Original article

Religiosity and spirituality of udergraduate nursing students

Religiosidade e espiritualidade dos discentes da graduação de enfermagem

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ABSTRACT | OBJECTIVE: To understand how nursing students perceive and manage the dimension of religiosity and spirituality (R/S) in the academic context. **METHOD:** an exploratory-descriptive study carried out with 21 nursing students from a private educational institution. Data was collected in 2024 and 2025 through semi-structured interviews. The analysis was based on Bardin's Content Analysis. **RESULTS:** Nursing students recognize the importance of R/S as a fundamental dimension for comprehensive care, especially in welcoming and alleviating suffering. Four categories emerged: 1. a subjective and personal belief; 2. the plurality of the sacred as support for personal and academic life; 3. spiritual care and respect for autonomy, and 4. gaps in academic training. **CONCLUSION:** Plurality was observed in the experiences of the sacred, with religiosity associated with faith and institutional rituals, and spirituality with subjective experiences focused on self-care. There are gaps in academic training and insecurity in the management of R/S, with the approach generally being superficial or avoidant. This stance reflects the persistence of the biomedical paradigm, which still neglects the subjectivity of the being.

KEYWORDS: Nursing Students. Spirituality. Religion.

RESUMO | OBJETIVO: Compreender como os estudantes de enfermagem percebem e manejam a dimensão religiosidade e espiritualidade (R/E) no contexto acadêmico. **MÉTODO:** estudo exploratório-descritivo realizado com 21 estudantes de enfermagem de uma instituição de ensino superior de caráter privado. Os dados foram coletados em 2024 e 2025, por meio de entrevista semiestruturada. A análise foi feita com base na Análise de Conteúdo de Bardin. **RESULTADOS:** Os estudantes de enfermagem reconhecem a importância da R/E como dimensões fundamentais para o cuidado integral, especialmente no acolhimento e alívio do sofrimento. Emergiram quatro categorias: 1. uma crença subjetiva e pessoal; 2. a pluralidade do sagrado como suporte para a vida pessoal e acadêmica; 3. cuidado espiritual e respeito à autonomia e 4. lacunas na formação acadêmica. **CONCLUSÃO:** Observou-se pluralidade nas vivências do sagrado, sendo a religiosidade associada à fé e rituais institucionais, e a espiritualidade com experiências subjetivas voltadas ao autocuidado. Existem lacunas na formação acadêmica e insegurança no manejo da R/E, sendo a abordagem, em geral, superficial ou evitativa. Tal postura reflete a persistência do paradigma biomédico, que ainda negligencia a subjetividade do ser.

PALAVRAS-CHAVE: Estudantes de Enfermagem. Espiritualidade. Religião.

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1. Introduction

Spirituality is inseparable from the human being and plays a fundamental role in coping with adverse situations and sufferings[1]. It represents an individual experience, in the search for the meaning of life through concepts that have connection with something greater than ourselves, which may or may not include a formal religious participation[2]. Establishes an intimate connection with the purpose of life, and its relationship with the world and transcendental[3]. Religiosity is related to community, with a set of beliefs and ideals of a social group, usually linked to religious rituals related to a particular creed[3,4].

The relationship of Religiosity/Spirituality (R/S) with care dates back to ancient times, when diseases were seen as a punishment coming from heaven and religious figures as protagonists with religious rituals in the search for healing. In the Middle Ages, the clergy, a class with scientific knowledge, were the providers of care. From the enlightenment there is a segregation of religion and science, subsidizing modern medicine and with it the biomedical model. The disease becomes the center of the process and relegating to the patient a secondary role[4].

In contrast, there is the biopsychosocial model (1977), proposing a care that considers the socio-cultural and spiritual dimensions[5]. For Jean Watson (1970), in the Human Care Theory, the integral approach of the individual will result in significant improvement, both in as for their results. Empathy becomes the basis of nursing actions by placing the human being as part of the sacred and integral to the divine[1]. She defends that the nurse knows how the patient faces their issues of health, life and death[6], for understanding that they are in moments of hopelessness, in the uncertainty of the future, that patients tend to feel discouraged and demotivated[7]. Thus, it is in the understanding that disease and death are inherent in human experience, that existential and spiritual anguish is revealed, and if care is in this perspective, they may find in the appreciation of life, in personal achievements and religious or spiritual faith a way to deal with suffering[7].

In this sense, R/S has been increasingly discussed in academia, which can be exemplified by a data search on the Virtual Health Library Portal, held in June 2025, using the search strategies 1 — "spirituality" AND "nursing" and 2 — "religiosity" AND "nursing" 2,283 works were located in the last 10 years. This finding suggests that scientific discussions focused on care and the spiritual and religious dimension are growing and can influence the formation of a theoretical-philosophical basis for professional exercise. Therefore, this study aims to understand how nursing students perceive and manage the dimension of religiosity and spirituality in the academic context.

2. Method

Exploratory-descriptive study of a qualitative nature. Exploratory descriptive research aims to approach the researcher of the subject, raising hypotheses and variables[8]. The qualitative approach allows the presentation of subjectivities and individuality allowing a greater theoretical and philosophical deepening[9].

The research was conducted with 21 nursing students from a private higher education institution. The inclusion criteria were: being regularly enrolled and attending the fourth (4th) — when there is an insertion of the academic in the field of assistance practice — to the ninth (9th) semester. These semesters were chosen because it is understood that the theoretical-practical experience will reveal how the R/S dimension can be perceived and managed during its academic trajectory. Minors under 18 years of age were excluded, those dismissed due to a medical certificate or legal absence, those who did not attend courses during the data collection period and those who gave up their participation or refused to record the interview. Saturation was the defining criterion of the sample[10].

The data collection instrument consisted of a characterization sheet for sociodemographic data (age, race-ethnicity, semester and religious belief)

and a semi-structured interview script with guiding questions. Participants were invited by message application, scheduled from convenience and preference, preserving comfort and flexibility. The data collection took place by telepresence through the platform Google Meet. The interviews were recorded through audio/video and transcribed in full. The confidentiality and anonymity of the participants were ensured, and their names were replaced by the letter "I" (Interviewee), followed by a sequential numbering of the interviews.

For data analysis, Bardin's Content Analysis was used and followed the phases: pre-analysis, exploration of the material and treatment of the results. The collection of material, carried out through non-directive interviews and that followed the rules of completeness, representativeness, homogeneity, relevance and exclusivity. At first, the floating reading of the collected content was made and in sequence hypotheses were formulated. In the second phase we have the corpus, which was analyzed further and succeeded by categorization by theme. In the third and last phase, data interpretation was done[11].

The project was previously approved by the Ethics Committee under CAAE 82354324.0.0000.5544.

3. Results

3.1 Characterization of participants

Of the 21 participants in the study, 20 were female. The age range was between 21 and 30 years. Regarding the ethnic-racial self-declaration approximately 48% (n=10) declare themselves as brown, 28% (n=6) white and 24% (n=5) black. They had representatives for the fourth, fifth, sixth and ninth semester with two representatives each, nine students of the seventh and four students of the eighth semester. As for religious belief, predominance of Evangelical participants (n=6), followed by Catholics (n=4), Spiritists (n=2), *Candomblecistas* (n=2), one participant associates simultaneously two religions (Catholic/Spiritists), two agnostic participants and four have no religion (Table 1).

Table 1. General data of interviewees. Salvador, Brazil, 2024 (to be continued)

Identification	Age	Color	Semester	Religious belief
I1	22	White	9th	Agnostic
I2	30	Black	9th	Candomblecista
I3	21	White	7th	Evangelical
I4	24	Brown	7th	Evangelical
I5	21	Brown	6th	Spiritist
I6	21	Brown	4th	Catholic
I7	22	Brown	6th	Evangelical
I8	22	Brown	7th	Agnostic
I9	21	Brown	7th	Evangelical
I10	21	Brown	7th	Catholic
I11	23	Black	7th	Evangelical
I12	20	White	5th	Does not have
I13	21	Brown	7th	Spiritist
I14	26	Brown	8th	Candomblecista

Table 1. General data of interviewees. Salvador, Brazil, 2024 (conclusion)

Identification	Age	Color	Semester	Religious belief
I15	23	Black	7th	Does not have
I16	23	Black	4th	Does not have
I17	22	White	5th	Does not have
I18	21	Black	7th	Catholic
I19	23	Brown	8th	Evangelical
I20	22	White	8th	Catholic/Spiritist
I21	21	White	8th	Catholic

Source: the authors (2024).

Fifteen reported having had some contact with the R/S theme throughout graduation and highlighted that they were punctual approaches. Only five affirmed that the knowledge acquired adds directly to nursing care, in terms of the construction of the care plan, respect for the patient's decision and encouragement to care for dimensions.

Thus, from the analysis of the speeches, it was possible to reveal how these students perceive the dimension of R/S, in addition to pointing out how the topics are approached in the university context. Therefore, it is understood that to recognize, address and alleviate the suffering of the other following the premises of an integral care is fundamental to understanding the subjectivities involved, know the belief systems, allowing the free expression of thoughts and feelings of the patient, Letting go of judgment. It is essential to cultivate a reciprocal relationship between the person to be cared for and his caregiver, regardless of the temporality of this meeting, provided that it is free from prejudice.

Thus, the results of this study were organized into four thematic categories, namely:

Category 1 – A subjective and personal belief

The constitution of the belief system of these students, within the scope of R/S, is based on individual experiences, which often converge to the conception of a Supreme Being, whose ontological definition is not linked to specific concepts. Religious dogmas were closely associated with the dimension of religiosity, which is presented with a symbolic framework. The excerpts illustrate the understanding of religiosity:

"A safe haven, a place I can always turn to in my bad times and my good times. Everything we believe in. Whether it's a God or a material possession, everything that can transmit positive energy." (I10)

Already spirituality emerged in a more fluid way, establishing variable — and sometimes nonexistent — relationships with institutionalized religious practices, distancing itself, therefore, from previously established doctrines.

"Spirituality for me is more fluid [...] it's not necessarily associated with religiosity, but with the belief that one can obtain good things through energy." (I2)

"Something more subjective [...] it's something more personal, which doesn't fit within the limits and characterization of what is religious, standardized [...]" (I4)

Nevertheless, the experience of the Sacred manifested itself in a transversal way, intertwined with the nature and perception of a transcendent higher instance, whose representation remains undefined and plural.

"It's a connection to something bigger. [...] it has to do with intuition. With the universe in general." (I13)

"The relationship between human beings and their beliefs, their soul, their spirit, so to speak, about being connected to nature and what you believe in." (I18)

Category 2 – The plurality of the sacred as a support for personal and academic life

Faith, rituals and participation in religious communities give meaning and generate a sense of belonging in the face of adverse situations both academic and personal. For most, religiosity emerges as a promoter of inner balance and motivation, revealing itself as a significant resource in the construction of well-being and emotional stability.

"I read a lot of Spiritist books, and every Wednesday at home we do the Gospel at Home. [...] We say a prayer, read the Gospel [...]. And sometimes I go to the Spiritist center to receive a healing pass." (I5)

"I attend Umbanda houses. [...] I go to services they hold inside the terreiro to worship an Orisha [...] I attach myself to a guardian angel, to God, and I say my prayers." (I14)

However, for others, it tends to limit their worldview, making them susceptible to the ideology prevalent in the religious context. The speeches reveal a negative and critical perception that in certain contexts restricts the autonomy and critical thinking of the individual as in the example:

"It's made to shape a person [...] it's to put the person inside a bubble [...] and make them submissive. Whether inside a terreiro or inside a church." (I16)

Spirituality emerged as a source of self-care, emotional resilience and inner connection, allowing a valorization of spiritual autonomy. There was a tendency to experience the sacred outside of institutional forms.

"I do it within myself, in my room, in my quiet, in my spirituality. [...] any moment that I feel good about myself, in fullness, that's how I try to practice and cultivate spirituality." (I3)

"Having faith, talking to God, connecting with myself and my faith." (I9)

Category 3 – Spiritual care and respect for autonomy

Different professional postures and levels of integration between understanding and care management to the R/S dimension were identified. A small portion of the students offered care to R/S through more active attitudes directed to the stimulation of belief. Respect for religious diversity, patient autonomy and the role of the professional in spiritual care were preserved. The cutouts illustrate the care offer:

"Encouragement to strengthen their religious beliefs [...] brings security, benefits... can lead to good things." (I2)

"Listening to their beliefs, their fears, respecting, which is the main thing, their religious practices, regardless of their religion, and always offering them words of comfort, based on their faith and beliefs." (I21)

It was still possible to perceive a subtle, albeit symbolic way of integrating the R/S of the patient without directly accessing religious conceptions.

"I always try to distance myself [...] it's a topic where we walk a fine line... I always hope the patient will open up to me. [...] when we talk about psychological health and providing psychological support, I realize there's a religious and spiritual bias. I usually say: 'God bless you', 'may everything work out', 'with faith in God you've already been cured'." (I19)

Although some students offered the care this was not the reality of most. The students reported behaviors of avoidance in front of the theme, reflecting tensions between knowledge and know-how.

"If the patient didn't comment, I wouldn't talk. I think it's very complex; everyone has their own religion, everyone has their own moment." (I16)

Category 4 – Gaps in academic training

The students pointed out the need for a biopsychosocial and spiritual approach as a tool of the care process and to understand it as a crucial means for building the professional/ student/patient bond. They also revealed a theoretical-practical deficiency in recognizing that there are no specific discussions and, therefore, they exposed the possibility that there were moments for debates and/or the creation of a specific component on the theme.

> *"It would be interesting to include more components [...] we're not prepared [...] it would be nice to have something more specific, some component." (I5)*

> *"Knowing how to recognize these two dimensions that require as much attention as any type of pathology, disease, or condition the patient may be experiencing." (I18)*

4. Discussion

Comenius points out the need to restructure how we deal with human care, unifying education and medicine from a holistic perspective[12]. By recognizing the totality of being and its multidimensions, it is possible to offer a more complete and humanized understanding meeting their needs and alleviating their sufferings[13]. In this context that the R/S dimension integrates as a key tool to alleviate suffering by providing subsidies for resilience, allowing the beliefs and subjectivities of the subject[14]. Crucial point perceived by academics, although they pointed out limitations to this management.

Christianity was predominant in the study group, highlighting the majority Evangelical faith for this group, which may be in line with significant growth of constructions of evangelical churches[15], although Brazil is still considered a country with Catholic predominance. The plurality of the sacred permeated the figure of a God, a supreme Being or a Divinity, and corroborates with Fuertes and Dugan by demonstrating that this "Being" is an important element for the maintenance of emotional and psychological equilibrium[16]. A strong link with faith, the figure of a God, with the insertion of the individual in religious environments and their participation in religious rituals as central elements[4].

Some criticisms of how religiosity can be experienced were expressed, pointing to the restrictions on autonomy and critical thinking. For this, it is necessary to understand how religious conceptions act as mechanisms of social control, historically influencing behaviors, values and social, political and economic organization. Religious norms, as instances of control, transmit patterns and expectations that shape the behavior of individuals[17].

Spirituality was marked by subjectivity and fluidity experienced with religion, although it does not need to be anchored to exist. It arises from the connection with the inner self and the environment and can be enhanced by the feeling of connection to God without direct dependence. In Silva et al.'s findings there was an almost inseparable relationship between spirituality and God, imputing conceptual limitations that could be derived from restricted discussions in the academic environment[18].

Regarding the management of the R/S dimension in the context of nursing care, the interviewees stated that they use the incentive to religious practices as their main resource, besides offering comfort words related to religiosity and an active listening on beliefs, fears and fears, which allowed the strengthening of trust, emerging feelings of hope and comfort[19,20]. There were those who had limitations in the approach, although they affirm the importance of discussing, corroborating with Nogueira et al.'s study[21]. This mismatch suggests the need for a more robust and integrated approach to these topics in the curriculum[22].

It is possible that there is an influence of the biomedical paradigm, which favors objective,

measurable and materialistic approaches, to the detriment of subjective and existential aspects of human experience[23]. What contributes to a direct interference in the construction of the look at the other, since it restricts the integral understanding of being and is justified by the fragility in the development of skills that can generate a sense of insecurity among students[24].

However, there is a search movement to integrate the theme into academic discussions, since its importance is recognized by health students themselves[25], making necessary discussions for adaptation of curricular components. This study presents as a limitation the sample composed of academics from a private institution, which may not reflect perceptions and practices of other nursing students from other institutions. We suggest intervention studies and investigate this reality in other educational units.

5. Conclusion

The nursing students recognize the importance of religiosity and spirituality (R/S) in the integrality of care, perceiving them as crucial dimensions for the reception, listening and relief of suffering. Religiosity was understood as a symbolic construction, rooted in faith in a Supreme Being and in the practices of institutional rituals. Already spirituality emerged freer and more associated with self-care and the search for meaning. There is a plurality of the sacred revealed complexity and multiple perceptions.

The study points out gaps in the process of academic training from the lack of knowledge of the subject as part of care and the realization of superficial approaches. It is suggested that it is a consequence of insecurity and lack of knowledge for management. Although there are initiatives for inclusion in the process of care, most resort to avoidance or sometimes hoping that the patient leads the dialogue. This posture suggests the absence or generalist discussions as well as may portray the influence of the biomedical paradigm, which has persisted and tends to neglect the subjectivities of the Being.

Authors' contributions

The authors declared that they have made substantial contributions to the work in terms of conception or design of the research; acquisition, analysis, or interpretation of data for the work; and drafting or critically revising it for relevant intellectual content. All authors approved the final version to be published and agree to take public responsibility for all aspects of the study.

Competing interests

No financial, legal, or political conflicts involving third parties (government, private companies and foundations, etc.) have been declared for any aspect of the submitted work (including but not limited to grants and funding, advisory board membership, study design, manuscript preparation, statistical analysis, etc.).

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