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Original Article

Religiosity, spirituality and the facing of cancer: a phenomenological study[1]

Religiosidade, espiritualidade e a vivência do câncer: um estudo fenomenológico

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Abstract

Different strategies are used by people with cancer to deal with the various events resulting from this condition, among which, spirituality/religiosity is an important aspect to be considered. In this article, we present the results of a research that aimed to understand how patients with cancer and in palliative care experience spirituality/religiosity in the treatment process and how this dimension manifests itself in coping with the disease. The qualitative research with phenomenological orientation was carried out in a hospital in the city of Belém-PA and involved six patients diagnosed with cancer admitted to the Oncology Palliative Care Clinic - CCPO. The data was obtained through semi-directed interviews recorded in audio, later transcribed and analyzed according to Ricoeur's hermeneutics from units of meaning. The main results point to spirituality/religiosity as a coping strategy in the face of the state of illness and hospitalization. This dimension is evident in the routine of patients who maintain involvement in individual and collective religious activities during treatment. The religious experience in the hospital environment proved to be a way to face the illness process and a device through which individualized strategies are created to minimize suffering.

Keywords: Religion, Spirituality, Cancer, Occupational Therapy.

Resumo

Diferentes estratégias são utilizadas por pessoas com câncer para lidar com os variados eventos advindos dessa condição; dentre elas, a espiritualidade/religiosidade tem se mostrado um aspecto importante a ser considerado. Neste artigo, apresentamos os

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resultados de uma pesquisa que objetivou compreender como pacientes com câncer e em cuidados paliativos vivenciam a espiritualidade/religiosidade no processo de tratamento e o modo como essa dimensão se manifesta no enfrentamento da doença. A pesquisa qualitativa de orientação fenomenológica foi realizada em um hospital na cidade de Belém-PA e envolveu seis pacientes com diagnóstico de câncer internados na Clínica de Cuidados Paliativos Oncológicos – CCPO. A obtenção das informações se deu por meio de entrevistas semidirigidas gravadas em áudio, posteriormente transcritas e analisadas de acordo com a hermenêutica de Ricoeur, por meio de unidades de significação. Os principais resultados apontam para a espiritualidade/religiosidade como estratégia de enfrentamento diante do estado de adoecimento e da hospitalização. Essa dimensão se mostra patente na rotina dos pacientes que mantêm o envolvimento em atividades religiosas individuais e coletivas durante o tratamento. A vivência religiosa no ambiente hospitalar se mostrou uma via para o enfrentamento do processo de adoecimento e um dispositivo por meio do qual se criam estratégias individualizadas para a minimização do sofrimento.

Palavras-chave: Religião, Espiritualidade, Câncer, Terapia Ocupacional.

Introduction

The occurrence of different types of cancer is currently a global public health problem and is among the four leading causes of death before the age of 70 in most countries. In Brazil, estimates indicate that there will be 625 thousand new cases in the triennium 2020-2022. These malignant neoplasms encompass more than a hundred diseases that are characterized by the disordered growth of cells that invade tissues, determining the formation of tumors that can proliferate through the human body in the form of metastasis (Instituto Nacional de Câncer, 2019).

Patients who receive a diagnosis of cancer usually react differently from those who receive diagnoses of other pathologies (Penna, 2004). The news that attests to the neoplastic disease brings with it the materialization of the suffering of those who are suddenly faced with the possibility of death and the social stigma surrounding cancer (Hart, 2008).

A study of women who were diagnosed with breast cancer revealed that during the period of diagnosis, reactions and feelings ranged from indifference to real fear. The time taken for examinations and confirmations is translated into the form of anxiety, feelings of helplessness, thoughts about death, panic, etc. (Bergamasco & Angelo, 2001). These are painful experiences that can generate uncertainty, anguish, disbelief, questioning, and late acceptance of their condition and reality (Silva & Zago, 2005).

This and many other forms of neoplastic manifestations do not have, to this day, an effective curative treatment, even currently, more advanced tests for early detection, less invasive surgeries, and increasingly efficient therapies result in the cure of many types of cancer, especially when treated at early stages (Instituto Nacional de Câncer, 2019).

Currently, although the main treatment option is surgical, the available methods usually involve the combination of more than one therapeutic resource to contain the

disease and offer a better quality of life to those affected. However, many procedures tend to leave lasting physical and psychological marks on the patient, whether due to the emotional stress resulting from the frequent episodes of hospitalization or the invasive procedures to which they are often submitted (Galbiatti et al., 2013).

Different strategies are used by people with neoplastic disease to deal with the various events arising from this condition that, in general, involve physical and occupational restrictions, and acute pain, in addition to the possibility of death. These occurrences can generate suffering of different kinds and, as a consequence, questions about finitude, the meaning of life, and other issues that demand the need for (re)signification of existence (Johannessen-Henry et al., 2013).

Religiosity/spirituality is one of the ways pointed out by the specialized literature among those that can contribute to how people with cancer deal with issues related to the disease and that contribute to improving the quality of life (Aquino & Zago, 2007; Koenig et al., 2001; Fornazari & Ferreira, 2010).

Religion, Religiosity, Spirituality, and Cancer: an Incursion

Some authors (Ancona-Lopez, 2005; Amatuzzi et al., 2006; Koenig et al., 2001) pointed out the dissent on demarcating the boundaries between religion, religiosity, and spirituality as an indication of the need to circumscribe these concepts. It is a design that aims to enhance communication between patients, therapists and researchers, also favoring the delimitation of the clinical or research object (Ancona-Lopez, 2005; Araújo, 2015; Freitas, 2017).

This task requires a debate that is beyond the scope of this text if we consider the similarities, the divergences fostered by different influences, and the wide range of related topics. However, even at the risk of oversimplifying this intricate web of meanings, we can consider religion as "[...] the fundamental cultural characteristic of peoples, as well as the mark of their practical behavior" (Bello, 1998, p. 103). It manifests as an organized representational system of beliefs, symbols, dogmas, rituals, and practices that seek to facilitate access to the sacred and constitute the personal and social identity of individuals (Ribeiro, 2004; Araújo, 2015).

Spirituality is related to the search for meaning, to an ontological transcendence, to the immersion that one makes in oneself, and which is related to deep values and meanings that govern the "self", which is not always compatible with the religious search (Giovanetti, 2005).

Religiosity is linked to the conception of the divine, a procedural nature, and can be related to the way an individual believes, follows, and practices a religion (Araújo, 2015). In Safra's (2005) conception, religiosity is complex, broad, and present in human subjectivity at ontological and ontic levels. As a dimension of human existence, it precedes historical-social formulations of religions (Alves, 2004).

The complexity of the terms religion, spirituality, and religiosity place us in a field that, despite tending to ambiguity and polarization, in individual experience, takes on its meanings, often amalgamated and manifest in different types of language (Amatuzzi et al., 2006; Pargament, 1997).

The poet and philosopher Adélia Prado (Prado, 1999, p. 19) accurately translate this question by stating that:

> Religious experience in everyday life is always paradoxical, as is a mystical experience because it is an attempt to speak of the ineffable, of what cannot be said and which has no words. So, this is the human struggle: it is to say, to try to say something that cannot be said because of its very nature.

Freitas & Vilela (2017, p. 100), in an attempt to "[...] synthesize the appropriate differentiations, connections and distinctions between the terms spirituality, religiosity, and religion, created a synthesis figure, seeking to integrate the contributions of different authors who have invested in this direction" (Figure 1).

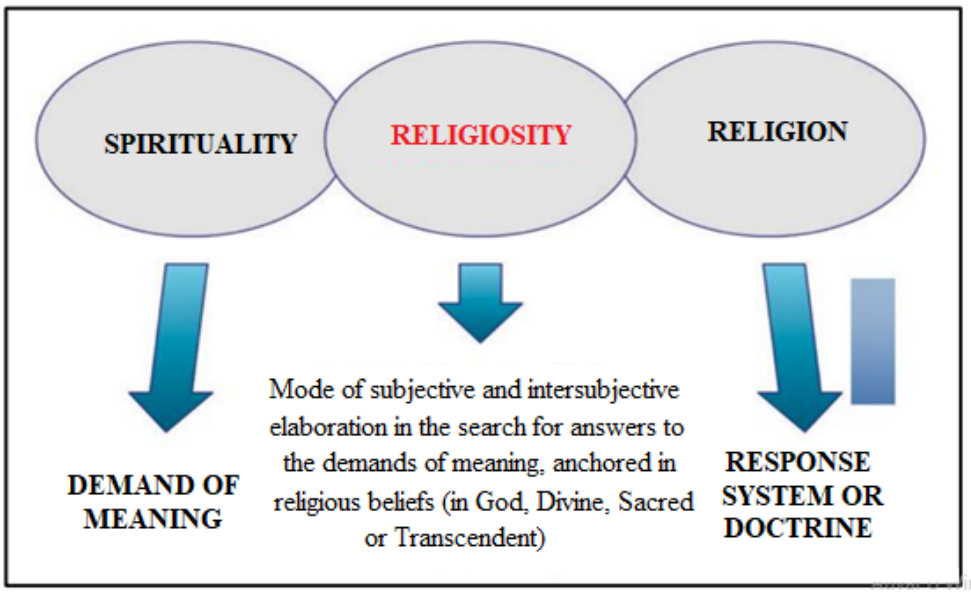

Figure 1. Conception of religiosity. Source: Freitas & Vilela (2017).

The conception of this representation considers that (Freitas & Vilela, 2017, p. 100-101):

> [...] religion is one of the possible alternatives for finding the answer to the spiritual dimension, as a search for existential meaning. It is a type of response that is shared and institutionalized. On the other hand, the term religiosity is, therefore, reserved to refer to the personal way, in which each person subjectively elaborates their responses to their demands for existential meaning, even though they are also anchored in the belief in the transcendent. Such responses may, in turn, be or may not be anchored in a specific system of religious beliefs [...] religiosity and religion both necessarily imply a reference to the transcendent, and in the second, the response is shared and institutionalized, regardless of whether it is organized according to the model of traditional religions or shown in new forms of religious expressions, according to historical, ethnic, temporal and cultural variations. Meanwhile, spirituality implies a reference to the search for meaning, which may or may not coincide with the religious search, with the possibility that the answer to

> this existential demand comes from another source, considered and experienced by the person as non-religious.

It is important to highlight that this theme has been of great relevance for occupational therapy, as it refers to dimensions that are part of the human condition and that can be expressed through occupations. Therefore, they have the potential to influence health, good living, and engagement in the world of life (Christiansen, 1997; Araújo et al., 2014).

Even before successive versions of the American Occupational Therapy Association (AOTA) "Structure of Occupational Therapy Practice: Domain and Process", a document widely known in the profession for guiding practice based on scientific evidence, stood out, in the same year 1997, the American Journal of Occupational Therapy and the Canadian Journal of Occupational Therapy, with editions specially dedicated to the theme of spirituality in the scope of occupational therapy – volume 51, number 3, of March 1997, and volume 64, number 3, of June 1997, respectively. They showed that the discussions on the subject in the formation and performance processes of occupational therapy precede the contemporary frames of reference.

Currently, in its fourth version, the "Structure of Occupational Therapy Practice: Domain and Process" cites spirituality as an "[...] experience of deep meaning that arises through involvement in occupations that imply the representation of personal values and beliefs, reflection and that of intention within a safe contextual environment" (Billock, 2005, as cited in Gomes et al., 2021, p. 17). According to this document, it is a factor that influences patients' motivation to "[...] engage in their occupations and give meaning to their life or existence" (Gomes et al., 2021, p. 17).

The approach of the spiritual/religious dimension in the context of research and professional practice and studies on the association between factors related to religiosity, religion, spirituality, and health, have been increasingly frequent in recent decades, not only in the occupational activity profession, an occurrence that may reflect the need to produce knowledge in this area (Koenig et al., 2001).

If we take into account the relevance of the theme in different societies, mainly based on the contexts in which the beliefs, attitudes, and practices implied by the sacred turn into health problems, we can have indications of fundamental characteristics of a culture or a cultural complex that involves certain individuals and populations (Gonçalves, 2016).

During advanced diseases without response to modifying treatments, palliative care is a process whose relevance to spirituality/religiosity tends to be considered. It is total active care for patients whose disease is no longer responsive to curative treatment in a context in which the control of pain, other symptoms, and psychosocial and spiritual problems is paramount. The objective is to provide the best possible quality of life for patients and their families, promoting the relief of suffering (Carvalho & Parsons, 2012).

In the case of people with cancer in palliative care, patients and family members often seek support in religious or spiritual beliefs as a way of dealing with difficulties and finding comfort. However, this finding, by itself, does not imply a consensual approach to these dimensions by professionals working in the field of oncology, nor does it indicate that the theme is part of the fields of interest of those who work with

this public. This is partly due to the difficulty in approaching spirituality/religiosity in daily clinical practice (Balboni et al., 2013).

In a context in which the experience of physical suffering tends to accentuate emotional fragility and the fear of death, involvement in religious and/or spiritual activities can mobilize the individual to deal more positively with situations that generate anguish and discomfort (Argyle, 1990).

Several studies have identified, in the speeches of cancer patients in palliative care whose treatment was permeated by stressful situations, contents that corroborate the positive influence of spirituality/religiosity in the experience of cancer. These studies show that patients used spiritual/religious coping as a strategy to reduce stress in the face of the relationship between the disease and the possibility of death, which directly contributed to improving their quality of life[2] (Koenig et al., 2001; Fornazari & Ferreira, 2010; Johannessen-Henry et al., 2013).

Thus, in this article, we present the results of a research that aimed to understand how patients with cancer and in palliative care experience their spirituality/religiosity in the treatment process and how this dimension is manifested in coping with the disease.

Method

This is qualitative research with a phenomenological and hermeneutic orientation, aimed at understanding non-quantifiable phenomena of human experience. Therefore, it does not use coding and tabulation programs for the analysis of empirical data (Muchielli, 1991).

The phenomenological method focuses on studying the phenomenon, something that takes place and is shown through a dynamism that does not exclude its cultural and institutional circumscription while trying to understand it through a world lived in common. In this sense, the objective of the phenomenological method is to describe the lived experience and the meanings of the experience for the subjects who experience it (Martins, 1993; Araújo, 2015).

Hermeneutics, when affiliated with the phenomenological approach, is based on the thesis that the lived experience is in itself an interpretive process. In this conjunction, the phenomenological task is to show the ways of being in the world, whose understanding of communication between people is interpreted through the use of language (Cohen & Omery, 1994).

Six patients admitted to an oncology referral hospital in the city of Belém-PA participated in the research, four female, and two males, with a mean age of 45 years old, and all residents in the metropolitan region. Data collection took place at the Oncological Palliative Care Clinic - CCPO, from August to December 2018.

The inclusion criteria in the study were: being aware, oriented, and accepting to participate in the research by signing the Informed Consent Term – ICF. The exclusion criteria were applied to those patients eligible for the research, but who had some clinical

[2]It is important to mention the counterpoint established by studies that indicate worse prognoses, exacerbation of stress and fear of death, usually associated with punitive thoughts through the patient's religious conception. Therefore, it must be considered that not necessarily spirituality/religiosity can contribute to quality of life, but its meaning for each person in their uniqueness (Moreira-Almeida & Cardeña, 2011; Medeiros, 2010; Marques, 2003; Melo et al., 2015).

condition that made it impossible for them to understand, reflect and/or make statements about their experience.

One of the basic principles of the qualitative method of phenomenological orientation is the deepening of the details of the lived experience (Goldenberg, 2003). Thus, the sample size is not defined by a sampling method based on statistical procedures, but by the saturation criterion that considers the quality of the information as an analytical framework that the information from that context and/or phenomenon does not add to the objective of the study (Muchielli, 1991). Thus, the choice of participants was based on convenience and saturation.

The strategy adopted to obtain the information was to carry out semi-structured interviews, which took place in such a way that the researcher could partially point out the direction in which the interview would go. In this case, the direction was alternated between the researcher and the interviewee, so that the latter could also take command of the dialogue at certain times (Turato, 2013).

The interviews were conducted in the hospital bed and involved ten guiding questions: 1) Do you consider yourself a religious person? Why?; 2) Could you talk about your religious history?; 3) How did you receive the news of the cancer diagnosis?; 4) How do you feel about the diagnosis?; 5) What are your expectations for the future?; 6) Do you usually participate in any religious activities at the hospital? Describe it; 7) Do you feel that something has changed in your spirituality/religiosity after your cancer diagnosis?; 8) How do you feel about your spirituality/religiosity at this moment in your life?; 9) Have you noticed any difference in your ability to deal with cancer due to any religious practice?; and 10) Do you receive any support and/or religious encouragement at the hospital? How does this happen?

The dialogues were audio recorded, later transcribed, and analyzed according to the foundations of Ricoeur's theory of interpretation (2009). This hermeneutic-based theory allows understanding and linguistic interpretation as the basis for the conception of all types of text interpretation, that is, it is a process that interprets an underlying content or meaning through the use of languages. For Ricoeur (2009, p. 74), discourse can be understood as an event and as meaning. In this way, what we intend to understand is not the event, "[...] insofar as it is fleeting, but its meaning that remains".

The information was analyzed based on units of meaning that constitute a mode of analytical structuring used to group, describe, interpret and understand the content of discursive origin, allowing for a deeper understanding of the meanings of shared experiences at a level that goes beyond common reading.

To maintain anonymity, in the transcribed excerpts of each interview, the participants were identified by pseudonyms assigned by themselves: Rosa, Bernadete, Ana, Ester, João, and Douglas. The transcripts of the audio-recorded interviews were made in full, keeping the grammatical and semantic construction of each collaborator.

The research was submitted and approved by the Ethics and Research Committee with human beings, under opinion number 2,008,748.

Results and Discussion

The set of interviews transformed into text enabled us to present and discuss the information obtained based on four units of meaning: Meanings of being religious;

Spirituality/Religiosity and the experience of cancer; Links between death and religious experience; and Religious practices and the hospital context.

Senses of being religious

The set of informants' speeches shows us different meanings about the way they understand their religious condition. In general, these inclinations are linked to belief in or involvement in activities linked to a system organized around the veneration of a deific figure. Thus, religious self-image seems to be linked to the fact that they perceive themselves as someone who believes in God.

Ana is one of the informants who defines herself as a religious person through these terms.

> ***I consider myself religious because I believe in God. And for being here, alive***, *right now* (Ana).

In addition to her belief in a deity, Ana says she considers herself religious for "*being here at this moment*", associating her cancer survival, in some way, with her religious experience. How he expresses his point of view allows us to infer that the inversion of the locution can also manifest one of the meanings of his religious self-image, that is, the act of perceiving himself as a religious person is reinforced by the testimony of the "effects" of this experience that, understood as a landmark event, it may or may not lead to speculations about the meaning of its existence (Baungart & Amatuzzi, 2007).

Another important aspect associated with this type of experience is the feeling of dependence on Another that transcends the limits of the human knowable spectrum. Collaborator Ester exemplifies this type of relationship:

> ***I don't consider myself religious.*** *I believe... I believe in God. I'm not that person who fights for religion. It's me and God. I attend church, but my church is me and my shield is Jesus,* ***my target is Jesus****. The world may be falling, but He is my strength* [...] (Ester).

Unlike Ana, Esther does not consider herself religious because she believes in a deity. In this way, she moves away from the perception of herself as a religious person and attributes the "religious being" to derogatory events of a religious experience demarcated by religious conflict. Her positioning also announces a religiosity that is not an end, but a means to achieve something like sustenance, support, consolation, forgiveness, sociability, prosperity, and, in her case, "strength" in the fight against the disease (Amaro, 2014).

Ana and Ester's discourses seem to establish, each in their way, a relationship of proximity with the Divine and corroborate the vision of Gaarder et al. (2000), that the religious experience takes place in the relationship between man and the superhuman power in which he believes or feels dependent. The emphasis of phrases such as "I believe in God" shows that the participants have a connection with the divinity that figures among their existential demands of the moment and can reinforce the thesis that

spirituality/religiosity can manifest as a human propensity to search for meaning in life through ways that transcend the tangible (Guimarães & Avezum, 2007).

Another way in which the research participants perceive themselves from a religious point of view seems to be conditioned to past or future participation in rituals that demarcate their formal religious attachments.

> *I'm Catholic. For me to consider myself, like, evangelical,* ***I have to be baptized in water****. When I am baptized in water, then I will belong to Jesus forever. So, I'm an evangelical* (Bernadete).

> *I consider myself a religious person* ***because I have been baptized*** *with God.* ***I was married*** *to God. That is why* (Douglas).

For Douglas and Bernadete, the maintenance of a certain religious identity is closely linked to the participation in rituals that symbolize and, in a certain way, also formalize the affiliation in the religion they have chosen, in addition to allowing adherents of different religious traditions to enter the divine world, bringing it closer to human reality.

The religious ritual, exemplified here by the baptism of Christian reference, marks for these people the seal they need to feel part of this or that religious orientation. In this context, there is no way to despise the role of religions in the construction of their personal and social identities, considering the potential that these systems have to give meaning to human values that, reflected in their experiences, can produce the expansion of consciousness necessary for important transformations (Ribeiro, 2004).

Spirituality/religiosity and the experience of cancer

The way each person experiences the illness process depends, among other things, on personal attributes, such as health and energy status, belief system, life goals, self-esteem, self-control, self-knowledge, and social support networks, domains in which spirituality/religiosity can play an important role (Pedrolo & Zago, 2002).

Participants Bernadete and Ester indicate that they use religious resources as a support strategy for coping with the cancer experience.

> *When I received the news,* ***I, as a Catholic****, did not despair. I became normal. Some people despair, right? If you surrender, you become someone else. I do not. I stayed in the same, in the same state that I received* ***I accepted****. I had to accept it. So, until now God is working.* ***In the first and until the end I know he will act*** *in a good way.* ***I believe*** *that, in the name of Jesus, my treatment will be great* (Bernadete).

> ***I looked and said: this was for the honor and glory of the name of the Lord Jesus.*** *I didn't cry, I didn't despair, I just found it funny. I didn't despair at all. It's no good to cry,* ***it's good for you to trust God that everything can.*** *That's what I think to this day* (Ester).

The reports of the two participants indicate that belonging to a certain religion can have a positive impact on their cosmovisions and, therefore, on the way they deal internally with the impact of the diagnosis (Geronasso & Coelho, 2012).

When starting the report affirming her religious connection, Bernadette gives indications that her reaction would be, according to her conception, the one expected of someone of the Catholic religious orientation, in which expressing despair and anguish could seem incompatible. This foreshadowing allows us to conjecture that the way he reacted to the news of the cancer diagnosis is related to a worldview outlined by his religious experience (Amaro, 2014; Araújo, 2015).

Esther seems to hold a similar attitude towards the diagnosis. Her opposition to despair reveals hope, and optimism and designates the particular attitude of his religious dynamics (James, 1911). Therefore, Bernadette and Ester, while depreciating the diagnosis received, demonstrate apparent tranquility: *"I believe", "God who can do everything",* manifesting the belief in divinity as the main factor associated with the feeling of hope, optimism, and positive expectations. In a way, at least immediately, it is possible to attribute to the informants' spirituality/religiosity the restrained posture adopted in the face of initial suffering triggered by the news of the cancer diagnosis.

In this context, what some authors call Religious/Spiritual Coping - RSC is established, which is characterized by the use of spirituality, religiosity, or faith to deal with stress and life problems (Panzini & Bandeira, 2007). For Pargament (1997), CRE aims to search for meaning, control, spiritual comfort, intimacy with God and other members of society, life transformation, and search for physical, psychological, and emotional well-being.

However, for other research collaborators, the experience of the first contact with the pathology was more difficult, mainly due to the projection of a scenario marked by the possibility of death.

> *It's* ***a very strong impact. It took me a long time to accept****. The first thing I thought of was my family. In my children mainly. How would they look. If I was going to die soon, if I was going to die tomorrow, it would be a lot of work* (Ana).

> ***It was*** *horrible. It was the worst thing. It was as if I had received a "tomorrow you will die" trophy. I just broke down in tears. I cried a lot. I thought about death, I thought about my children, my family, anyway... I was desperate* (Rosa).

> ***I was devastated****. I didn't want to treat me. I don't know... something happened to me, a big nervousness I didn't want to do. I gave myself to her [disease], but I didn't do it* [treatment] (João).

For the informants Ana, Rosa, and João, spirituality/religiosity seems to play another role in the experience of cancer. As they continue in their speeches, the rescue of their religious stories announces that previous experiences remain alive and activate new meanings to life and the experience of living with a serious and potentially fatal disease.

> [...] ***At first, I rebelled****. But after joining the prayer groups, I accepted. Accepting because I believe God has a purpose for my life.* [...] *I began to value my life* (Ana).

> *I wanted to have an Our Lady of Nazareth in my hands and I had one in my hand. I am feeling very happy.* [...]. ***Today I don't suffer*** (João).

The rescue of experiences related to spirituality/religiosity is a strategy commonly adopted by cancer patients to face the disease, and many of them become more religious after diagnosis (Carvalho, 2008). Furthermore, spirituality/religiosity can also provide explanations or frames of reference for understanding illness (Inoue & Vecina, 2017). In these cases, the intensity of involvement in liturgies and the approximation of religious symbols contribute to the construction of a structure that allows a reflexive expansion of the meanings and senses of existence and finitude.

In this perspective, the relationship with the sacred can help in the way of dealing with the demands arising from the illness and favoring the capacity for resilience, the recognition of potential, and the feeling of hope (Amaro, 2014).

This coping strategy is predominant in a large part of the population affected by cancer and appears as an important ally in situations considered difficult, such as diagnosis and stressful events (Fornazari & Ferreira, 2010).

Links between death and religious experience

The theme of death appears in the informants' speeches spontaneously and, in general, terms seem to relate to their religious experiences in two ways. In the first, the religious/spiritual dimension emerges as support that sustains the denial of death, generates an attitude that overcomes fear, and accentuates the belief in the cure of the disease.

> *It certainly won't happen [death]. I believe, I believe... I believe...* ***I'm not afraid****... I'm not afraid at all... because my faith in Jesus is greater. [...] He cured me of the first one, he will cure me of the second one, and I anything else,* ***I believe in the name of Jesus****...* (Bernadete).

> *The day I go [to die] I'm sure where I'm going. I go to glory. It's no use getting the tension ahead of time.* [...] *We are dust and to dust, we will return. That's it.* ***I'm not afraid****. It's... To be born, grow, and die* (Esther).

Fear is often the most common psychological response to the possibility of death; in this field, patients face a better death when they have a religious belief (Kovács, 2008). On this issue, Safra (2018) adds that, in the process of crossing this experience towards the future, the referral of illness can move to the field of spirituality and suffering translates into both language and meaning.

Therefore, the religious experience of Ester and Bernadette seems to provide the necessary elements for the (re)signification of death manifested in the symbolism of religious language.

The second form evidenced by the informants regarding the relationship between the theme of death and their religious experiences announces the influence of the religious/spiritual dimension in a process of acceptance of death and the conviction of the continuity of *post-mortem* life.

> *It's enough for us to die, we're alive, isn't it? And if it's His will, we'll go, right?* ***We got closer to God****.* [...] *Nowadays I don't think about salvation, because when I die, I will be saved* (João).

> *When she [death] arrives* ***I have the conviction****, I wait, right? That as our* [Christian] *religion says I go to live in heaven with Jesus* (Ana).

> *If God takes me, anyway, from this illness or another...* [...] ***When I die He will take care of my life****. Of my life, no, my spirit* (Douglas).

The fact that the theme of death is tangent to the discourses analyzed adds to the studies that establish that patients with malignant neoplasms tend to associate the disease with imminent death, which often leads them to manifest signs of anxiety and intense suffering (Melo & Caponero, 2009).

Values and beliefs can be related to the processes of death and dying in two ways: collaborating in the preparation for death or increasing the difficulty in facing dying (Carvalho, 2008). The denial of death and, therefore, the minimization of its meanings is one of the ways of not having to deal with the painful face of this experience. It is a rationalization mechanism that happens when we deny what we cannot deal with or deal with indifference to things that go beyond our ability to explain (Ribeiro, 2004). However, despite being able to give the impression of strength and control, in practice, this is an action that can be followed by poor mourning (Cassorla, 1999).

Finitude, although inevitable, triggers several personal questions and, in this sense, spirituality/religiosity can present as a "[...] point of convergence where it is possible to find answers to existential questions" (Ribeiro, 2004, p. 31).

Death has always been a great mystery to humanity. In an attempt to understand it and find answers to this phenomenon, man, since ancient times, seeks in religions and other symbolic systems support and explanations about his finitude and especially about the possibility of continuing life after death (Silva et al., 2012).

For Christians, death represents the passage to another way of life, an eternal life. Belief in these attributes conveys the feeling of comfort in which João, Ana, and Douglas' speeches are organized. In this way, guided by their religious dogmas, these patients demonstrate that they find subsidies to believe that death brings joy and happiness, as it will be the day, they will have a meeting with their creator. In this perspective, life and death intertwine and finitude comes to represent, in a summary way, only the end of the body as matter (Brustolin & Pasa, 2013). In summary, "[...] religious experience is at the heart of human experience" (Ribeiro, 2004, p. 23), including the experience of the possibility of death and dying. Given this, the research informants are people who, imbued with a peculiar religious census, attribute meanings about the disease process and human finitude, which are shared by the religious systems to which they declare a link: therefore, they manifest themselves through a "[...] consciousness transformed by the experience of the numinous" (Jung, 2012, p. 21).

Religious practices and the hospital context

The set of speeches enabled us to verify that, in the hospital routine, all employees practiced religion during the period of hospitalization. The involvement of patients in these activities took place through a vast repertoire that involved prayers, Bible reading, and participation in liturgies through radio and television programs.

These actions took place in different spaces of the hospital environment, usually limited to the bed or outside the wards. The first situation is related to the personal practice of religious activities related to the religious system in which they participate and according to the degree of involvement with these systems. In the space of the wards, there are also visits by religious volunteers who provide spiritual/religious assistance to those who are willing to receive them.

> *When I get up in the morning I sit in my stroller [wheelchair]. I ask my sister to put me in front of her* [image of a saint]. ***Then I say my "little prayers" (sic). Every day I have to*** (João).

> *I* ***read the bible*** *and I've been trying to watch the masses on TV* (Rosa).

> *I have already received a visit from two pastors, each from a congregation.* ***They prayed to God****; they prayed the Our Father. They* ***put me in the anointed oil*** *and prayed* (Pink).

Religious assistance in public hospitals in Brazil is guaranteed by Law 9,982 (Brasil, 2000) and can be justified by the historical existence of religious assistance groups in these spaces. The religious assistance received by the research collaborators came mainly from voluntary religious representatives due to the lack of a hospital chaplaincy service in the organizational structure of the institution.

Although the practice of chaplaincy still does not fully work in the reality of our country, studies confirm the importance of caring from the perspective of this service, given that this mode of intervention stands as a possibility to fill the current gaps in the spiritual/religious assistance of the patients who are facing the imminence of death, especially in services where the professional hospital chaplain is inserted in the palliative care team like any other professional who proposes to meet the religious/spiritual demands of hospitalized patients (Pugh et al., 2010; Pedroso, 2018).

Concerning religious practices that take place outside the space of the wards, the participation in religious celebrations held in the chapel that is located within the hospital institution itself stands out.

Douglas is an example of a patient who, in addition to exercising religious practices when confined to bed, despite the general commitment to cancer, maintains, with the help of relatives who accompany him during hospitalization, the habit of frequenting the hospital's chapel space.

> *In addition to* ***going to the chapel, I pray with myself****. I pray my prayer which is the Our Father, which is the Ave Maria. I bless myself before going to bed when I get up. I bless myself by asking God to give me a good day* (Douglas).

According to Elmescany & Barros (2015), the experience of cancer and its different stages of treatment occupies a central place in the daily life and concerns of the affected subjects. It also implies disruptions in the individual's life and various physical, psychological, social, and occupational repercussions that require patients to adapt and cope. In this sense, the presence of the Catholic reference chapel inside the hospital allowed the patient to express and maintain their religious practices and rituals despite their experience in the hospital environment.

The intention of going to the chapel seemed to favor the rescue of a significant occupation of her daily life: attending masses in Catholic churches – an action that had been interrupted by the hospitalization process. The deprivation of these activities can have repercussions on the difficulty in meaning of life and affect their well-being and their religious expression (Elmescany & Barros, 2015).

Meaning and purpose are important dimensions that touch the structure of human occupations (Christiansen, 1997). This allows us to speak, in terms of Egan & DeLaat (1997), of a spirituality implicit in the practice of occupational therapy. This point of view argues that there are unnamed spiritual perspectives on the process of how and why occupational therapy takes place. Some of these factors would be the fact that the practice of occupational therapy reflects a concern with everyday life by favoring that its patients meet their needs through involvement in occupations so that they can connect and build meanings, which is important for both spirituality and occupation.

Also, the social vision of occupational therapy (Nilsson & Townsend, 2010, p. 58) works to ensure "[...] inclusive participation in the daily occupations of all people, regardless of age, ability, gender, social class or other differences", that is, the universal character of spirituality would be at the heart of the occupational therapy ethos: "[...] to care about people and their occupational natures" (Peloquim, 2006, p. 99).

Final Considerations

The spiritual/religious dimension of the human is still a topic that requires extensive discussion in academic spaces based on different epistemologies. It is necessary to broaden and deepen the debates that return to the sacred in its religious/spiritual manifestation as a founding element of the human event and that can compose important support tools for those who experience different states of suffering.

The research presented in this article aimed to understand how patients with cancer and in palliative care experience their spirituality/religiosity in the process of treating the disease and how this dimension is manifested in coping with cancer. To this end, the contact with each of the participants, through listening to the report of their experiences, allowed us to identify that the spiritual/religious dimension mediated by the sacred plays numerous roles in the way they deal with the demands arising from the experience of cancer during hospitalization. hospital.

For some, it is support and hope. For others, calm and acceptance. Together, the way these people react, manage and deal with suffering through a positive copping of a religious/spiritual basis expands a hermeneutic horizon that goes beyond discourse and written text. It helps to decipher the great text of life with its rites, myths, and symbols, whether religious or not.

The maintenance of a routine in the hospital environment that offers conditions for the religious/spiritual expression of patients showed reverberations in the global quality of life of these people who, in addition to having their values and beliefs respected, were able to engage in an experience rich in meanings for their lives and that can prove to be singularly important in the evolution of their clinical condition and for the way they face illness and finitude.

These people seem to go against the grain of a process that desacralizes the world or that still points to a moral necessity for the existence of God. Their shared experiences as a personal ontology absorb existential demands that lead us to approach their ways of being in the world.

In this sense, the religious experience seems to have an impact on the way each research participant deals with the experience of cancer and the possibility of death, demonstrating that, in the face of anguish, fears, and concerns, they found, in a deific entity, the opportune transcendent element to share the emotional burden implicit in the illness process and proceed with the necessary lightness, for the development of a transforming experience.

Regarding the possibility of considering the approach of the spiritual/religious dimension in the occupational therapy process with cancer patients in palliative care, it is important to recognize spirituality as a dimension of the patient. This is perhaps the core value of the spiritual dimension in everyday life, which reiterates the need for an occupational therapy approach extended beyond the limits of the body and the subjective formation of the individual, so that "[...] spirituality is valued and recognized as an element capable of to influence the meaning of occupations and affect the occupational performance of patients" (Araújo et al., 2014, p. 04).

Some limitations of the study were the number of informants and the difficulties of accessing them from a phenomenological point of view among so many invasive procedures in a mass hospital routine, which certainly interfere with the necessary immersion that the genuine sharing of the lived experience requires. The approach of a family member to the religious routine of patients during the period before hospital admission is also recommended in future research on the phenomenon in focus with this population.

References

Alves, V. P. (2004). Fenomenologia da Religião: pesquisas sobre a experiência religiosa com universitários e suas implicações para o ensino religioso. In A. F. Holanda (Ed.), *Psicologia, religiosidade e fenomenologia* (pp. 79-95). Campinas: Alínea.

Amaro, L. D. S. (2014). *Resiliência, religiosidade e sentido de vida em mulheres com câncer de mama* (Dissertação de mestrado). Universidade Federal da Paraíba, João Pessoa.

Amatuzzi, M. M., Cambuy, K., & Antunes, T. A. (2006). Psicologia clínica e experiência religiosa. *Revista de Estudos da Religião*, *3*, 77-93.

Ancona-Lopez, M. (2005). A espiritualidade e os psicólogos. In M. M. Amatuzzi (Ed.), *Psicologia e espiritualidade* (pp. 147-160) São Paulo: Paulus.

Aquino, V. V., & Zago, M. M. F. (2007). O significado das crenças religiosas para um grupo de pacientes oncológicos em reabilitação. *Revista Latino-Americana de Enfermagem*, *15*(1), 42-47. PMid:17375231.

Araújo, L. (2015). *Religiosidade e saúde mental: enredos culturais e ecos clínicos.* Jundiaí: Paco Editorial.

Araújo, L. S., Oliveira, I. B. S., & Jaramillho, S. R. (2014). Espiritualidad em la práctica de la terapia ocupacional: interfaces en el campo de la ocupación humana. *TOG (A Coruña)*, *11*(20), 1-19.

Argyle, M. (1990). The psychological explanation of religious experience. *Psyke & Logos*, *11*(2), 267-274.

Balboni, M., Sullivan, A., Amobi, A., Phelps, A. C., Gorman, D. P., Zollfrank, A., Peteet, J. R., Prigerson, H. G., Vanderweele, T. J., & Balboni, T. A. (2013). Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses and physicians and the role of training. *Journal of Clinical Oncology*, *31*(4), 461-467. PMid:23248245.

Baungart, T. D. A. A., & Amatuzzi, M. M. (2007). Experiência religiosa e crescimento pessoal: uma compreensão fenomenológica. *Revista de Estudos da Religião*, *4*, 95-111.

Bello, A. A. (1998). *Cultura e religiões: uma leitura fenomenológica.* Bauru: EDUSC.

Bergamasco, R. B., & Angelo, M. (2001). O sofrimento de descobrir-se com câncer de mama: como o diagnóstico é experienciado pela mulher. *Revista Brasileira de Cancerologia*, *47*(3), 277-282.

Billock, C. (2005). *Delving into the center: women's lived experience of spirituality through occupation* (Tese de doutorado). Universidade do Sul da Califórnia, Los Angeles.

Brasil. (2000, 14 de julho). Lei nº 9.982, de 14 de julho de 2000. Dispõe sobre a prestação de assistência religiosa nas entidades hospitalares públicas e privadas, bem como nos estabelecimentos prisionais civis e militares. *Diário Oficial [da] República Federativa do Brasil,* Brasília, seção 1, p. 3.

Brustolin, L. A., & Pasa, F. M. L. (2013). A morte na fé cristã: uma leitura interdisciplinar. *Teocomunicação*, *43*(1), 54-72.

Carvalho, R. T., & Parsons, H. A. (2012). *Manual de cuidados paliativos.* São Paulo: ANCP.

Carvalho, V. A. (2008). *Temas em psico-oncologia.* São Paulo: Summus.

Cassorla, R. M. S. (1999). *Da morte: estudos brasileiros.* Campinas: Papirus.

Christiansen, C. (1997). Acknowledging a spiritual dimension in occupational therapy practice. *The American Journal of Occupational Therapy*, *51*(3), 169-172. PMid:9048155.

Cohen, M. Z., & Omery, A. (1994). Schools of Phenomenology. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 135-156). London: Sage Publications.

Egan, M., & DeLaat, M. D. (1997). The implicit spirituality of occupational therapy practice. *Canadian Journal of Occupational Therapy*, *64*(3), 115-121.

Elmescany, E. N. M., & Barros, M. L. P. (2015). Espiritualidade e terapia ocupacional: reflexões em cuidados. *Revista Nufen: Phenomenology and Interdisciplinarity*, *7*(2), 1-24.

Fornazari, S. A., & Ferreira, R. E. R. (2010). Religiosidade/espiritualidade em pacientes oncológicos: qualidade de vida e saúde. *Psicologia: Teoria e Pesquisa*, *26*(2), 265-272.

Freitas, M. H. (2017). Psicologia religiosa, psicologia da religião/espiritualidade, ou psicologia e religião/espiritualidade? *Revista Pistis Praxis*, *9*(1), 89-107.

Freitas, M. H., & Vilela, P. R. (2017). Leitura Fenomenológica da religiosidade: implicações para o psicodiagnóstico e para a práxis clínica psicológica. *Revista da Abordagem Gestáltica*, *23*(1), 95-107.

Gaarder, J., Hellern, V., & Notaker, H. (2000). *O livro das religiões.* São Paulo: Companhia de Bolso.

Galbiatti, A. L. S., Padovani-Junior, J. A., Maníglia, J. V., Rodrigues, C. D. S., Pavarino, E. C., & Goloni-Bertollo, E. M. (2013). Head and neck cancer: causes, prevention and treatment. *Revista Brasileira de Otorrinolaringologia*, *79*(2), 239-247. PMid:23670332.

Geronasso, M. C. H., & Coelho, D. (2012). A Influência da religiosidade/espiritualidade na qualidade de vida das pessoas com câncer. *Revista Interdisciplinar Saúde e Meio Ambiente*, *1*(1), 173-187.

Giovanetti, J. P. (2005). Psicologia existencial e espiritualidade. In M. M. Amatuzzi (Ed.), *Psicologia e espiritualidade* (pp. 129-145). São Paulo: Paulus.

Goldenberg, M. (2003). *A arte de pesquisar: como fazer pesquisa qualitativa em Ciências Sociais.* Rio de Janeiro: Record.

Gomes, D. M., Teixeira, L., & Ribeiro, J. (2021). *Enquadramento da prática da terapia ocupacional: domínio & processo.* Leiria: Escola Superior de Saúde, Instituto Politécnico de Leiria.

Gonçalves, A. M. (2016). A doença mental e a cura: um olhar antropológico. *Millenium - Journal of Education, Technologies, and Health*, (30), 159-171.

Guimarães, H. P., & Avezum, A. (2007). O impacto da espiritualidade na saúde física. *Revista de Psiquiatría Clínica*, *34*(1), 88-94.

Hart, C. F. M. (2008). A família frente ao diagnóstico do câncer. In V. E. S. Ceolin (Ed.), *Câncer: uma abordagem psicológica* (pp. 118-128). Porto Alegre: AGE.

Inoue, T. M., & Vecina, M. V. A. (2017). Espiritualidade e/ou religiosidade e saúde: uma revisão da literatura. *Journal of the Health Sciences Institute*, *35*(2), 127-130.

Instituto Nacional de Câncer – INCA. (2019). *Estimativa 2020: incidência de câncer no Brasil.* Rio de Janeiro: INCA.

James, W. (1911). *Pragmatism.* Londres: Meridian Books.

Johannessen-Henry, C. T., Deltour, I., Bidstrup, P. E., Dalton, S. O., & Johansen, C. (2013). Associations between faith, distress and mental adjustment: a Danish survivorship study. *Acta Oncologica*, *52*(2), 364-371. PMid:23215830.

Jung, C. G. (2012). *Psicologia e religião.* Petrópolis: Vozes.

Koenig, H. G., Mccullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health.* New York: Oxford University Press.

Kovács, M. J. (2008). *Morte e existência humana: caminhos de cuidados e possibilidades de intervenção.* Rio de Janeiro: Guanabara Koogan.

Marques, L. F. (2003). A saúde e o bem-estar espiritual em adultos porto-alegrenses. *Psicologia*, *23*(2), 56-65.

Martins, J. (1993). *Um enfoque fenomenológico do currículo:* a *educação como poíesis.* São Paulo: Cortez Editora.

Medeiros, B. (2010). *A relação entre religiosidade, culpa e avaliação de qualidade de vida no contexto do HIV/AIDS* (Dissertação de mestrado). Universidade Federal da Paraíba, João Pessoa.

Melo, A. G. C., & Caponero, R. (2009). Cuidados paliativos: abordagem contínua e integral. In F. S. Santos (Ed.), *Cuidados paliativos: Discutindo a vida, a morte e o morrer*. São Paulo: Editora Atheneu.

Melo, C. D. F., Sampaio, I. S., Souza, D. L. A., & Pinto, N. S. (2015). Correlação entre religiosidade, espiritualidade e qualidade de vida: uma revisão de literatura. *Estudos e Pesquisas em Psicologia*, *15*(2), 447-464.

Moreira-Almeida, A., & Cardeña, E. (2011). Diagnóstico diferencial entre experiências espirituais e psicóticas não patológicas e transtornos mentais: uma contribuição de estudos latino-americanos para o CID-11. *Revista Brasileira de Psiquiatria*, *33*(1), 21-28.

Muchielli, A. (1991). *Les methodes qualitatives: que je sais?* Paris: Presses universitaires de France.

Nilsson, I., & Townsend, E. (2010). Occupational justice: bridging theory and practice. *Scandinavian Journal of Occupational Therapy*, *17*(1), 57-63. PMid:20170412.

Panzini, R. G., & Bandeira, D. R. (2007). Coping (enfrentamento) religioso/espiritual. *Revista de Psiquiatría Clínica*, *34*(1), 126-135.

Pargament, K. I. (1997). *The psychology of religion and coping.* New York: The Guilford Press.

Pedrolo, F. T., & Zago, M. M. F. (2002). O enfrentamento dos familiares à imagem corporal alterada do laringectomizado. *Revista Brasileira de Cancerologia*, *48*(1), 49-56.

Pedroso, R. M. (2018). O papel do capelão como membro da equipe de profissionais de saúde. In F. M. T. Pereira (Ed.), *Espiritualidade e oncologia: conceitos e prática* (pp. 147-154). Rio de janeiro: Atheneu.

Peloquim, S. (2006). El arte de la terapia ocupacional: el spíritu llevado a la práctica. In F. Kronenberg, S. S. Algado & N. Pollark (Eds.), *Terapia ocupacional sin fronteras: aprendiendo del espíritu de superviventes* (pp. 98-109). Buenos Aires: Médica Panamericana.

Penna, T. L. M. (2004). Dinâmica psicossocial da família de pacientes com câncer. In J. Mello Filho & M. Burd (Eds.), *Doença e família* (pp. 379-389). São Paulo: Casa do Psicólogo.

Prado, A. (1999). A arte como experiência religiosa. In M. Massimi & M. Mahfoud (Eds.), *Diante do mistério: psicologia e senso religioso* (pp. 17-32). São Paulo: Loyola.

Pugh, E. J., Smith, S., & Salter, P. (2010). Offering spiritual support to dying patients and their families through a chaplaincy service. *Nursing Times*, *106*(28), 18-20. PMid:20715649.

Ribeiro, J. P. (2004). Religião e psicologia. In A. F. Holanda (Ed.), *Psicologia, religiosidade e fenomenologia* (pp. 11-36). Campinas: Alínea.

Ricoeur, P. (2009). *Teoria da interpretação: o discurso e o excesso de significação.* São Paulo: Edições 70.

Safra, G. (2005). Espiritualidade e religiosidade na clínica contemporânea. In M. M. Amatuzzi (Ed.), *Psicologia e espiritualidade* (pp. 205-211). São Paulo: Paulus.

Safra, G. (2018). A espiritualidade no adoecimento e na terminalidade. In F. M. T. Pereira (Ed.), *Espiritualidade e oncologia: conceitos e práticas* (pp. 53-60). Rio de Janeiro: Atheneu.

Silva, C. R., Portella, S. D. C., Reis, L. R., & Bispo, T. C. F. (2012). Religião e morte: qual a relação existente? *Revista Enfermagem Contemporânea*, *1*(1), 130-141.

Silva, V. C. E., & Zago, M. M. F. (2005). A revelação do diagnóstico de câncer para profissionais e pacientes. *Revista Brasileira de Enfermagem*, *58*(4), 476-480. PMid:16514959.

Turato, E. R. (2013). *Tratado da metodologia da pesquisa clínico-qualitativa.* São Paulo: Vozes.

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