Revista Brasileira de Enfermagem
REBEn

Religious/spiritual coping and spiritual distress in people with cancer

Coping religioso/espiritual e a angústia espiritual em pessoas com câncer

El coping religioso/espiritual y la angustia espiritual en individuos con cáncer

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How to cite this article:
Silva GCN, Reis DC, Miranda TPS, Melo RNR, Coutinho MAP, Paschoal GS, et al. Religious/spiritual coping and spiritual distress in people with cancer. Rev Bras Enferm. 2019;72(6):1534-40. doi: http://dx.doi.org/10.1590/0034-7167-2018-0585

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Submission: 08-26-2018 **Approval:** 04-10-2019

ABSTRACT

Objective: To investigate the relation between the presence of spiritual distress and use of RSC and sociodemographic, clinical and religious/spiritual variables in people with cancer. **Method:** Cross-sectional study conducted in an association for support to people with cancer. The data obtained with the tools were analyzed using the Spearman's correlation coefficient and the Mann-Whitney Test. **Results:** 129 volunteers participated in the study, of which 57% showed moderate spiritual distress, 96% used medium and high positive religious/spiritual coping. Spiritual distress showed positive correlation with negative religious/spiritual coping (P<0.001) and inverse correlation with age (p 0.002). The use of positive religious coping was statistically significant in people who have religious practices (p 0.001). **Conclusão:** Spiritual distress is a phenomenon that is present in the lives of people with cancer and has significant relation with the use, in a negative manner, of religion/spirituality as a way of coping with the disease.
Descriptors: Spirituality; Religion; Religion and Science; Neoplasms; Nursing.

RESUMO

Objetivo: Investigar a relação entre presença de angústia espiritual e uso do *coping* religioso/espiritual com variáveis sociodemográficas, clínicas e de aspectos religioso/espiritual em pessoas com câncer. **Método:** Estudo transversal, realizado em uma associação de apoio à pessoa com câncer. Os dados obtidos dos instrumentos foram analisados por meio do coeficiente de correlação de Spearman e do teste Mann-Whitney. **Resultados:** Participaram do estudo 129 voluntários; 57% apresentaram moderada angústia espiritual, e 96% faziam uso de médio e alto *coping* religioso/espiritual positivo. A angústia espiritual apresentou correlação positiva com o *coping* religioso/espiritual negativo (P < 0,001) e inversa com a idade (p 0,002). O uso do *coping* religioso positivo foi estatisticamente significativo em pessoas que desenvolvem práticas religiosas (p 0,001). **Conclusão:** A angústia espiritual é um fenômeno presente na vida de pessoas com câncer e tem significativa relação com o uso, de maneira negativa, da religião/espiritualidade como forma de enfrentamento da doença.
Descritores: Espiritualidade; Religião; Religião e Ciência; Neoplasias; Enfermagem.

RESUMEN

Objetivo: Examinar la relación entre la presencia de angustia espiritual y el uso del *coping* religioso/espiritual con variables sociodemográficas, clínicas y de aspectos religioso/espiritual en individuos con cáncer. **Método:** Estudio transversal, realizado en una asociación de apoyo a la persona con cáncer. En el análisis de datos recolectados se utilizó el coeficiente de correlación de Spearman y el test de Mann-Whitney. **Resultados:** En el estudio participaron 129 voluntarios; el 57% presentó moderada angustia espiritual, y el 96% utilizaba medio y elevado *coping* religioso/espiritual positivo. La angustia espiritual presentó una correlación positiva con el *coping* religioso/espiritual negativo (P < 0,001) e inversa con la edad (p 0,002). Se observó que el uso del *coping* religioso positivo fue estadísticamente significativo en los sujetos que participan en prácticas religiosas (p 0,001). **Conclusión:** La angustia espiritual es un fenómeno presente en la vida de los individuos con cáncer y tiene una significativa relación con el uso negativo de la religión/espiritualidad como forma de luchar contra la enfermedad.
Descriptores: Espiritualidad; Religión; Religión y Ciencia; Neoplasia; Enfermería.

INTRODUCTION

Spirituality has been defined by several researchers[1-4] in different constructs; however, it has had consensus as to the dynamic and intrinsic aspect of human beings – and, although it may be associated with religion, these are considered different phenomena. The first refers to the inherent pursuit of connection to the sacred, transcendent that adds meaning to existence, while the second is the expression of one's own spirituality through beliefs, rites, and practices[4].

When facing the suffering caused by severe and chronic diseases, many people seek support in spirituality or religion, which may occur through the use of the religious/spiritual coping (RSC) strategy. Hence, RSC refers to the use of religious beliefs and behaviors that facilitate the resolution of problems and prevent or relieve negative emotional consequences from stressful life situations[5-6]. At times, the use of RSC may be both positive and negative.

It is considered as positive RSC (PRSC) that which includes strategies that provide beneficial effect to the individual,such as the pursuit of God's love/protection or greater connection to transcendental forces, while negative RSC (NRSC) involves strategies that generate deleterious consequences, such as seeking escape and delegating to God the resolution of problems[7].

One of the most favorable times for the use of RSC is when dealing with chronic diseases[8] – especially cancer, due to the stigma that the disease still represents in society. It is considered incurable, which highlights the proximity to the finitude of life, although there are various resources for its treatment, which enable the cure[9]. In addition, learning of the diagnosis causes negative impact on the lives of people, leading to physical overload, alteration in quality of life, and changes in the survival of patients, as well as psychological suffering, spiritual crises, anxiety, and depression[1].

A systematic review of 65 studies showed that the main reports of cancer patients include complaints of fatigue, pain, nausea, vomiting, constipation, and insomnia[10]. In addition, adults with cancer self-assessed their health as intermediate (44%) and very poor/weak (22%), and reported that the disease causes limitations in the ability to perform activities of daily life[11-12].

The variety of symptoms presented begins with the diagnosis and remains in the course of the disease and treatment; with that, other distressing feelings, such as despair, fear, anger, uncertainty, and disbelief, among others, may prevail[13-14]. When this distress is related to disorder of the system of values and beliefs, there is the presence of the spiritual distress[15] phenomenon. It is expressed through concerns regarding the meaning of life/death and/or the belief system, with behavioral changes, anger toward God, pursuit of spiritual assistance, and acceptance of the limits of knowledge, among others[16].

Considering this context, it is clear that being diagnosed with cancer involves significant changes in people's lives, in particular with regard to issues concerning the meaning of life, and consequently this may influence the way of coping with the disease process, based on their spiritual and religious principles. However, these needs are often neglected by health professionals, due to their subjective and individual characteristics[17].

Accordingly, there is still little evidence of the involvement of religious and spiritual phenomena, such as spiritual distress, and of possible strategies to minimize them, which justifies the conduct of research on such aspects, since the results will contribute significantly to practical and accurate assessment of these phenomena[18]. Moreover, shedding light on aspects related to the spiritual needs of patients enables health professionals to develop a plan of care aimed at those dimensions, and to conduct evidence-based practices and broaden the perspective of their theoretical knowledge, since the implementation of spiritual care integrates all aspects of individuals and provides them with psychological adaptation to the experience underway[19-20].

OBJECTIVE

Investigate the relation between the presence of spiritual distress and use of RSC and sociodemographic, clinical and religious/spiritual variables in people with cancer.

METHOD

Ethical aspects

We complied with the ethical precepts of Resolution no. 466/2012 of the National Health Council, and the research was approved by the Research Ethics Committee of the Federal University of Alfenas, under opinion no. 2302432.

Study design, location, and period

This is a cross-sectional, exploratory study, with a quantitative approach, held in an Association for Support to People with Cancer of a municipality in the South of the Minas Gerais state, from October 2017 to March 2018. The Association is a non-profit, non-political and non-religious NGO that provides assistance through the distribution of medicines, meals, lodging and psychotherapy, among others, for adults and children with cancer of 23 municipalities that are part of the Regional Health Management. It has a multidisciplinary team comprising a nurse, nursing technician, dentist, nutritionist, psychologist, and social worker.

Population and sample

Since 2002, approximately 2,000 people were registered in the Association. However, participation in activities proposed by the entity occurs randomly and, therefore, due to this great variability in the pattern, the study included a sample of convenience, composed of 129 volunteers who met the eligibility criteria: being aged 18 years or more and having no speech or hearing deficit. These last two criteria were adopted due to data collection employing interview.

Study protocol

For the development of this study, we sought to investigate the use of RSC and the presence of spiritual distress as independent variables and the demographic, clinical, and religious/spiritual aspects as dependent variables, the latter ones obtained by using a form prepared by the authors and validated by experts.

The use of RSC was investigated by using the abbreviated RSC scale[21]. This is a summarized version of the RSC scale validated

for Brazil by Panzini and Bandeira in 2005, adapted from the North American tool, which contains 105 items[7]. The scale has 49 items designed to assess the positive and negative religious/spiritual coping strategies, of which 34 items refer to the first and 15 items refer to the latter. It has five-point, Likert type answers, ranging from "1) not even a little" to "5) very much." The means of the items may range from 1 to 5, with high values indicating high use; in the analysis of internal consistency, the scale presented Cronbach's alpha of 0.97, proving to be a reliable tool[21]. We point out that the adoption of the cut-off points of the scale used in this study was in line with the recommendations presented by the authors that validated it in the Brazilian setting[21].

To assess spiritual distress, we used the spiritual distress scale, translated, adapted, and validated for use in Brazil by Simão, Chaves and Iunes[15] based on the spiritual distress scale developed by Ku, Kuo and Yao[22]. It is a Likert type scale consisting of 30 items covering four domains: relationship with oneself, relationship with others, relationship with God, and coping with death. Answers may range from "1) totally disagree" to "6) totally agree"; the total score may range from 30 to 180, with higher scores indicating greater spiritual suffering[15]. Considering the psychometric measures examined, in general the scale presented analysis of internal consistency through the Cronbach's alpha of 0.87[15].

The data were collected through interviews, in order to facilitate understanding the tools; after they were instructed and signed the Free and Informed Consent Form, the study participants were interviewed in a private room. The data collection team was composed of nursing students, who underwent previous training for application of the tools, which occurred prior to collection, in order to ensure methodological standardization and rigor for the study. There was no interpretation of the scale items by the interviewer, and the answers were recorded fully and faithfully and with visual possibilities. The interviews had an average duration of 30 minutes.

Analysis of results and statistics

The data collected were organized into spreadsheet using Microsoft Office Excel 2010 and analyzed by SPSS Statistics program, version 20.0. Descriptive statistics was used to describe and summarize the results found. To determine the internal consistency of each tool, we used analysis of reliability through Cronbach's alpha. Spearman's correlation coefficient and Mann-Whitney test were used for analytical study; the option for the use of nonparametric tests was due to the dependent variables presenting non-normal distribution. We considered, for all tests, a significance level of 5%.

It is worth mentioning that, according to PASS software, version 11[23], sample calculation was performed for a correlation study assuming a significance level of 5% and minimum power of 80%, for a 0.25 correlation.

RESULTS

Sociodemographic, clinical, and religious/spiritual profile

The sample was composed of 129 volunteers with mean age of 57 years (standard deviation = 14 years). Among them, 82 (64%) were female, 72 (56%) had marital status of married or in cohabitation, 111 (86%) reported having children, 86 (66%) studied up to elementary school, and 73 (57%) reported income of one minimum wage.

As for diagnosis time, 47 (36%) volunteers reported having found out about the disease 1–12 months ago, 64 (50%) learned about it 13 months to 5 years ago, and 18 (14%) have known the diagnosis for more than 5 years. As for treatment, 71 (55%) volunteers underwent chemotherapy and 57 (44%) underwent radiation therapy; among them, 87 (67%) reported presenting no side effects.

With regard to religious/spiritual practice, 96 (74%) reported being catholic, 22 (17%) evangelicals, 2 (2%) protestant, 1 (1%) spiritualist, and 8 (6%) reported having no religion, but leading a spiritual life. As for prayer/meditation individually or in group, most (95%) of the volunteers reported the practice. With regard to the importance of religion and spirituality, 21 (24%) volunteers considered it important and 98 (76%) considered it very important.

Religious/spiritual coping and spiritual distress

With respect to the RSC variable, we observed that the greatest range of values found among the volunteers corresponded to the PRSC (2.03–4.62) compared with NRSC and total RSC. With regard to spiritual distress, the highest value found was 161.

The profile of volunteers as to use of RSC and presence of spiritual distress is presented in Table 1.

When evaluating the parameter for each RSC variable as established in the literature[21], we observed predominantly medium and high use of PRSC and low use of NRSC by the volunteers (Table 2).

To determine the possibility of correlation between the RSC and spiritual distress variables, Spearman's correlation coefficient was used. We observed positive correlation between RSCn and spiritual distress – that is, the higher the negative use of RSC, the greater the spiritual distress found. We also observed that the greater the spiritual distress of volunteers, the lower their age, indicating indirect correlation between these variables (Table 3).

Table 1 – Profile of volunteers as to religious/spiritual coping and spiritual distress, Minas Gerais, Brazil, 2018 (N= 129)

Variables	Range of values		Median	Mean	Standard deviation
	Possible	Found			
	Religious/spiritual coping				
Positive religious/spiritual coping	1.00-5.00	2.03-4.62	3.50	3.47	0.46
Negative religious/spiritual coping	1.00-5.00	1.00-2.93	1.67	1.71	0.45
Total religious/spiritual coping	1.00-5.00	1.60-3.29	2.58	2.59	0.32
Spiritual distress	30-180	34-161	89.00	86.01	26.46

Table 2 – Classification of religious/spiritual coping according to answers of study volunteers, Minas Gerais, Brazil, 2018 (N= 129)

Variables	n (%)				
	Irrelevant	Low	Medium	High	Very high
Positive religious/spiritual coping	0 (0)	4 (3)	62 (48)	62(48)	1(1)
Negative religious/spiritual coping	45 (35)	76 (59)	8 (6)	0 (0)	0 (0)
Total religious/spiritual coping	0 (0)	49 (38)	80 (62)	0 (0)	0 (0)

Table 3 – Spearman's correlation coefficients between religious/spiritual coping, spiritual distress, and variables studied, Minas Gerais, Brazil, 2018 (N= 129)

Variables	Correlation coefficient	CI	*P*
Positive religious/spiritual coping × spiritual distress	–0.135	[–0.295; 0.034]	0.128
Negative religious/spiritual coping × spiritual distress	0.373	[0.208; 0.515]	**< 0.001***
Spiritual distress × age	–0.273	[–0.439; 0.095]	0.002*
Spiritual distress × importance of religion	–0.056	[–0.241; 0.132]	0.528
Spiritual distress × diagnosis time	0.007	[–0.164; 0.171]	0.940

*Note: * Significant at the 5% level.*

Table 4 – Correlation between religious/spiritual coping and spiritual distress and religion/religious practice according to the Mann-Whitney test, Minas Gerais, Brazil, 2018 (N= 129)

Variables		Catholic		Has religious practice	
		Yes	No	Yes	No
Positive religious/spiritual coping	Median	3.515	3.500	3.559	2.838
	Mean	3.472	3.457	3.503	2.745
	SD	0.448	0.521	0.439	0.438
	p	0.850		0.001*	
Negative religious/spiritual coping	Median	1.600	1.933	1.667	2.100
	Mean	1.636	1.915	1.691	2.033
	SD	0.421	0.485	0.446	0.528
	p	0.004*		0.103	
Spiritual distress	Median	85.50	96.00	89.00	65.50
	Mean	84.91	89.21	86.19	82.33
	SD	27.507	23.224	25.676	42.608
	p	0.362		0.513	

*Note: * Significant at the 5% level.*

Table 5 – Reliability of the abbreviated religious/spiritual coping and spiritual distress scales, according to the Cronbach's alpha, Minas Gerais, Brazil, 2018 (N= 129)

Variables	Cronbach's alpha
Positive religious/spiritual coping	0.814
Negative religious/spiritual coping	0.675
Total religious/spiritual coping	0.783
Spiritual distress	0.907

Another aspect investigated in the volunteers was the presence of associations between the RSC and spiritual distress variables and the sociodemographic, clinical, and religious/spiritual variables through the Mann-Whitney test. Thus, we observed that non-catholic volunteers showed higher use of NRSC compared with catholic volunteers (p-value=0.004). In addition, a significant difference was observed in the category of religious practice, which included praying/meditating alone or in a group: the volunteers who performed this practice presented a higher use of PRSC compared with those who did not (p-value=0.001) (Table 4).

Moreover, we verified the internal consistency of the abbreviated RSC and spiritual distress scales; both tools proved to be reliable – however, the highest result for reliability (0.907) was presented by the spiritual distress scale (Table 5).

DISCUSSION

In this study, the use of RSC presented inverse correlation coefficient to the presence of spiritual distress. When the strategy was used in a negative way, a statistically significant relation was found among the volunteers who presented spiritual distress. Additionally, spirituality/religiosity proved to be a very important aspect, a coping strategy much used by most volunteers who participated in the study. These results corroborate the assertion that cancer reflects the finitude and the meaning of the life of a person, which not unusually can generate spiritual distress, in the same way it converts spirituality/religiosity into an important way to deal with the pain and stress resulting from illness[24].

Both spirituality and religiosity are mechanisms to find meaning when faced with the illness process, which relates such phenomena to a source of support and hope[25-26]. The cancer diagnosis often requires aggressive and painful therapies, resulting in undesirable side effects[27]. Handling the situation from the perspective of spirituality and religiosity may mitigate and/or prevent such effects, not only as coping strategies, but also as a practice that is integrative or complementary to traditional therapy[1,28].

With regard specifically to aspects of religiosity, most volunteers investigated in this study practiced prayer, both in group and individually – in the same way they also practiced catholicism; which seems to

favor the use of RSC in a positive manner. This fact may be attributed not only to the reason that motivates prayer, which is the desire to facilitate the health-disease transition process and enable a better management of the stressful situation experienced, but also to the recognition of religious/spiritual needs by the very person, which promotes the use, positively, of RSC for dealing with cancer and its impact[29-33].

On the other hand, the lack of recognition of religious/spiritual needs in health care has been reported in the literature[34], which is attributed to the lack of professional experience and/or knowledge, or even to the personal conviction that spirituality is empirical or has no importance in contemporary society. Certainly, the lack of recognition of the spiritual needs, associated with the suffering and the impact of the diagnosis and treatment of cancer, may generate the presence of spiritual distress, as observed here, which may be understood as a possible consequence of the experience of deep disharmony in the belief or value system[35].

Still with regard to spiritual distress, this investigation found inverse correlation with the age variable — that is, the phenomenon is present more frequently in younger volunteers. This result corroborates the literature, which suggests that young adults are focused on developing their life project, which includes, for example, aspects related to professional development and to conjugality; however, the diagnosis of cancer may interfere temporarily or even definitively with these plans[36]. Furthermore, the literature indicates that there is low level of spirituality among younger subjects, which would possibly limit their experience of transcendence[37].

Although we observed low use of RSC in a negative way by the volunteers in the study, this deserves attention from health professionals, since it may generate negative impact on the clinical conditions of the individual, because of possible disregard for health self-care[38]. This may be aggravated by the presence of spiritual distress, as found here during the correlation analyzed. Considering this, it is worth noting that negative religious/spiritual methods reflect the tensions and struggles resulting from the concern regarding divine retribution, anger toward God, and the disconnection from a spiritual community[39].

Study limitations

Because it is a subjective and personal phenomenon, the respondent may be influenced by the alternatives presented. In addition, the fact that the study design is cross-sectional may have reduced the comprehension of the totality of phenomena related to spirituality, to the detriment of statements of causality. Also, there is the barrier of the Likert type answers of the scales used, which, even facilitated by the visual presentation, as performed here, have high level of difficulty as to distinguishing between them.

Contributions to the field of nursing, health or public policy

The use of tools in clinical practice, as used here, enables the investigation of spiritual needs by the nursing staff, which will favor the determination and understanding of the elements involved in the process of RSC, as well as in that of spiritual distress. This fact enables performing the needed adjustments and planning appropriate interventions to provide care aimed at this dimension.

CONCLUSION

The importance of spirituality/religiosity reported by volunteers in this study, as well as the prevalence of involvement with their religious belief, may have been a factor that led to low prevalence of spiritual distress and increased use of PRSC as coping mechanism when experiencing cancer and its treatment, reinforcing the importance of this strategy.

Moreover, the religious/spiritual phenomena, such as the use of RSC and the presence of spiritual distress, were present regardless of the volunteers' stage of diagnosis, and they showed significant relations. One of them refers to the presence of the spiritual distress phenomenon, which presented positive correlation with NRSC and inverse correlation with age. As a result, these variables came to be the focus of greater attention, since their oscillation can influence the spiritual distress of people with cancer. The other relation presented concerned the greater use of PRSC by volunteers, who carried out religious practices such as praying/meditating alone or in a group.

Thus, considering the data presented, it is clear that health care is not limited to biological aspects, and that professionals should take into account diagnoses and interventions relating to the religious and spiritual dimensions in their evaluation process, thus favoring better results in health care

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