



## Religious coping and hope in chronic kidney disease: a randomized controlled trial\*

Enfrentamento do *coping* religioso e esperança na doença renal crônica:  
estudo controlado randomizado

Estrategias de afrontamiento religioso y de esperanza en la enfermedad renal crónica:  
estudio controlado randomizado

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-  Suzana Mara Cordeiro Eloia<sup>1</sup>
-  Maria Aline Moreira Ximenes<sup>1</sup>
-  Sara Cordeiro Eloia<sup>1</sup>
-  Nelson Miguel Galindo Neto<sup>2</sup>
-  Lívia Moreira Barros<sup>3</sup>
-  Joselany Áfio Caetano<sup>1</sup>

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<sup>1</sup> Universidade Federal do Ceará, Programa de Pós-Graduação em Enfermagem, Fortaleza, CE, Brazil.

<sup>2</sup> Instituto Federal de Educação, Ciência e Tecnologia de Pernambuco, Departamento de Enfermagem, Pesqueira, PE, Brazil.

<sup>3</sup> Universidade da Integração Internacional da Lusofonia Afro-Brasileira, Departamento de Enfermagem, Redenção, CE, Brazil.

### ABSTRACT

**Objective:** To evaluate the effect of prayer on religious/spiritual coping and on the hope of patients with chronic kidney disease undergoing hemodialysis. **Method:** Randomized, controlled and blinded clinical trial, carried out in a dialysis unit, with a total of 62 patients undergoing hemodialysis – 31 participants in intervention group and 31 in the control group. Intercession prayer was applied three times, in alternate weeks, during hemodialysis sessions. Differences between groups in the outcome of the effect of prayer on religious/spiritual coping and hope were analyzed. **Results:** Participants used positive coping at high mean scores in both groups (control – 3.62 and intervention – 3.26) and negative coping had little use (control – 1.66 and intervention – 1.47). The use of total coping was between 2.35 and 2.48 in the intervention group ( $p = 0.015$ ). Hope variables were better in the intervention group: optimism ( $p = 0.001$ ), short- and long-term plans ( $p = 0.004$ ), remembering happy moments ( $p = 0.039$ ) and valuing life ( $p = 0.050$ ). **Conclusion:** The use of prayer promotes an increase in religious/spiritual coping and hope. Brazilian Registry of Clinical Trials: RBR-4pphkf.

### DESCRIPTORS

Renal Insufficiency; Renal Dialysis; Spirituality; Nephrology Nursing.

### Corresponding author:

Maria Aline Moreira Ximenes  
Alexandre Baraúna Street, 1115, Rodolfo Teófilo  
60430-160 – Fortaleza, CE, Brazil  
[aline.ximenes11@hotmail.com](mailto:aline.ximenes11@hotmail.com)

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## INTRODUCTION

Chronic Kidney Disease (CKD) is considered an important health problem, which incidence has been on the rise in recent years. In Brazil, in 2017, the total number of patients with CKD was estimated at 126583, which represents an increase of 3% of cases, compared to the previous year<sup>(1)</sup>.

The progressive and irreversible kidney injury in its most advanced stage requires substitute treatment and, currently, hemodialysis is the most used one. However, this process can become a difficult experience for the patient due to the numerous changes in habits, the recommended restrictions and the dependence on clinical monitoring<sup>(2)</sup>. Given these conditions, individuals are more susceptible to isolation, anxiety and depression, which can negatively influence treatment<sup>(3)</sup>.

It is important to consider that the health professional must be sensitive to this problem, knowing how to identify which coping strategies the patient has and which can be stimulated. Studies report that spirituality and religious involvement are mechanisms used by people with CKD to improve happiness, well-being and quality of life, in addition to being associated with lower rates of depression and suicide<sup>(2,3)</sup>. In this perspective, the practice of religious activities to face stressful situations in life is related to Religious/Spiritual Coping (RSC). When using religious resources for this purpose, the patient has religious coping.

RSC is defined as the way in which individuals use faith to deal with stressful problems and situations, as well as to prevent or alleviate the negative emotional consequences of these circumstances<sup>(4)</sup>. Some definitions of religious coping do not specifically address spirituality. However, this experience is configured as an important coping mechanism<sup>(5)</sup>, as it can serve as therapeutic support and as an important element in caring for the person. Prayer is one of the experiences capable of providing improvement in the RSC of patients with CKD. A clinical study pointed out that this spiritual activity is efficient to improve hope, reduce anxiety and vital parameters during hemodialysis treatment<sup>(6)</sup>.

Therefore, by understanding how spirituality influences the lives of patients on hemodialysis, professionals can support therapeutic interventions in order to provide quality of life, despite CKD and treatment. However, the evidence on the benefits of these practices in patients with the aforementioned profile is still limited.

In this context, this study aimed to assess the effect of prayer on religious/spiritual coping and on the hope of patients with CKD undergoing hemodialysis.

## METHOD

### DESIGN OF STUDY

This is an experimental study, single-blinded Randomized Controlled Trial (RCT). The prayer was considered a health intervention and was applied to the Intervention Group (IG) during the hemodialysis sessions, during a five-week follow-up. Its effect was compared with the Control

Group (CG), which received routine care offered by the institution's professionals.

### POPULATION

Participants were recruited from September to December 2018 in the Dialysis Unit of a public hospital in Northeastern Brazil. The study population was represented by 245 chronic renal patients undergoing hemodialysis at the aforementioned institution during the data collection period. For the sample, those who met the following criteria were included: being over 18 years old; literate; clinically stable; oriented about time and with minimum score required in the Mini Mental State Examination (MMSE), according to their level of education<sup>(7)</sup>. Patients with deafness were excluded, a condition that would make it impossible to listen to the prayer with the aid of earphones, with speech limitations and use of anxiolytics, within 24 hours, before the intervention.

### SAMPLE DEFINITION

The sample was estimated according to the formula for clinical trial studies with continuous outcome<sup>(8)</sup>. Therefore, 31 chronic renal patients were allocated to the IG and 31 patients to the CG, which totaled a sample of 62 individuals, considering the possible occurrence of losses. The same number of participants in both groups aimed to contribute to the performance paired-wise data analysis.

Randomization by cluster occurred, in which the participants were not allocated individually, but in groups, being distributed in the CG (with hemodialysis scheduled on Monday, Wednesday and Friday) and IG (submitted to hemodialysis on Tuesdays, Thursdays and Saturdays). Thus, there was randomization of the two groups of patients, which made it possible to reduce meetings between them and possible contamination of the sample. For allocation, it was pre-defined that the number 1 would be assigned to the GC and the number 2 to the IG. Subsequently, on the website randomizer.org, the generation of a random sequence of numbers 1 and 2 was carried out.

In a visit to the study scenario, which preceded the data collection, the service coordination and the daily nurse recommended that the best time for the first contact with the participants would be in the early morning, as the service routine led the environment to have more distractors over the hours, which could result in impaired participants' attention to the content presented and impair their adherence to the research. For this reason, the selection of participants considered the chronological order of hemodialysis: the participants who were part of the CG were the first 31 who, within the selection criteria, arrived to perform hemodialysis, on the first Monday of data collection; likewise, the participants who made up the IG were the first 31 who, within the selection criteria, underwent hemodialysis on the first Tuesday of data collection.

In the methodological path used, the researcher (who applied the prayer) recognized the allocation of patients

in the CG and IG. However, blinding occurred with the participants and the research statistician.

## DATA COLLECTION

The intervention applied in this study was the intercession prayer. Elaborated from Psalm 139, the prayer constitutes Christian prayer, with no connection to any specific religious belief, invocation of saints or sanctities.

The prayer was recorded in audio in the voice of a musician with good diction and evaluated by a speech therapist. With a duration of six minutes and one second, the prayer melody was recorded using the sound of a guitar. The audio was saved on cell phones, which remained in airplane mode during the intervention. Listening occurred through earphones, made available to the patient along with bring disposable, to ensure individual protection.

The prayer was applied three times with the patients, in alternate weeks, during the hemodialysis sessions. Thus, each patient was followed for five weeks.

Before starting the intervention, the patient was invited to position himself comfortably, sitting or lying down, with their eyes closed, in order to promote a moment of personal concentration. The number of applications of the prayer and the time accompanied by each patient was determined based on the research by Brasileiro et al. (2017)<sup>(6)</sup>, who evaluated the effect of prayer on vital parameters, verifying significant results in the reduction of values. The primary outcome was measured using the Brief Religious-Spiritual Coping scale (RSC-brief)<sup>(4)</sup> and the secondary outcome was measured using the Herth Hope scale (HHS)<sup>(9)</sup>.

The steps of data collection were similar for the control and intervention groups, differing only in the application of prayer for the IG and the routine care of the institution for the CG. In the pre-intervention moment (M0), the profile of the participants was identified through questionnaires, which included sociodemographic, clinical and spiritual characterization. Subsequently, the RSC-brief and HHS scales were applied. In the third week (M1), only the HHS scale was used, and in the fifth week (M2), the RSC-brief and HHS scales were used.

Both measuring scales used were Likert. The parameters used to analyze the values of the RSC-brief averages are as follows: none or negligible (1.00 to 1.50), low (1.51 to 2.50), average (2.51 to 3.50), high (3.51 to 4.50) and very high (4.51 to 5.00) (4). The HHS scale ranges from 12 to 48, in which the higher the score, the higher the level of hope<sup>(9)</sup>.

The individuals in the CG received the same approach as in the first stage, consisting of the application of all instruments at moment zero (M0), however, they did not receive the intervention. They just followed the routine care of the hospital and, after the same time as the one used to assess the IG, the results of the RSC-brief and the HHS were measured.

## DATA ANALYSIS

The data of the sociodemographic, clinical and spiritual characteristics, as well as the data referring to the

religious/spiritual Coping and HHS scales, were organized in an electronic spreadsheet using the Microsoft Office Excel 2013 software. Then, the IBM SPSS Statistics software was used, version 25, for statistical analysis between individuals in the same group and between CG and IG. The data were organized in charts with absolute and percentage frequencies.

The level of significance adopted was 5% and the 95% confidence interval was. To assess the normality of continuous data and define the choice of the parametric or nonparametric test, the Shapiro-Wilk test was used. The results showed rejection of the null hypothesis, indicating that the data had a non-normal distribution.

Pearson's chi-square test was used to verify the differences between proportions and between categorical variables<sup>(10)</sup>. For the comparison between the IG and the CG, the Mann-Whitney test was used for two independent samples. The Friedman test was used to compare intragroup data at the three moments of data collection.

## ETHICAL ASPECTS

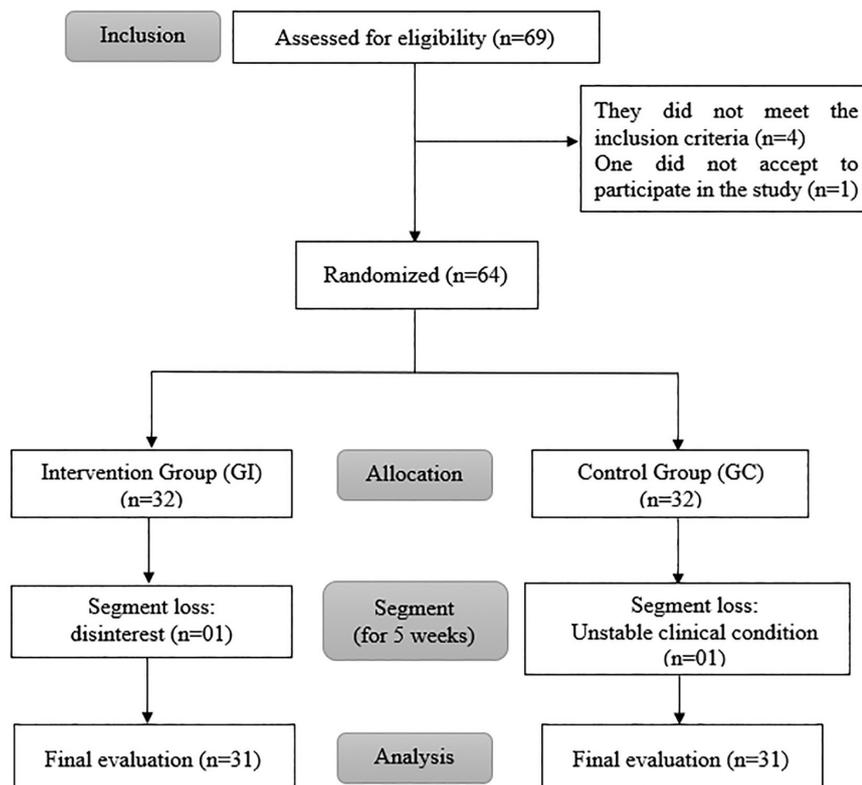
The study was approved by the Research Ethics Committee of the State University of Vale do Acaraú, protocol 2890991, in 2018, following the precepts of Resolution CNS 466/12, of the National Health Council, on research with human beings. After approval, it was registered on the Brazilian Clinical Trials Registry platform, under number RBR-4pphkf. All participants signed the Informed Consent Form.

## RESULTS

A total of 64 patients were randomly assigned: 32 in the IG and 32 in the CG. There was a loss of follow-up due to clinical instability and lack of interest in participating in the research. Thus, we had a total of 62 patients, allocated to both groups. To clarify the randomization and allocation of participants in the groups, a flowchart adapted from the CONSORT protocol<sup>(11)</sup>, was constructed, as described in Figure 1.

Most were men, with a frequency of 67.7% (21) in the CG and 61.3% (19) in the IG. The average age of participants in the CG was 45.8 ( $\pm 15.1$ ) years old, while in the IG it was 47.3 ( $\pm 17.1$ ). As for the years of study, the average in the CG was 8.6 ( $\pm 4.2$ ) years, and in the IG the average corresponded to 8.8 ( $\pm 4.8$ ) years.

Most of these patients reported living with a partner: 74.2% (23) in the CG and 54.8% (17) in the IG. With regard to place where they came from, most patients lived in cities surrounding Sobral: 83.9% (26) in the IG and 77.4% (24) in the CG. When assessing the occupational situation, 51.6% (16) of patients in both groups received the benefit of the sickness aid. The predominant family income in both groups was a minimum wage, with 45.2% (14) in the CG and 64.5% (20) in the IG. Based on the characteristics of the participants, it was possible to verify the homogeneity of the CG and GI groups, making it possible to make comparisons.



**Figure 1** – CONSORT flowchart for research development.

The sample distribution of participants in the CG and IG according to each item of the HHS is shown in Table 1.

These results correspond to the first pre-intervention moment (M0). It is possible to observe that both groups are homogeneous in M0 regarding hope, since the averages of all questions on the scale are similar.

Table 2 shows the description and comparison of the groups during the three post-intervention moments (M0, M1, M2), according to the HHS.

Regarding the items evaluated by the HHS in the three moments, it was observed, in Table 2, that both groups showed improvement in the average of the scores in the

**Table 1** – Comparison of the means and standard deviation of the answers in each EEH statement in the first moment (M0) – Sobral, CE, Brazil, 2019.

Variables	M0				p <sup>†</sup>
	Control		Intervention		
	Mean	SD	Mean	SD	
1. I'm optimistic about life	3.65	0.755	3.68	0.541	0.706
2. I have short- and long-term plans	3.48	0.890	3.26	1.064	0.391
3. I feel very alone	3.45	0.810	3.52	0.926	0.522
4. I can see possibilities where there are difficulties	3.39	0.919	3.61	0.667	0.362
5. My faith comforts me	3.90	0.301	3.97	0.180	0.305
6. I'm afraid of my future	3.52	0.811	3.29	1.101	0.652
7. I can remember happy and pleasant times	3.71	0.461	3.71	0.783	0.305
8. I feel very strong	3.55	0.675	3.77	0.425	0.155
9. I feel capable of giving and receiving affection/love	3.87	0.341	3.87	0.341	1.000
10. I know where I want to go	3.65	0.709	3.81	0.477	0.340
11. I believe in the value of each day	3.87	0.341	3.90	0.301	0.691
12. I feel that my life has value and usefulness	3.94	0.250	3.84	0.374	0.232

<sup>†</sup>Mann Whitney test.

**Table 2** – Comparison of answers in each EEH statement in the first, second and third moments (M0, M1, M2) – Sobral, CE, Brazil, 2019.

Variables	Control			p <sup>†</sup>	Intervention			p <sup>†</sup>
	M0	M1	M2		M0	M1	M2	
1. I'm optimistic about life	3.74	3.71	3.87	0.097	3.71	3.74	3.97	0.001
2. I have short- and long-term plans	3.42	3.42	3.61	0.027	3.35	3.48	3.74	0.004
3. I feel very alone	3.65	3.65	3.74	0.717	3.42	3.58	3.74	0.178
4. I can see possibilities where there are difficulties	3.32	3.32	3.68	0.011	3.55	3.71	3.74	0.273
5. My faith comforts me	3.94	3.94	4.00	0.368	3.94	3.90	4.00	0.097
6. I'm afraid of my future	3.58	3.58	3.87	0.103	3.23	3.45	3.42	0.310
7. I can remember happy and pleasant times	3.68	3.71	3.90	0.030	3.71	3.87	3.90	0.039
8. I feel very strong	3.39	3.65	3.77	0.009	3.77	3.71	3.90	0.135
9. I feel capable of giving and receiving affection/love	3.94	3.97	3.97	0.779	3.87	3.94	3.97	0.097
10. I know where I want to go	3.87	3.84	3.84	0.882	3.84	3.90	3.97	0.091
11. I believe in the value of each day	3.87	3.97	3.97	0.050	3.87	3.94	4.00	0.050
12. I feel that my life has value and usefulness	3.87	3.94	3.94	0.368	3.87	3.94	4.00	0.050
<b>Total Herth Scale Score</b>	<b>44.26</b>	<b>44.68</b>	<b>46.16</b>	<b>0.001</b>	<b>44.13</b>	<b>45.16</b>	<b>46.35</b>	<b>0.000</b>

<sup>†</sup>Friedman test.

**Table 3** – Intra and intergroup comparison (CG and IG) of medians of religious/spiritual coping in the two moments (M0 and M2) – Sobral, CE, Brazil, 2019.

Religious/Spiritual Coping	M0		p <sup>†</sup>	M2		p <sup>†</sup>	M2-M0*	
	CG	IG		CG	IG		CG	IG
Total RSC	2.57	2.35	0.418	2.64	2.48	0.116	0.001	0.015
Positive RSC (PRSC)	3.17	2.94	0.294	3.62	3.26	0.105	0.000	0.000
Negative RSC (NRSC)	1.70	1.63	0.668	1.66	1.47	0.451	0.269	0.258
NRSC/PRSC ratio	0.54	0.575	0.569	0.48	0.500	0.773	0.000	0.000

<sup>†</sup>Mann Whitney test; \*Wilcoxon test.

items “I have short- and long-term plans”, “I can remember happy pleasant times” and “I believe in the value of each day”.

The CG presented statistical significance in the items “I can see possibilities where there are difficulties” ( $p = 0.011$ ) and “I feel very strong” ( $p = 0.009$ ). The IG had a significant increase in “I am optimistic about life” ( $p = 0.001$ ) and “I feel that my life has value and usefulness” ( $p = 0.050$ ). The level of hope of patients in the CG averaged 44.26 scores at M0, with M2 at 46.16 ( $p = 0.001$ ). The IG also had an improvement in the level of hope, where the average went from 44.13 to 46.35 points ( $p = 0.000$ ).

The medians of the total RSC values improved significantly in both the CG and the IG, as can be seen in Table 3. The average of the NRSC/PRSC ratio of the CG was 0.540 to 0.048 ( $p = 0.000$ ). In the IG, the average varied from 0.575 to 0.500 ( $p = 0.000$ ).

In Table 4, when comparing the M2 x M0 moments, it is possible to identify a significant improvement in the behavior of the participants of the CG and IG regarding the use of negative strategies, such as having a negative reevaluation of God (N1) and presenting dissatisfaction with the other institutional (N4).

## DISCUSSION

In this study, the use of prayer was an important strategy for strengthening the RSC among the participants. Thus, when providing health care considering the individual's spirituality, it is possible to encourage the overcoming of the difficulties and sufferings imposed by CKD<sup>(12)</sup>.

Regarding the levels of hope through the HHS, it was found that, in the pre-intervention moment, the groups were homogeneous and, after the use of the prayer, there was a significant improvement in both groups. In the IG, the variables related to optimism-, short- and long-term plans, remembering happy moments and valuing life showed better scores.

Corroborating these findings, a study carried out in Portugal with caregivers of people in palliative care found that the highest levels of hope are related to remembering happy and pleasant times, with an average of 3.57, and having short and long-term goals, with an average of 3.33<sup>(13)</sup>. In Brazil, a study carried out in Espírito Santo, which sought to assess the anxiety levels of older adults, identified averages similar to the results of this study in the variables optimism

**Table 4** – Intra and intergroup comparison (CG and IG) of negative and positive factors of religious/spiritual coping in the two moments (M0 and M2) evaluated – Sobral, CE, Brazil, 2019.

RSC variables	M0		p <sup>†</sup>	M2		p <sup>†</sup>	M2-M0*	
	CG	IG		CG	IG		CG	IG
<b>Negative factors</b>								
N1 – Negative reevaluation of God	1.00	1.00	0.654	1.00	1.00	0.535	0.025	0.007
N2 – Negative positioning towards God	2.33	2.66	0.404	2.33	2.66	0.196	0.360	0.507
N3 – Negative reevaluation of meaning	2.33	1.33	0.114	2.00	1.00	0.016	0.564	0.151
N4 – Dissatisfaction with the other institutional	1.00	1.00	0.357	1.00	1.00	0.298	0.076	0.008
<b>Positive factors</b>								
P1 – Transformation of you and/or your life	3.55	3.22	0.126	4.00	3.55	0.030	0.000	0.000
P2 – Actions in search of spiritual help	2.20	2.20	0.471	3.00	2.40	0.363	0.000	0.000
P3 – Offering help to people	3.40	3.20	0.067	4.00	3.60	0.046	0.016	0.010
P4 – Positive positioning towards God	3.00	3.20	0.897	3.40	3.40	0.803	0.103	0.031
P5 – Actions in search of the other institutional	3.25	3.25	0.428	3.75	3.50	0.566	0.014	0.008
P6 – Personal search for spiritual knowledge	2.33	2.33	0.788	3.00	2.33	0.179	0.000	0.109
P7 – Getting away from God, religion and/or spirituality	4.00	4.33	0.604	4.66	4.33	0.726	0.010	0.078

<sup>†</sup>Mann Whitney test; \*Wilcoxon test.

about life (3.06), memories of happy moments (3.01) and feelings of appreciation of life (3.05)<sup>(14)</sup>.

The total scores, represented by 44 to 46 points, were shown to be high after the intervention with the use of prayer. These results are similar to the findings of the study carried out in Pernambuco with patients undergoing chemotherapy, which identified scores between 34 and 48<sup>(12)</sup>.

Interventions to strengthen the patients' spirituality benefit physical, social, mental and spiritual aspects. In addition, they provide hope and a feeling of appreciation for life, despite the adverse circumstances imposed by CKD and its treatment<sup>(12)</sup>. It is also worth mentioning that there was an improvement in the hope scores in the CG patients, which may be related to the religious profile and high level of hope of the sample participants.

It is understood that during the treatment of patients with CKD it is necessary for the professional to carry out interventions that stimulate hope and perspectives for the future. The use of prayer is a strategy that can be used in this process to encourage reflection on life, the future and the possibilities of restoring health status<sup>(6)</sup>.

A previous study demonstrated a strong relationship between RSC and the level of hope through HHS. It was found that the group with a high RSC classification had a higher average of hope (44.12 points)<sup>(12)</sup>. Based on this, it can be said that the use of prayer interfered not only in the variables of hope, but also in the evaluation of the RSC, as observed in the findings.

After the intervention through prayer, the participants used PRSC at high average scores in both groups (CG – 3.62 and IG – 3.26), and NRSC had low use (CG – 1.66 and

IG – 1.47). The use of TRSC was between 2.64 in the CG and 2.48 in the IG.

A study carried out in Minas Gerais with 129 cancer patients consolidates the results of this study due to similar scores in the control and intervention groups in M2, represented by PRSC of 3.47, NRSC of 1.71 and TRSC of 2.59<sup>(15)</sup>.

Another study carried out in patients with Human Immunodeficiency Virus (HIV) also showed a predominance of PRSC compared to NRSC (NRSC/PRSC ratio = 0.65 ± 0.46). In addition, respondents consider religiosity and spirituality as something important in coping with the disease<sup>(16)</sup>.

The findings of a survey conducted in Parana found that individuals with religious and spiritual ties had significantly higher averages of PRSC and TRSC than those who said they did not have it. According to the authors, religiosity and spirituality can provide a worldview in which disease, suffering and death have better acceptance and understanding<sup>(17)</sup>.

CG participants also had better RSC scores on M2. This finding can be attributed to the influence of positive factors to the detriment of negative ones, since, in this group, there was a predominance of strategies such as transformations in their life, seeking spiritual help, helping others and personal search for spiritual knowledge, which constitute a positive confrontation to CKD.

In the IG, it is observed that after the use of the prayer there was a statistically significant difference in the PRSC variables related to the transformation of oneself and one's life (p = 0.000), actions in search of spiritual help (p = 0.000), offer of help to others (p = 0.010), positive positioning

towards God ( $p = 0.031$ ) and actions in search of the institutional other ( $p = 0.008$ ).

These positive coping factors are directly related to religious practices, mainly in the reading of sacred books, participation in spiritual rites and the pursuit of social well-being. A study carried out in Jordan with 218 patients on hemodialysis found that individuals also used religious practices as a positive coping mechanism to overcome treatment difficulties<sup>(18)</sup>. A prospective study, even more comprehensive, with 59 000 black women in the United States showed that the degree to which a woman relates to her religion influences the positive coping with stressful situations, supporting the hypothesis that RSC is an attenuator against adverse impacts of stress<sup>(19)</sup>.

The results presented here corroborate another study carried out with 429 patients with HIV, which investigated relations between RSC and viral load, differentiation group count 4 (DC4), quality of life, HIV symptoms, depression and spiritual well-being. PRSC was associated with better positive results, as well as negative RSC with worse results<sup>(20)</sup>.

Negative religious coping reflects an insecure relationship with spirituality and has been consistently associated with mental and physical health problems<sup>(19)</sup>. In this study, NRSC was little used by patients with CKD.

By knowing the importance of religiosity/spirituality for the patient, professional nurses can create mechanisms to strengthen their RSC<sup>(16)</sup>. In this context, prayer can be used as a care strategy, since it can provide improvements to conventional treatment, in addition to serving the person in their spirituality. The application will be able to promote rapprochement and build a bond between professional and patient.

Questioning the patient about their RSC is a strategy that provides coping with the disease and the development of possible improvements that may result from this process<sup>(5)</sup>. It is important that nurses attend the patient in the physical,

social and spiritual aspects. As for the spiritual dimension, based on the results of this study, prayer is an alternative therapy that can be used continuously, free of charges and does not imply a change in the hospital service routine.

This study presented limitations related to the absence of evidence on a standard model for the application of prayer with patients, which limited the theoretical basis for defining the way the patient would be approached and how the prayer would be applied. It should also be noted that, because it was carried out in a public institution, the results found may differ from the private health care network. Another limitation refers to the fact that the data collect occurred with participants who underwent routine hemodialysis. Thus, the findings cannot be generalized to patients on emergency hemodialysis.

## CONCLUSION

The application of the prayer resulted in better averages in the RSC, in addition to high PRSC scores, corresponding to an effective intervention to face the condition imposed by the CKD. Regarding the variables on the Herth scale, it was evident that most patients value their lives, have plans for the future and are optimistic, even though they are periodically submitted to hemodialysis.

Therefore, it appears that the use of prayer during the hemodialysis session promotes an increase in RSC and hope. Thus, it can support nursing interventions that seek to improve the coping of patients with CKD undergoing treatment on hemodialysis. Prayer is a simple activity that does not generate costs and can be easily applied, without causing changes in the hospital routine.

It is also suggested that further studies be carried out in order to assess the relationship between the RSC and the levels of hope at different times of treatment, in order to identify specific factors that may influence these levels. In addition, there is a need to develop future studies that can establish protocols that ensure the use of prayer by nursing.

## RESUMO

**Objetivo:** Avaliar o efeito da prece no *coping* religioso/espiritual e na esperança de pacientes com doença renal crônica em tratamento hemodialítico. **Método:** Ensaio clínico randomizado, controlado e cego, realizado em unidade de diálise, com 62 pacientes em tratamento hemodialítico – 31 formaram grupo intervenção e 31 o grupo controle. Foi aplicada prece de intercessão, três vezes, em semanas alternadas, no decorrer das sessões de hemodiálise. Foram analisadas as diferenças entre os grupos nos desfechos efeito da prece no *coping* religioso/espiritual e esperança. **Resultados:** Os participantes utilizaram *coping* positivo em escores médios altos em ambos os grupos (controle – 3,62 e intervenção – 3,26) e *coping* negativo teve baixo uso (controle – 1,66 e intervenção – 1,47). O uso de *coping* total esteve entre 2,35 e 2,48 no grupo intervenção ( $p = 0,015$ ). As variáveis de esperança foram melhores no grupo intervenção: otimismo ( $p = 0,001$ ), planos a curto e longo prazo ( $p = 0,004$ ), lembrança de momentos felizes ( $p = 0,039$ ) e valorização da vida ( $p = 0,050$ ). **Conclusão:** O uso da prece promove o aumento do *coping* religioso/espiritual e esperança. Registro Brasileiro de Ensaio Clínicos: RBR-4pphkf.

## DESCRITORES

Insuficiência Renal; Diálise Renal; Espiritualidade; Enfermagem em Nefrologia.

## RESUMEN

**Objetivo:** Evaluar el efecto de la oración en el afrontamiento religioso/espiritual y en la esperanza de pacientes con enfermedad renal crónica en tratamiento de hemodiálisis. **Método:** Se trata de un ensayo clínico randomizado, controlado y ciego, realizado en una unidad de diálisis entre 62 pacientes en tratamiento de hemodiálisis, de los cuales 31 formaban parte del grupo intervención y 31, del grupo control. La oración de intercesión se aplicó tres veces, en semanas alternadas, durante el transcurso de las sesiones de hemodiálisis. Las diferencias entre los grupos se analizaron bajo los resultados del efecto de la oración sobre el afrontamiento religioso/espiritual y la esperanza. **Resultados:** Los participantes utilizaron el afrontamiento positivo en puntuaciones medias altas en ambos grupos (control – 3,62 e intervención – 3,26) mientras que el uso del afrontamiento negativo fue bajo (control – 1,66 e intervención – 1,47). El

uso del afrontamiento total osciló entre 2,35 y 2,48 en el grupo intervención ( $p = 0,015$ ). Las variables de esperanza fueron mejores en el grupo intervención: optimismo ( $p = 0,001$ ), planes a corto y largo plazo ( $p = 0,004$ ), remembranza de momentos felices ( $p = 0,039$ ) y valoración de la vida ( $p = 0,050$ ). **Conclusión:** El uso de la oración promueve un mayor afrontamiento religioso/espiritual y de esperanza. Registro Brasileño de Ensayos Clínicos: RBR-4pphkf

## DESCRIPTORES

Insuficiencia Renal; Diálisis Renal; Espiritualidad; Enfermería en Nefrología.

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