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INFLUENCE OF SPIRITUALITY AND RELIGIOSITY IN CANCER TREATMENT: A SYSTEMATIC REVIEW

INFLUÊNCIA DA ESPIRITUALIDADE E RELIGIOSIDADE NO TRATAMENTO DO CÂNCER: UMA REVISÃO SISTEMÁTICA

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ABSTRACT

Objective: To evaluate the influence of spirituality and religiosity in the treatment of cancer patients and the therapeutic response.

Methology: Systematic review study using PubMed, SciELO, and VHL databases to search for studies published from 2012 to 2022. The research was conducted considering the terms “spirituality”, “religiosity”, “cancer”, “influence” and “treatment”. The quality of articles was assessed using the Study Quality Assessment Tool from the Department of Health and Human Services (NHLBI).

Results: A total of 82 studies were identified; 10 studies were eligible and included. Standard cancer care (n=7), Palliative care (n=2), and standard cancer care and Palliative care (n=1) were the types of treatment received by study participants. S/R was used as a coping strategy for the disease during treatment, regardless of type, and influenced a better quality of life, general health status, and physical and emotional symptoms. The predictors associated with coping strategies were religion, mood, behavioral disconnection, maladaptive coping, religious practices, faith, social support, family caregiver, and trust in beliefs.

Contribution: S/R consists of a strategy for coping with cancer throughout the treatment and illness process. Still poorly integrated into the care of cancer patients, its influence on treatment was directly related to the benefits achieved with the improvement in quality of life, general health, and physical and emotional symptoms. It is expected that the use of S/R as a coping strategy for cancer patients can have a positive impact on predictors related to response assessment.

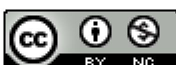
Keywords: Cancer patients; Religiosity; Spirituality; Treatment; Quality-of-life.

RESUMO

Objetivo: *Avaliar a influência da espiritualidade e religiosidade no tratamento de pacientes com câncer e na resposta terapêutica.*

Metodologia: *Estudo de revisão sistemática utilizando as bases de dados PubMed, SciELO e BVS para busca de estudos publicados de 2012 a 2022. A pesquisa foi realizada considerando os termos “espiritualidade”, “religiosidade”, “câncer”, “influência” e “tratamento”. A qualidade dos artigos foi avaliada por meio do Study Quality Assessment Tool do Departamento de Saúde e Serviços Humanos (NHLBI).*

Resultados: *Foram identificados 82 estudos; 10 estudos foram elegíveis e incluídos. Cuidados padrão de câncer (n=7), cuidados paliativos (n=2) e cuidados padrão de câncer e cuidados paliativos (n=1) foram os tipos de tratamento recebidos pelos participantes do estudo. A S/R foi utilizada como estratégia de enfrentamento da doença durante o tratamento, independentemente do tipo, e influenciou na melhor qualidade de vida, estado geral de saúde e sintomas físicos e emocionais. Os preditores associados às estratégias de enfrentamento foram religião, humor,*



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desconexão comportamental, enfrentamento mal adaptativo, práticas religiosas, fé, apoio social, cuidador familiar e confiança nas crenças.

Contribuição: *S/R consiste em uma estratégia de enfrentamento do câncer ao longo do processo de tratamento e adoecimento. Ainda pouco integrado ao cuidado de pacientes com câncer, sua influência no tratamento esteve diretamente relacionada aos benefícios alcançados com a melhora da qualidade de vida, saúde geral e sintomas físicos e emocionais. Espera-se que o uso de S/R como estratégia de enfrentamento para pacientes com câncer possa ter um impacto positivo nos preditores relacionados à avaliação da resposta.*

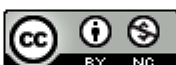
Palavras-chave: *Pacientes com câncer; Religiosidade; Espiritualidade; Tratamento; Qualidade de vida.*

1 INTRODUCTION

Cancer, a global public health problem, is considered a life-threatening disease [1]. Therapeutic options for cancer can be used in isolation or associations to better control the disease [2]. Patients diagnosed with cancer are affected by physical, psychological, and spiritual symptoms secondary to the disease and its treatment that in a complex way impair the patient's quality of life and can influence the therapeutic response and prognosis [3].

In the evolutionary process of the disease and treatment, cancer patients live a period of anxiety and suffering, and commonly raise questions about the purpose and meaning of life, mortality, and doubts involving spirituality and religion [4]. Complementary medicine through meditation, body manipulation, and especially religiosity and spirituality as a means of coping with cancer, is an alternative to promote control of biopsychosocial symptoms and improve the quality of life of cancer patients [5].

Spirituality can be interpreted as a personal quest to understand issues related to life, to its meaning, about relationships with nature, the sacred or transcendent that may, or may not, lead to the development of religious practices or the formation of religious communities, but that the individual interacts with himself and seeks to understand the moment he is experiencing. As for religiosity, we can state it as; an individual's behavior towards the community, the extent to which an individual believes



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in, follows norms, and practices a religion, which may be organizational, such as attending churches or temples, or non-organizational, which includes saying prayers, reading books, or watching programs religious [6,7].

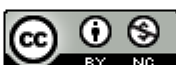
In recent years, a growing number of studies8-12 have shown that the use of complementary methods, such as spirituality/religiosity (S/R), when properly addressed and used as a set of cognitive and behavioral coping strategies, positively influences the patient during the cancer journey. Improvement in quality of life [8,9], physical and emotional symptoms8, and coping with the disease [8,10,11] are the positive effects observed. A study developed by Souza et al. [13] investigated the religious/spiritual confrontation used by cancer patients during chemotherapy treatment. The results showed that religion/spirituality can be considered a positive coping strategy that reflects on treatment adherence and reduction of situational stress and anxiety [13]. In the scenario of breast cancer patients receiving radiotherapy, the positive effects identified were on the quality-of-life score [9].

Given the importance of a comprehensive look at patients undergoing cancer treatment, which is capable of considering the spiritual/religious dimension and based on previous studies on the benefits of S/R in patients' coping with cancer, this study aims to understand the background and evaluate the influence of S/R on the treatment of the cancer patient and the response to the cancer treatment received. It is expected that the use of S/R as a coping strategy for cancer patients can predict a positive impact on the response rate of cancer treatment.

METHODS STUDY DESIGN

A systematic literature review study registered in PROSPERO [14], the international database of systematic reviews in health and social care of the Center for Reviews and Dissemination at the University of York.

SEARCH STRATEGY



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Three online access databases were selected for the research: Pubmed/Medline, Scientific Electronic Library Online (SciELO), and Virtual Health Library (BVS). With a controlled vocabulary in the search strategy in each of the bibliographic databases, Pubmed/Medline (MeSH terms), SciELO (DeCs terms), and BVS (DeCs terms), the following terms were used: “spirituality”, “religiosity”, “cancer”, “influence”, “treatment”, as well as their synonyms and combinations.

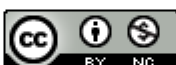
SELECTION OF STUDIES

To carry out this research, the following question was asked: What are the influence of spirituality and religiosity in the treatment of cancer patients and the therapeutic response of the disease? The study population included cancer patients undergoing cancer treatment. The intervention studied was the implementation of spirituality and/or religiosity. A comparison group was not needed. The following outcome was necessary: at least one positive or negative influence of spirituality and/or religiosity must be reported. These results included both quantitative and qualitative results (Table 1).

Table 1. PICOT eligibility criteria.

PICOT Question: What are the influence of spirituality and religiosity in the treatment of cancer patients and the therapeutic response of the disease?
Population: Cancer patients undergoing cancer treatment
Intervention: Implementation of spirituality and/or religiosity
Comparison: not applicable
Outcome: At least one positive or negative influence of spirituality and/or religiosity.
Type of study: Experimental and observational

A database was prepared, and all studies identified in the initial database search were archived in Excel software (Version 16.4). The following eligibility criteria were adopted: (1) studies published in the last 10 years (2012 to March 2022); (2) studies without the restriction of age, type of cancer, and type of cancer treatment; (3) studies in English and Portuguese; (4) studies that included the assessment of spirituality and/or religiosity involving a patient at any stage of treatment, for any type



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of cancer; and (5) studies that analyzed at least one positive or negative outcome resulting from spirituality and/or religiosity in cancer treatment or coping with the disease; Gray literature, case series, case studies, proceedings and conference abstracts, parts of commentary, and protocols were excluded. At the end of this process, the full text of the studies independently selected by the three study authors was obtained for final inclusion or exclusion based on pre-defined eligibility criteria. The quality of the included articles was assessed using the Department of Health and Human Services study quality assessment tools [15].

STEP 1: IDENTIFICATION OF ARTICLES BY SEARCHING ELECTRONIC DATABASES

Electronic searches were performed by two independent reviewers. Subsequently, the titles and abstracts of independently identified studies were evaluated for suitability for the research objective. Studies that did not specifically address spirituality and religiosity in oncology were excluded. Disagreements were resolved by consensus between the two reviewers, or by a third reviewer when necessary. Duplicate studies were removed.

STEP 2: ELIGIBILITY ASSESSMENT OF FULL-TEXT ARTICLES

Studies selected according to eligibility criteria were read in full. Throughout the selection process, uncertainties were discussed among the authors until a consensus was reached. A flow of information originates in the different phases of the systematic review, and concerning eligibility, studies that did not specifically address the positive and/or negative influence of spirituality and religiosity in cancer patients

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were excluded. The methodological quality assessment of the reviewed articles was performed using the quality assessment tools available at the US Department of Health and Human Services [15].

STEP 3: STUDIES INCLUDED IN THE QUALITATIVE SYNTHESIS

The number of articles identified, screened, assessed for eligibility, and included in this review were recorded, as were the reasons for exclusion. The characteristics (eg location, design, sample size, methods, results, and conclusions) of each study were recorded and summarized. The methodology of the studies and the measures of evaluation of the results were varied, therefore it was chosen to carry out a qualitative synthesis, instead of combining the data in a meta-analytical statistical approach.

This systematic review was carried out based on the guidelines proposed by the Preferred Reporting Items for Systematic Reviews (PRISMA) [16]. The flowchart with the different phases of a review, and the description of information regarding the number of articles identified, included, and excluded and the reasons for exclusions originated in this systematic review (Figure 1).

RESULTS

According to the electronic search, a total of 82 references were found: 34 (PubMed/Medline), 18 (SciELO), and 30 (BVS). After excluding 16 duplicate references, 66 references were selected for eligibility assessment. After reading the titles and abstracts (n=66), a total of 49 studies were excluded for not meeting the pre-established criteria (Figure 1).

The full text of the remaining 17 articles was evaluated for eligibility, and 7 articles were excluded for the following reasons: not presenting a description of the methodology (one); review article (one); did not specifically address the influence of S/R in cancer patients (five), with one study targeting S/R in cancer prevention, one

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study investigating the influence of S/R on family caregivers, and three studies the population were health professionals. health (example: oncologists and nurses). At the end of the entire process, 10 articles were selected for inclusion in this review (Figure 1).

Table 2 presents the characteristics of the selected articles. These articles were analyzed regarding the objective, study design, the population studied, country of origin of the research, type of cancer treatment of patients, instruments used to evaluate S/R, the influence of S/R during cancer treatment, and the investigation of this influence on the therapeutic response. A total of 6 studies were of quantitative observational methodology [6,8,9,17-19], 2 qualitative-quantitative [11,20] and 2 qualitative [21,22]. The studies were performed more frequently in Brazil (n=6) [9,11,17,20-22], Spain (n=1) [6], Germany (n=1) [18], United States of America (n=1) [19], and 1 multicenter study in 3 Latin American countries (Chile, Guatemala and the United States of America)8. The population studied was predominantly adult, 1 study was conducted with elderly patients (age >=60 years) [21] and 1 study with adolescents (12-18 years) [22]. Respectively, standard cancer treatment (n=7) [6,9,11,19-22], Palliative care (n=2) [8,18] and standard cancer treatment and Palliative care (n=1) [17] were the treatments received by the participants of the studies.

Regarding the S/R assessment instruments, a relevant predominance among the studies was not identified. The Brief COPE and RCOPE instruments were used in 2 (two) studies [6,8], and the FACIT-Sp18 and its expanded version, called FACITSp-Ex [8] were used each in 1 (one) study. Regarding the assessment of S/R of cancer patients, the studies reinforced that S/R was present and increased among patients and was used as coping strategies in the daily life of the illness process of these cancer patients during treatment, regardless of the type.

Because S/R is used as a coping strategy by cancer patients, it has influenced a better quality of life [8,9,17,19,20], general health [9], physical [8,9,19,20], and emotional [8,9,19] symptoms [20]. The statistically significant predictors of the use of coping strategies were religion, mood, behavioral disconnection, maladaptive coping [3], religious practices, faith, social support, family caregiver participation [17], and trust in religious and spiritual beliefs [19]. In addition, 1 (one) study [18] evaluated the

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predictors associated with the spiritual needs of patients, through four main factors contemplated in the Spiritual Needs Questionnaire (SpNQ): religious needs, existential needs, need for inner peace, and need for active giving/generativity. Significant predictors for religious needs were confidence in religion, "call for help" interpretation of illness, and living with a partner; for existential needs, it was a "call for help"; for the need for inner peace, it was the tendency to interpret the disease as a "challenge". Existential needs are negatively influenced by the interpretation of illness as a "threat". No significant predictors associated with a need for active giving/generativity [18] were identified.

Of the 10 included studies analyzed a total of 1516 patients. The influence of S/R on cancer therapeutic response was not objectively investigated in studies through response rate, and survival, among others. All included studies were analyzed using the Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (U.S. Department of Health & Human Services) and had sufficient information to determine that the risk of allocation bias was low for more than half of the studies.

DISCUSSION

According to the characteristics of the 10 articles included, it was possible to observe that S/R was predominantly important, present, or with moderate to high scores among cancer patients undergoing cancer treatment, depending on the investigation methodology of each study. In the daily lives of these patients, S/R was adopted as a strategy to face the disease itself and the entire biopsychosocial context originated by the disease and treatment. Five studies concluded that the influences observed were improvement in quality of life [8,9,19,20,23], four in physical and emotional symptoms [8,9,19,20] and one in general health status9. One study observed the influence of S/R in decision-making regarding care [22]. Spiritual pain was evaluated by a study and associated with worsening physical and psychosocial suffering [8]. Response rate, and survival, among others, considered a measure of cancer therapeutic response, were not objectively investigated in the studies. Attention

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to the spiritual/religious needs of cancer patients was considered an important part of care [8,19].

Attention to S/R, prevention, and treatment of biopsychosocial symptoms, promotion of quality of life, and support for caregivers and family members are the care promoted by medical science called Palliative Care (PC) [24,25]. This care is intended for patients with cancer, or with a diagnosis of life-threatening chronic diseases, and it is strongly recommended that it be integrated into standard cancer treatment so that patients benefit from this type of care26. Although the population of the present study was predominantly oncological, which in itself suggests an indication for PC, we identified one study with PC associated with standard cancer treatment, two individualized PC studies, and both studies had patients diagnosed with advanced cancer. The findings reflect that PC happens later and later or is not a reality for everyone who needs it [27].

Although most of the studies were carried out in Brazil, and the others in Europe (Spain and Germany) and Latin American countries (USA, Chile, and Guatemala), and the population differed between types of cancer and oncological treatment, it was a frequent S/R [6,8,9,17-20] is observed. In the study by Arbinaga et al.6, participants with cancer compared to those without a cancer diagnosis were significantly more likely to identify with religious beliefs ($p<0.001$), and mean spirituality scores were higher (71.47 vs. 59.13; $p. < 0.001$). The findings reinforce that S/R has been conceived as an important element for the care of patients diagnosed with cancer [8,18].

Overall, S/R was used as a cognitive and behavioral strategy in the active coping of the disease among cancer patients undergoing treatment [6,8,9,11,17-22]. Elderly diagnosed with cancer and undergoing chemotherapy reported the experience of S/R in the face of the reality of illness and the installed existential void, and thus, use them as resilience strategies in the face of suffering, feelings of guilt, and death in everyday life [21]. Adolescents with hematological cancer receiving standard oncological treatment expressed that belief, faith in God, and religious practices were the source of comfort and support for coping with the stress and difficulties generated by the disease, and in the search for the meaning of life [22]. For patients with

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advanced cancer undergoing standard cancer treatment and palliative care for S/R, religious practices, social support, and the presence of a primary family caregiver were used to cope with cancer [17]. In addition, Alcorn et al. [28] showed that involvement in religious services allows patients to better cope with their illness due to the reduction of social isolation and feelings of anger.

As observed in the literature [9,10,12], the use of S/R as a strategy for coping with cancer by patients receiving some type of treatment positively influenced a better quality of life [8,9,17,19,20], better general health status [9], and physical [8,9,19,20] and emotional [8,9,19,20] symptoms. Predictors significantly associated with spiritual and religious needs contribute to improving patients' quality of life [8,9,19,20] by increasing patients' psychological, emotional, functional, and affective well-being [13]. The positive association between religion and health identified is consistent with the findings of Souza et al. [13], who concluded that religious beliefs and practices can evoke positive emotions, resilience, comfort, hope, and spiritual well-being.

S/R can be considered a path to emotional and psychological support not only for cancer patients who are facing the disease but also for all those involved in care, such as family caregivers, doctors, nurses, and other health professionals. In inpatient care, they experience situations of stress, suffering, crises, and emotional disorders with depression [9,17,23]. In this sense, it is worth mentioning that care aimed at the spiritual/religious needs of cancer patients who suffer from their anguish is considered important by professionals [8,19,29,30]. According to Marvin et al, offering compassionate and quality spiritual care has its barriers, including the absence of training and education on spiritual care, time restricted by the high demand for clinical activities and assistance aimed at biological care, and cultural differences that generate discomfort to address, discuss and explore spiritual/religious beliefs with patients and their family caregivers [8,31]. Therefore, education to health professionals about spiritual/religious care, although necessary, we still lack the training that is globally accessible, support from health administrators, and promotion of spiritual leadership to make it possible to provide spiritual/religious care and support [8,31].

Considering the context related to the education of health professionals and the global factors that make it possible to promote spiritual/religious care in an

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institution, the authors believe that there may be a relationship between S/R not yet being a well-established and performed care in practice a clinical trial with the absence of objective results on the influence of S/R on the therapeutic response of cancer. More research is needed to better understand these relationships. This study had some limitations. This is a systematic review; although the main search strategy was broad, our selection criteria may have missed articles. We excluded gray literature, case series, case studies, proceedings abstracts, parts of commentary, and protocols. Studies use different instruments to investigate S/R and this limits comparisons. The results commonly evaluated on the influence of spirituality and religiosity in the treatment of cancer patients and the response to cancer treatment were few, and in general, the studies were heterogeneous concerning the results and study design. More studies are needed to better characterize the impact of S/R in the care of cancer patients and especially in the therapeutic response.

CONCLUSION

The evidence found indicates that S/R constitutes a strategy for positive coping with cancer and directly influences the improvement of quality of life and the biopsychosocial and spiritual needs of the patient during cancer treatment. Additional studies are needed to confirm this finding. It is expected that S/R will be adequately integrated into clinical practice and its impact on therapeutic response can be investigated.

ACKNOWLEDGMENT

Not applicable.

ETHICAL APPROVAL

Not applicable.

INFORMED CONSENT

Not applicable.

DATA SHARING STATEMENT

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No additional data are available.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

SIMILARITY CHECK

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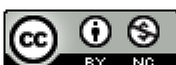

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