCS 2, it is clear that most participants delegate the role of providing spiritual care to other professional classes, religious entities and even family members.

CSD 2 - In fact, it was not our job. Is not it? To be working on these psychosocial, spiritual aspects, but as in the internment, nursing is more involved than any other professional there we try a little. A care focused on spirituality being offered by nursing continuously, this does not happen. We also have visits, because here is a hospital open to all faiths and religions and creeds, so every creed, belief, has its spiritual support. So this spiritual part is more up to the volunteers. We promote the listening moment and are more focused on prescription. It is what is written there, it is the care. Being that in some moments, the patient just wants a word of comfort, a friendly word and, by our routine, sometimes, it is impossible to do that. Then sometimes the family also takes on this very important role.

According to reports, representatives of various religions are welcomed to provide spiritual support, and according to the participants, mistakenly, this role is not seen as an assignment of nursing professionals. It is possible to perceive some contradictory concepts and this shows us that the participants confuse the meaning of spirituality with religiosity, and may impair the choices of interventions to be provided during spiritual care, since religion supplies only part of the spiritual dimension.Participants, while attributing the spiritual approach to religious volunteers, promote and encourage therapeutic listening which is one of the main methods used in spiritual care. However, they do not realize that this is a therapeutic moment in the care process, nor is it of importance to the patient. In CSD 3, we can see the importance of including the family in the care process. A family educated about the conduct within the palliative care acts as an aid to the team. However, an uninformed family with little participation assumes the role of subject to be cared for with the patient.

CSD *3 - If the family does not participate, the patient feels rejected, feels more angry, many times, he has accepted that it is no use caring, that he will die, so if he realizes that the family is more present, he accepts more because he knows that the family is there and being taken care of, that there is still a prospect of improvement, that he can go home. So all this influences. The family is an antidepressant, the family is often better than the medicine. The medication soothes their pain, their internal pain, that pain suffered, but for the mind, only the family itself. The approach of the family is essential. So family not only wife, children and grandchildren, you know? Family is what the patient considers as a family, be it a friend, a partner, a cousin, a neighbor or even a pet. I think someone's participation is very important. No one wants to die alone.*

In care, the importance of the family is notorious, since patients accompanied by their relatives have a greater response to the treatment provided, that is, often what relieves pain and discomfort is not only the medications, but the support of the patients. relatives. In contrast, those who remain alone, besides feeling abandonment, do not express expectations of progress and improvement of symptoms. It is possible to observe the benefits as the team includes family members in the process, however it is noteworthy that it is essential for the professional to consider as familiar who the patient thinks is familiar. 2) Favorable and unfavorable factors for offering spiritual care to elderly patients. In CSD 4, we can observe that when professionals act in a cohesive manner and focused on the needs of patients and their families, care becomes qualified and patients experience humanized care.

CSD *4 -What makes it easier? It really is the team, because here the team is very united, organized, we see this commitment with the patients. Here, the team is very human. It is important to try to respect the patient's autonomy. The elderly patient wants to do some distracting activity, a painting, a craft or something he has always done at home, we detect this desire, if the patient has conditions, we offer. We had a patient she painted. She had been a teacher and made several drawings during the day and she gave to the other patients. So we would put it on the headboard and it would be really cool. She felt good painting. It ended up conveying that she was satisfied. When she was doing this the whole team was involved, encouraging.*

It is clear that the interventions can evolve and go beyond a simple conversation, thus giving a new meaning to spiritual care, alleviating their anxieties and enabling quality of life. When the team is united and communication flows effectively among professionals, even the simplest practices result in a diverse and individualized welcome.Based on the reports, the promotion of activities that stimulate happiness, pleasure and satisfaction alleviate the disabilities that elderly patients experience during hospitalization. These dynamics allow the growing desire to live and the search for feelings of usefulness and functionality during palliative care. In CSD 5, we can infer that professionals do not feel prepared to provide spiritual support, presenting obstacles such as lack of time due to hospital demand, lack of a private environment for this approach, difficulty to talk about religious issues, the patient's lack of confidence in the professional, and also because they lack knowledge or adequate preparation.

CSD *5 - And there had to be training, right? I find this very essential because sometimes we don't know how to deal with the patient, how to deal with the family. The familiar is equal to a cliff. Because for them, I do not know if it is not well explained or do not accept the patient's condition. They are quite shaken. As much as they know it's palliative, they want them to make often unnecessary interventions until the last moment. There is also the issue of work overload, I consider as the main factor that makes it difficult. Sometimes you even*

want to provide good care, but because of the large contingent of patients, you cannot provide such assistance as you would like. Nobody accepts death, it makes it very difficult. Today, everyone's vocational training is to take care of those who will survive. You leave college thinking you will save lives. It's very complicated. Another thing that I think makes it difficult is also the lack of communication, the lack of dialogue between the different professions. I can hardly, for example, talk to the psychologist or the doctor. This is a problem.

The nurses clarify during the interview that the family can be a hindrance for not understanding the patient's condition. Therefore, professionals should be able to provide spiritual care for this group, facing limitations such as grief, the constant search for life and interference through the care provided by the team.

DISCUSSION

The perception about the continuity of life in contrast with the experience of its terminality is explicit, among several aspects, in the pursuit of spirituality by patients in end-of-life care. Each patient undergoing palliative care perceives in a unique and personal way this moment of wide complexity (Benites, 2017). The difficulty in dealing with death, the attachment to the constant struggle to maintain life and the fear and the search for prevention and relief of pain and suffering are significant aspects in the living of elderly patients who are in vulnerable conditions. It is important for patients at this moment to highlight feelings such as the relevance of faith, the meaning of life and the hope of healing, even without possibilities, and which may contribute to the relief of various symptoms (Evangelista, 2016). The Theory of Transpersonal Care inserts the faith-hope stimulus and correlates it with nursing care in promoting patient stability. By respecting each patient's beliefs and limitations, transpersonal care is guided beyond human needs and the health recovery process (Santos, 2016). The inclusion of spiritual care is essential in hospice care, as family support, love, hope, and faith are key characteristics of meeting client needs during team interventions (Savieto, 2016). Health practices, for the most part, are still limited in caring for the spiritual dimension. Many times due to lack of skills and abilities of professionals, taking care of aspects that involve body, mind and spirit, has still been a big challenge. Thus, it is important to understand the relevance of comprehensive care in order to overcome paradigms that may impact on therapy and the entire care process (Benites, 2017). In considering the assumptions of Transpersonal Human Care, we note that the theorist makes clear the need to promote incentives that also include integral care for families. Thus, such conditions should always permeate spiritual care both for the elderly patient during the experience of the terminal life process, as well as for the family until the end of the bereavement period (Guerrero-Ramírez, 2016).

The family is one of the most important sources of support for the elderly patient in palliative interventions. It enables and facilitates spiritual care by enabling staff to gain insight into the patient's life history, beliefs, dogmas, expectations and reluctances. Sometimes, the team faces a patient who does not have the traditional family formation of father, mother, children and grandchildren, so it is up to the professionals to promote the inclusion of people who represent an affectionate bond to the patient, so as to assist in care and contribute to the nurse's performance. These family members and friends also suffer from the patient's illness and it is up to the team to welcome and mitigate the suffering of all involved (Lima, 2015 and Matos, 2018). One of the central axes presented by Jean Watson in his theory of Transpersonal Human Care, is the development of a relationship of help and trust that enriches the individual growth of the nurse and the patient, ensuring a relationship without therapeutic impasses and enabling the establishment of new goals to be reached in the care process (Guerrero-Ramírez, 2016 and Izquierdo, 2015). The performance of nursing professionals involved in teamwork is a practice that enables humanized care to patients and their families. A spiritual approach is not only limited to theories and protocols, so it is necessary to promote moments of listening, pay attention to patient preferences and provide moments that value their comfort and well-being (Evangelista, 2016). The nurse analyzes the responses of the patient as a whole, and because they are in continuous contact due to the particularities of the profession, the nurse has greater opportunities to understand the needs of the patient and family, and thus encompass the spiritual area in care. The methods used by them focus on effective communication and qualified listening that favors an increase in the bond with the sick, as well as others such as music, occupational therapies, enabling the meeting with family members, and other conducts that bring the patient closer to what he considers sacred. They are also used to assist in the promotion of spiritual care (Kelly, 2018 and Tonin, 2017). It is relevant to analyze how the treatment of elderly patients in palliative care is still an obstacle for nursing. In order to build a transpersonal relationship, it is necessary for the nurse to disconnect from previously determined principles and be willing to be involved in integral care. This means that emotional involvement with the patient is essential (Santos, 2016 and Evangelista, 2016).

The process of finitude in life stimulates various emotional reactions, involving the professional, the patient and the family, since it requires everyone to analyze their own finitude. Proposing to the nursing staff that their performance is humanized even in the face of so many vulnerabilities, becomes complex due to the fact that many professionals in their academic education were instructed to always prioritize the protection and preservation of life, becoming thus unprepared to deal with death (Evangelista, 2016). Due to the difficulty of nurses to approach spiritual care in care, the lack of preparation and insertion of this practice in the routine of the nursing team, it is crucial to motivate the search on this subject, in order to collaborate with care and add new knowledge about palliative care and spirituality.In this sense, it was noticed that the limited number of literatures about spirituality and the participants' lack of knowledge about spiritual care were the main factors that limited the research.

Conclusion

Through the study it was possible to reach the proposed objective of apprehending the nurses' perception about spiritual assistance in palliative care. It was also possible to analyze the perspective of nurses on the meaning and importance of spiritual assistance in palliative care through a comprehensive approach, which is essential to develop

practices that in addition to favoring faith and spirituality, perseverance and expectations about the end of life, glimpses the various aspects of human existence. The biggest challenge for the research participants was to visualize how the spiritual dimensions should have greater relevance in the daily life of the caregiver. Sometimes, what made spiritual assistance difficult was the lack of knowledge about concepts such as religiosity and spirituality, the demand for exhaustive work routine, a care centered on the physical-biological aspects and with that the lack of time for spiritual approach, lack emotional support to the team and even a fragmented professional formation that contributed little to the insertion of this practice in palliative care. Throughout the development of the study, it was possible to show that family support, listening moments and activities that motivate inner peace are significant for nurses. However, dealing with the patient's spirituality in palliative care reveals aspects that go beyond assisted gaze, currently focused mainly on pain relief and promotion of comfort. Given this, it is essential that the entire care team look at the patient holistically, treating the human being in their biopsychosocial and spiritual dimension. Thus, a new research proposal on this topic could involve the understanding of other professionals of the multidisciplinary team, besides covering other hospital sectors involved in the process to add and optimize spiritual care in all dimensions of care and identify coping strategies. in other contexts.

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