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ORIGINAL ARTICLE

Integrative, spiritual practices and quality of life of cancer patients during treatment*

Práticas integrativas, espirituais e qualidade de vida do paciente com câncer durante o tratamento

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ABSTRACT

The objective was to identify the use of integrative, spiritual practices and to evaluate the quality of life related to the health of adult cancer patients during the chemotherapy treatment. Quantitative and cross-sectional research conducted with 275 patients during chemotherapy at a hospital in Minas Gerais. Instruments used: Sociodemographic and clinical questionnaire and Quality of Life Questionnaire-Core30 (QLQ-C30) with data analysis by Statistical Package for the Social Sciences software (for Windows). Most of the interviewees were women, between 40 and 79 years old, married, retired, with low education level and low income. The most prevalent cancers were colorectal, breast and stomach. Only 13 (4.9%) patients used some integrative practice such as phytotherapy, homeopathy, meditation, floral and acupuncture. About 94 (34.2%) individuals performed spiritual therapy with predominance of prayer, passes, fluidized water and promise. There was an adequate/satisfactory level (scores between 50 and 70) of quality of life and functions evaluated.

Descriptors: Neoplasms; Complementary Therapies; Spiritual Therapies; Quality of Life.

RESUMO

Objetivou-se identificar o uso de práticas integrativas, espirituais e avaliar a qualidade de vida relacionada à saúde de pacientes adultos com câncer durante o tratamento quimioterápico. Pesquisa quantitativa e transversal realizada com 275 pacientes durante quimioterapia em um hospital de Minas Gerais. Instrumentos utilizados: questionário sociodemográfico e clínico e *Quality of Life Questionnaire-Core30* (QLQ-C30) com análise de dados pelo software *Statistical Package for the Social Sciences* (SPSS) (*for Windows*). A maioria dos entrevistados era mulher, entre 40 a 79 anos, casadas, aposentadas, com baixo nível de escolaridade e baixa renda. Os cânceres mais prevalentes foram colorretal, mama e estômago. Apenas 13 (4,9%) pacientes utilizavam alguma prática integrativa como fitoterapia, homeopatia, meditação, floral e acupuntura. Cerca de 94 (34,2%) indivíduos realizavam terapia espiritual com predominância da oração, passes, água fluidificada e promessa. Houve nível adequado/satisfatório (escores entre 50 e 70) da qualidade de vida e das funções avaliadas.

Descritores: Neoplasias; Terapias Complementares; Terapias Espirituais; Qualidade de Vida.

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INTRODUCTION

The diagnosis of cancer generates feelings such as sadness, fear, disbelief, anguish, anxiety and despair at the same time that it causes changes in the routines, roles, habits, beliefs and lifestyles of individuals. Likewise, its conventional chemotherapy treatment culminates in physical, emotional and psychosocial side effects, which vary in symptoms, intensity and frequency, and negatively impact on quality of life (QL)[1,2].

Although the World Health Organization (WHO) has previously defined QL as "the individual's perception of his/her position in life in the context of the culture and value system in which he/she lives and in relation to his/her goals, expectations, standards and concerns"[3], its evaluation is a complex task, since its concept is abstract, non-consensual, subjective and multidimensional, since it involves associations between personal beliefs, social relationships, environment and physio-psychological state. Thus, the impact of a chronic disease and its stage, symptoms, types and treatment protocols interfere in the individuals' QL[3,4].

Faced with the changes caused by the diagnosis and treatment of cancer, patients reevaluate their lives, starting a process of changing beliefs and behaviors, in addition to the search for meaning and coping strategies, in order to obtain greater biopsychosocial-spiritual well-being, QL, a feeling of control of the disease and autonomy in decision making. In this sense, they can utilize integrative therapies and modify and/or intensify strategies of spirituality and religion[2,5].

Integrative and complementary practices are therapeutic practices based on a health model, usually bioenergetic/vitalist overlapping with the biomedical/machine model, which can be used in conjunction with allopathic treatment. These therapies are used in the perspective of promoting integral care through the search for natural mechanisms to prevent aggravations or diseases and recover health, strengthening the therapeutic bond and integrating the human being with the environment and society[6,7].

The Unified Health System (SUS), through the National Policy of Integrative and Complementary Practices (PNPIC), supports the structuring of these practices in a multiprofessional character, through norms on deployment, implementation, financing mechanisms and articulation among the levels of care. In its creation, in 2006, five procedures were offered, namely: acupuncture, homeopathy, medicinal plants and phytotherapy, social thermalism/crenotherapy, and anthroposophical medicine; in 2017, 14 were incorporated and in 2018, 10 other integrative and complementary practices were added[7]. However, their availability is restricted in relation to therapy options and the health facilities that offer them.

The decision for using these practices by cancer patients is influenced both by the limitation of conventional/allopathic treatment, due to its exclusively body-centered approach and the presence of immediate or late side effects, as well as by the significance of present benefits such as increased perception of general health, better sensation of cancer control, treatment potentiation, stagnation of the disease, prevention of metastasis and recurrence, increased chance of cure, symptom relief, improvement of psychological, spiritual and emotional well-being, among others[8-10].

During the coping with the disease, the patients pay more attention to spirituality and religion, since they play a protective role against psychological morbidity[11]. However, although they present overlapping dimensions, spirituality and religion present different characteristics. Spirituality is broader, dynamic and subjective, being understood as the essence of the individual, a search for meaning and purpose in life, related to intimate values, inner completeness, harmony, connection with oneself, with other people, with nature and with the universe[1].

Religion, on the other hand, is a partial expression of spirituality, which has rituals, sacred traditions, dogmas and doctrines transmitted by culture and shared by a group that believes in a divine force or being superior[1,2]. In general, the proper use of spirituality and religion can provide the individual with cancer with increased psychological well-being and QL, decreased anxiety, depression, stress and the search for meaning, peace and hope[2,11]. In this study, we will use the terms spirituality and spiritual practices, considering them more comprehensive.

Thus, the objective of this research is to identify the use of integrative, spiritual practices and to evaluate the health-related quality of life (HRQL) of adult cancer patients during chemotherapy treatment.

METHODS

It is a quantitative, non-experimental, descriptive and cross-sectional exploratory survey, conducted at a chemotherapy center of a public hospital, which is a reference in high complexity care for 27 municipalities that make up the Southern Triangle macro-region of Minas Gerais. Patients aged 18 years or older, of both genders, diagnosed with cancer under chemotherapy treatment, were selected by means of a purposeful (or intentional) sampling, where subjects considered typical of the population in question are chosen[12].

Patients who did not agree to participate by verbalizing and/or not signing the Term of Free and Informed Consent were excluded from the study, in addition to the patients who presented some kind of difficulty in understanding the questions, which consequently could harm the content of the answers, making them incompatible with the required objectives and the reality experienced.

Data were collected during the period from September 2016 to September 2018, totaling 275 patients who responded

to two instruments. The first was a sociodemographic and clinical-therapeutic questionnaire, validated by three independent judges, which evaluated the social and clinical aspects of the participants, through information such as age, gender, race/color, city, profession, family income, level of education, religion, diagnosis, treatments performed — including integrative and spiritual practices — and side effects of chemotherapy.

The second instrument was the Quality of Life Questionnaire-Core 30 (QLQ-C30) of the European Organization for Research and Treatment of Cancer (EORTC), duly validated[13], for evaluation of HRQL in cancer patients. This instrument contains 30 questions that evaluate five functional scales (physical, emotional, cognitive, social and paper function), one general health status scale, three symptom scales (fatigue, pain, nausea/vomiting), five items to evaluate symptoms (dyspnea, insomnia, loss of appetite, constipation and diarrhea) and one item to evaluate financial difficulties during the disease and treatment.

The results of the scores are converted on a scale from 0 to 100. In functional scales and in the general health scale, zero is related to inadequate HRQL level and 100 to high HRQL level, and scores between 50 and 70 indicate satisfactory HRQL result and scores equal or higher than 70 refer to good HRQL. On the other hand, in symptom scales and items, zero indicates absence of severe symptoms, and 100 refers to high level of symptoms and side effects, with consequent worsening of HRQL[13].

For the statistical analysis the Statistical Package for the Social Sciences (SPSS) (for Windows) software was used. Frequencies, percentages, means and standard deviations were calculated for descriptive data analysis. This research is part of a larger project that was submitted and approved by the Ethics and Research Committee of the responsible institution under approval of CEP 1.715.819_E of 09/05/2016. It was kept confidential as to the identity of the patients, with identification of the subjects by numbers, attending the Resolution n. 466/12, of the National Health Council.

RESULTS

Based on inclusion and exclusion criteria, 275 subjects were interviewed, most of whom were female, between 40 and 79 years of age, married, retired, coming from Uberaba, with incomplete elementary schooling and income of up to R$ 1,000.00 per month (Table 1).

As for the chemotherapy treatment, the number of sessions performed was between one and six (154 individuals — 56.2%), with a predominance of two sessions (44 individuals — 16.0%). However, the number of patients who performed more than 10 sessions (39 subjects — 14.2%) was also significant. Thus, the beginning of treatment occurred in up to six months (185 subjects — 67.3%), with predominance in less than one month (90 patients — 32.7%), as well as over one year (35 patients — 12.7%).

About 104 (37.8%) patients reported no chemotherapy-related side effects, while 87 (31.6%) patients reported physical and gastrointestinal side effects — sweating, malaise, weakness, insomnia, alopecia, fatigue, pain, dyspnea, nausea, diarrhea, constipation, mucositis, among others — , 40 (14.6%) patients reported only gastrointestinal side effects and 38 (13.8%) physical effects. Only five (1.8%) patients presented emotional effects such as anxiety, depression, anguish, irritability and worry.

Regarding the chemotherapy protocol, 66 different schemes were found in 196 researched subjects. Thus, there was a loss of data in 79 subjects due to the absence of explicit protocol registration and/or access to medical records. Of the present schemes, the most used were Fluorouracil associated to Leucovorin and Oxaliplatin (31 subjects — 11.3%) both in slow form (FOLFOX) and in bolus (FLOX) and the schemes Fluorouracil (5 — FU) and Fluorouracil associated to Leucovorin with 14 (5.1%) subjects in each scheme.

Table 2 shows the mean and standard deviation of the QLQ-C30 domains. The mean scores of functions and general health status presented satisfactory results, as they varied between 52.37 and 67.05. Moreover, the cognitive function presented good results (score 70.44). Regarding scales and items of symptoms the most prevalent were loss of appetite, fatigue, pain and insomnia, besides financial difficulties.

In the data analysis regarding integrative and spiritual practices, it was found that most patients did not use either practice. Only 13 (4.7%) patients performed some integrative practice and 262 (95.3%) did not practice them and/or did not inform. Among those who practiced, nine (3.3%) individuals used phytotherapy, while homeopathy, meditation, flowers and acupuncture had only one (0.4%) individual who practiced each therapy.

Regarding spiritual practices, about 94 (34.2%) individuals practiced them and 181 individuals (65.9%) did not perform and/or did not inform their practice. In addition, many used more than one type of religious therapy in a combined manner (Table 3).

As for the time of use, about 34 (12.4%) patients have been using spiritual practices for more than one year, followed by between one and three months (24 patients — 8.7%), less than one month (12 patients — 4.4%) and between three and six months (11 patients — 4.0%).

Although few patients used spiritual practices, the presence of religion was significant in 264 (96%) of the patients, with a predominance of Catholic (167 subjects — 60.7%), Spiritist (40 subjects — 14.5%) and Evangelical (39 subjects — 14.2%). 183 (66.5%) reported being practitioners, but many reported that they could not perform

Table 1. Frequency and percentage of the sample's sociodemographic characteristics. Uberaba (MG), Brazil, 2016–2018.

	Features	Total n (%)
Gender	Female	140 (50.9)
	Male	135 (49.1)
	Total	275 (100)
Age group (years old)	18 to 19	10 (3.6)
	20 to 39	34 (12.4)
	40 to 59	101 (36.7)
	60 to 79	109 (39.6)
	80 to 99	21 (7.6)
	Total	275 (100)
Marital status	Single	66 (24.0)
	Married	135 (49.1)
	Widower	40 (14.5)
	Others	34 (12.4)
	Total	275 (100)
Profession/ occupation	Retired	86 (31.3)
	Homeowners, housewives	56 (20.4)
	Cleaners, manicures, seamstresses, cooks	21 (7.6)
	Traders, sellers	16 (5.8)
	Engineer, designer, architect	14 (5.1)
	Others	82 (29.8)
	Total	275 (100)
City origin	Uberaba	162 (58.9)
	Cities of the South Triangle	90 (32.7)
	Other cities in the State of Minas Gerais	21 (7.6)
	Other States	2 (0.7)
	Total	275 (100)
	Illiteracy	2 (0.7)
Level of education	Incomplete elementary school	135 (49.1)
	Complete elementary school	32 (11.6)
	Incomplete high school	32 (11.6)
	Complete high school	57 (20.7)
	Incomplete higher education	2 (0.7)
	Complete higher education	12 (4.4)
	Incomplete post-graduation	2 (0.7)
	Complete post-graduation	1 (0.4)
	Total	275 (100)
Family income	No considerable income	2 (0.7)
	Up to R$ 1000,00 monthly	100 (36.4)
	R$ 1001,00 to R$ 1500,00 monthly	35 (12.7)
	R$ 1501,00 to R$ 2000,00 monthly	69 (25.1)
	R$ 2001,00 to R$2500,00 monthly	21 (7.6)
	R$ 2501,00 to R$ 3000,00 monthly	23 (8,4)
	Above R$ 3000,00 monthly	25 (9.1)
	Total	275 (100)

Source: elaborated by the authors, 2018.

their practices and rituals with the desired frequency due to disease and treatment.

DISCUSSION

The results showed that most of the patients were women, between 40 and 79 years old, married, retired, with low education and income. This socio-demographic information is compatible with other studies related to integrative and complementary practices[10], spiritual[4] and HRQL[14].

Only 4.9% of cancer patients interviewed used some form of integrative practice, although the research site offered Reiki once a week to patients. This result may be related to a number of issues ranging from the difficulty of accessing therapies to the lack of knowledge and positive beliefs by patients regarding their effectiveness[15].

Currently, SUS offers 29 types of integrative and complementary practices in an integral and free way for the population. However, the distribution of these practices is insufficient, occurring in about 56% of Brazilian municipalities, since the PNPIC describes the general guidelines for their incorporation, but it does not provide financial and administrative investment for their implementation, being configured as one of the few public health policies without its own budget. The elaboration of technical norms for insertion and the definition of financial

Table 2. Mean and standard deviation of the scales and items of the Quality of Life Questionnaire-Core30 instrument. Uberaba (MG), Brazil, 2016–2018.

Scales and symptoms	Average	Pattern deviation
GSH	61.98	23.68
CF	70.44	34.27
SF	67.05	34.21
PF	60.57	31.29
EF	60.16	33.59
RP	52.37	38.62
LAP	33.92	40.31
FAT	33.56	29.96
Pain	31.68	32.99
INS	30.29	37.81
NAV	17.44	26.41
CON	16.35	31.49
DYS	14.29	28.71
DIA	11.62	25.81
FD	29.92	37.40

Source: prepared by the authors, 2018.
GSH: general state of health; CF: cognitive function; SF: social function; PF: physical function; EF: emotional function; RP: role performance; LAP: loss of appetite; FAT: fatigue; INS: insomnia; NAV: nausea and vomiting; CON: constipation; DYS: dyspnea; DIA: diarrhea; FD: financial difficulties.

resources for its implementation, including the definition of practices to be offered, is the responsibility of municipal management. In addition, the PNPIC has prioritized the incorporation of therapies in primary health care with a 78% coverage, while 16.7% of the therapies offered are in services of medium complexity — specialized clinics and polyclinics — and 3.4% in hospital and high complexity care[16].

In July 2018, the hospital where we conducted this research established the Nucleus of Integrative and Complementary Practices (NUPIC) in the institution and started to structure operational functions for its operation, aiming at serving internal and external clients to the hospital complex[17]. However, the data collection of this study ended in September 2018, when only Reiki was carried out by volunteers, who attended the chemotherapy center once a week, offering this practice to patients.

In addition, patients may not adhere to therapies due to unavailability and lack of knowledge about the existence and therapeutic effects of these practices; personal philosophies/beliefs when using therapies, mainly with negative reflections about the consequences of use in conjunction with conventional allopathic treatment; influence of other people and scarce time for their performance. In addition to the preference for practices that have satisfactory results more quickly, since dissatisfaction related to inefficacy and the presence of adverse effects may result in a view of the uselessness of these therapies, which consequently compromises their use and/or their continuity[15].

Table 3. Types and amount of spiritual practices performed by the sample. Uberaba (MG), Brazil, 2016–2018.

	Characteristics	Total n (%)
Types of spiritual practices	Prayer	57 (20.7)
	Healing touches	36 (13.1)
	Energization of water	23 (8.4)
	Promise	14 (5.1)
	Blessing	10 (3.6)
	Spiritual surgery	10 (3.6)
	Religious groups	7 (2.5)
	Others	6 (2.3)
	Total	**163 (59.3)**
Amount of spiritual practices	A practice	51 (18.5)
	Two combined practices	26 (9.5)
	Three combined practices	11 (4.0)
	Four combined practices	4 (1.5)
	Five combined practices	1 (0.4)
	Six combined practices	1 (0.4)
	Total	**94 (34.2)**

Source: elaborated by the authors, 2018.

Another issue is that a large number of people who use these practices do not inform health professionals of their use — type, time, desirable and undesirable effects — mainly due to fear of trials and reprisals, thus generating, in addition to underreporting, possible health problems related to negative drug interactions of these therapies with conventional treatment[18,19].

Regarding spiritual therapies, although 96% of patients report having a defined religion and being practitioners, there is a great inadequacy of their practices justified by the daily life of the disease and the chemotherapy treatment, since only 32.4% of patients perform spiritual practices, even if some practice more than one type and in combination.

This may be related to the way faith, religion and spirituality are employed in stressful situations such as cancer, since this confrontation can result in both positive and negative strategies. In the latter case, there is a prevalence of anguish and spiritual struggle related to hopelessness and fear about the uncertainty of the future, with harmful consequences and actions such as questioning the existence and power of God, believing that illness is a divine punishment/chastisement, hoping that God will solve all problems, among others[4].

Patients also express religion and spirituality in a number of different ways within affective contexts — related, for example, to religious conflict, guilt, spiritual and existential well-being–; behavioral — related to religious practices and religious and spiritual involvement — and/or cognitive — related to meaning and cognitive orientation in relation to spirituality and beliefs, for example. Furthermore, these contexts still vary according to gender, age, race, type of cancer, stage, type and phase of treatment, health recovery or disease progression[20].

In agreement with these justifications and with the result of this research, a study[21] found a high rate of spiritual distress nursing diagnosis (42.2%) in elderly oncologic patients, especially in those with shorter diagnosis time and chemotherapy treatment. Although all participants have a defined religion and 71.1% of the sample affirm that spirituality and religion are important and very relevant in their lives. In addition, about 44.4% of the elderly reported that the importance of spirituality and having a defined religion did not change after the discovery of cancer and 2.2% reported less importance after disease.

Furthermore, few patients receive any kind of instruction, support and spiritual intervention during the chemotherapy treatment. According to one study[22], about 93% of patients consider the spiritual care approach important, 80% would like to receive some kind of spiritual assistance, but only 16% received some kind of spiritual intervention. A similar fact occurs in this research, since the referred chemotherapy center has a voluntary group that applies a healing touch once a week, but the number of patients who perform spiritual therapies is low. Demonstrating that this action is not enough to satisfactorily address the spiritual needs of the sample.

As for the evaluation of HRQL, the high value in standard deviations of the analyzed functions and predominant symptoms highlights a heterogeneous sample. Thus, although there is a high number of patients who experience the analyzed functions and symptoms, there is also a significant number of individuals who do not experience the researched symptomatology or experience an insufficient intensity to negatively impact HRQL.

The scales of emotional function and paper performance were the ones that obtained the lowest average scores, despite satisfactory results. This shows that patients may be stressed, depressed, worried and/or irritated about the treatment and their health conditions. The average of the item financial difficulties resembles the symptoms, indicating that although the treatment is offered by SUS, it is complex and expensive, and may cause financial concerns[14].

A survey[23] showed compatibility both in the scales of physical, cognitive, social, emotional, and role-playing functions, with satisfactory results and in the items of symptoms, with the presence of insomnia, fatigue, and loss of appetite, although there are differences in the order of their prevalence. In another study[14], despite the presence of the same symptoms, their intensities were high — fatigue (64.57), insomnia (56.90) and loss of appetite (50.71). Furthermore, there were unsatisfactory results regarding the functions with a mean variation between 54.81 and 41.18.

The limitations of this study are perceived as its non-experimental model, cross-sectional design and performance in a single chemotherapy treatment center. Thus, it was not possible to compare the use of integrative and spiritual practices between control and experimental groups, in order to observe possible beneficial effects and undesired effects. In addition, it was not possible to see the possible variations of the therapies used throughout the chemotherapy and cancer treatment nor whether the results found are compatible with other sites and contexts.

CONCLUSION

Integrative and spiritual practices can provide control and increase HRQL of cancer patients, since they help in the control of physical symptoms and enable psychological, social and spiritual well-being, thus ensuring the construction of senses for the disease that allow them to confront, helping in effective decision making. Among the 275 patients interviewed, although there are satisfactory rates in the evaluation of HRQL, only 13 subjects performed some kind of integrative practice and only 94 practiced spiritual

therapies, although 164 individuals reported the presence of a defined religion, which may indicate instability of the biopsychosocial-spiritual control.

Most patients are unaware of the types and numerous benefits of these practices in controlling treatment and disease. Thus, nursing has an essential role in the planning of care with the disclosure, guidance, monitoring and control of these therapies. However, professionals need to have the safety and knowledge to transmit, through open conversation, without judgment and with respect to existing beliefs and values, the appropriate information of the practices according to the individual needs of each patient. In addition, the monitoring of therapies is crucial to ascertain the results achieved and to make sure that positive effects are present.

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