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Original article

SPIRITUALITY AND HEALTH-RELATED QUALITY OF LIFE OF WOMEN WITH BREAST CANCER

ESPIRITUALIDADE E QUALIDADE DE VIDA RELACIONADA À SAÚDE DE MULHERES COM CÂNCER DE MAMA

ESPIRITUALIDAD Y CALIDAD DE VIDA RELACIONADA CON LA SALUD DE MUJERES CON CÁNCER DE MAMA

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Objective: to evaluate the association of religious-spiritual coping with the health-related quality of life of women with breast cancer undergoing cancer treatment. Method: cross-sectional, exploratory, quantitative, descriptive and analytical research, conducted from March to October 2020, in an oncological hospital. Three assessment instruments were used (Sociodemographic and Clinical Characterization, Functional Assessment of Cancer Therapy-Breast plus Arm Morbidity and Religious-Spiritual Coping Scale), descriptive and statistical analyzes were performed. Results: sample size composed of 39 women, mostly adults (79.5%), married/stable union (48.7%), submitted to mastectomy along with lymphadenectomy (53.8%), Catholic (53.8%), among which 94% believed that spirituality/religiosity helped in coping with cancer. There was a positive correlation between the domain Social/family well-being and health-related quality of life with levels of positive and total religious-spiritual coping. Conclusion: Spirituality/religiosity and health-related quality of life positively influenced women during cancer treatment, with greater use of these strategies.

Descriptors: Breast Neoplasms. Adaptation, Psychological. Spirituality. Quality of Life. Therapeutics.

Objetivo: avaliar a associação do enfrentamento religioso-espiritual com a qualidade de vida relacionada à saúde de mulheres com câncer de mama em tratamento oncológico. Método: pesquisa transversal, exploratória, quantitativa, descritiva e analítica, desenvolvida nos meses de março a outubro de 2020, em hospital oncológico. Foram utilizados três instrumentos de avaliação (Caracterização Sociodemográfica e Clínica, Functional Assessment of Cancer Therapy-Breast plus Arm Morbidity *e Escala* Coping *Religioso-Espiritual) e realizadas análises descritivas e estatísticas. Resultados: amostra composta de 39 mulheres, maioria adulta (79,5%), casada/união estável (48,7%), submetida à mastectomia junto com a linfadenectomia (53,8%), católica (53,8%), dentre as quais 94% acreditavam*

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que espiritualidade/religiosidade ajudava no enfrentamento do câncer. Houve correlação positiva entre o domínio Bem-estar social/familiar de qualidade de vida relacionada à saúde com níveis de enfrentamento religioso-espiritual positivo e total. Conclusão: espiritualidade/religiosidade e qualidade de vida relacionada à saúde influenciaram positivamente à mulher durante tratamento oncológico, havendo maior utilização dessas estratégias.

Descritores: Neoplasias da Mama. Adaptação Psicológica. Espiritualidade. Qualidade de Vida. Terapêutica.

Objetivo: evaluar la asociación entre el afrontamiento religioso y espiritual y la calidad de vida relacionada con la salud de mujeres con cáncer de mama en tratamiento oncológico. Método: estudio transversal, exploratorio, cuantitativo, descriptivo y analítico realizado entre marzo y octubre de 2020 en un hospital oncológico. Se utilizaron tres instrumentos de evaluación (*Caracterización Sociodemográfica y Clínica,* Functional Assessment of Cancer Therapy-Breast plus Arm Morbidity y *Escala* Coping *Religioso-Espiritual*) *y se realizaron análisis descriptivos y estadísticos. Resultados: la muestra era de 39 mujeres, en su mayoría adultas (79,5%), casadas/en unión estable (48,7%), sometidas a mastectomía junto con apendicectomía (53,8%), católicas (53,8%), 94% de las cuales creían que la espiritualidad/religiosidad las ayudaba a afrontar el cáncer. Hubo una correlación positiva entre el ámbito de bienestar social/familiar de la calidad de vida relacionada con la salud y los niveles de afrontamiento religioso-espiritual positivo y total. Conclusión: la espiritualidad/religiosidad y calidad de vida respecto a la salud influenciaron positivamente a la mujer durante el tratamiento oncológico al utilizar esas estrategias.*

Descriptores: Neoplasias de la Mama. Adaptación Psicológica. Espiritualidad. Calidad de Vida. Terapéutica.

Introduction

Cancer is the main public health problem on the planet. Among the various types, breast cancer stands out, the most incident among women worldwide. In Brazil, it is no different, since breast cancer is the most frequent type in all regions and predominates in women, when not considering non-melanoma skin cancer[1].

The breast has several symbologies for women, including femininity and breastfeeding, in addition to being an important factor for self-esteem and beauty. In view of this, the appearance of cancer represents a stigma of suffering and death, with diverse repercussions in the present and in the future. The presence of this type of cancer in a woman's life can influence her behavior and impact several domains of her life: physical, functional, social, family, emotional and spiritual.

Thus, health-related quality of life (HRQoL) refers to the individual's perception of their health condition and is also considered similar to the term "perceived health status". It is a subset of the umbrella term quality of life (QoL)[2]. Even considered a subjective assessment and a self-report, there is an attempt to scientifically quantify this individual's perception of diagnostic and therapeutic processes and their impacts.

Due to the diagnoses and treatments with new technologies and the number of women living with breast cancer, the greater interest in improving the HRQoL of these patients is justified[3]. The assessment of HRQoL makes it possible to observe the therapy and its repercussions, as well as the planning of Nursing actions and that of other health professionals, for patient adherence, rehabilitation and better HRQoL conditions during therapy and survival[4].

As cancer affects individuals in terms of the body, mind and spirit triad, the domain spirituality, religiosity and personal beliefs is a fundamental item for better coping, relief from the impacts caused by the disease and better knowledge to help health professionals. Furthermore, it is able to offer well-being and comfort, even in the face of suffering and the expectation of the disease[5].

Spirituality encompasses subjects related to the meaning of life and the reason for living, not being restricted to religious issues, types of beliefs and practices related or not. Religion involves faith in the Sacred, in the creator of the universe, in addition to the set of worship and specific doctrine shared in a group. Religious-spiritual

coping (RSC) is a variable related to HRQoL, which expresses the use of religion, faith and spirituality to face stress and life difficulties[6].

The physical, emotional, social and cognitive repercussions need to be continuously evaluated in order to accurately assist the woman who experiences breast cancer, from diagnosis to the end of life[4]. Thus, this study aims to evaluate the association of religious-spiritual coping with the health-related quality of life of women with breast cancer undergoing cancer treatment.

Method

This is cross-sectional and exploratory research, of a quantitative nature, with descriptive and analytical approaches. For data collection, face-to-face interviews were carried out with women with breast cancer undergoing cancer treatment, between March and October 2020, in reserved environments at the Mastology Outpatient Clinic and in the Clinical Oncology and Radiotherapy sectors of the philanthropic institution. Pernambuco Cancer Hospital (PCH), in Recife, Pernambuco, Brazil.

The sample size was defined in relation to the number of women diagnosed with breast cancer at the Outpatient Clinic, in the year 2018 (n=2,046). Based on a 95% confidence level, an 8% margin of error, and a standard deviation of 0.46 for the RSC from a study of women with breast cancer[7], the total sample of 65 patients was determined. To protect against possible losses, 10% were added to the calculated sample. Thus, the calculation of the final sample of this study resulted in 71 patients.

Women aged over 18 years, with a diagnosis of breast cancer confirmed by histology or cytology, at any stage of the disease, undergoing treatment (chemotherapy, radiotherapy, after the first cycle and the first application, respectively, and/or or hormone therapy) and submitted to breast surgery (partial removal of the breast and total removal of the breast with or without lymphadenectomy), aware of their diagnosis and with satisfactory cognitive conditions to respond alone to the presented questionnaires. Women with brain metastasis, any other type of brain damage or difficulty in understanding and communicating, which interfered with their consent to participate in the research and understanding the content of the questionnaires, were excluded from the study.

Three instruments were applied in data collection with the interviewees: Sociodemographic and Clinical Characterization instrument; FACT-B+4 (Functional Assessment of Cancer Therapy-Breast plus Arm Morbidity), Portuguese version[8]; and RSC Scale (Religious-Spiritual Coping Scale) validated for the Brazilian culture[9].

For the characterization of the sample, a questionnaire was prepared with personal, socioeconomic, and clinical data.

The FACT-B+4 questionnaire, specific for women with breast cancer undergoing surgery for treatment, was used to assess quality of life. This instrument comprises 40 questions in six domains: Physical Well-Being, Social/Family Well-Being, Emotional Well-Being, Functional Well-Being, Additional Concerns about Breast Cancer and Additional Concerns about the Arm. After calculating the formula for each domain, the summed results can present a final score of 0-164. The higher the score, the better the patient's quality of life. The FACT-B+4 questionnaire was selected for this research, as it presented the best results regarding validation and reproducibility compared to other questionnaires on quality of life specific to breast cancer[8].

The RSC Scale was applied to assess religious-spiritual coping. It comprises 87 items, and four main indexes are considered for the evaluation: Positive RSC (RSCP, 8 factors, 66 items), Negative RSC (RSCN, 4 factors, 21 items), RSCN/RSCP ratio and Total RSC. RSCP and RSCN indicate the level of positive and negative religious-spiritual coping, respectively. The higher the values, the greater the positive and negative RSC usage. The RSCN/RSCP ratio indicates the ratio of negative RSC used relative to positive RSC. The higher the value, the greater the use of RSCN. The lower the value, the greater the use of RSCP referring to RSCN. Thus, this index turns out to be inversely

proportional, as the lowest values are considered the best. The Total RSC reveals the total amount of RSC used. This scale was also selected for this research because its multidimensional assessment demonstrates clinical advantage, as the wide range of religious-spiritual behaviors covered provides a deeper and more detailed idea of the person[9].

At first, with the authorization of the health professionals responsible for the three defined sectors, an analysis was carried out on the patients' records for selection, according to the established inclusion criteria, and to confirm and complement information. Subsequently, an invitation was made to participate in the research and data collection began. The interviews took place in reserved rooms before and/or after consultations, exams and treatment sessions, with an average duration of 50 minutes.

Initially, all data were gathered and organized in the Microsoft® Office Excel® program. Sociodemographic and clinical data will be presented through absolute and relative frequency with the description of the questionnaire variables. As for the FACT-B+4 questionnaire and the RSC Scale, the scores were calculated and analyzed according to the validation productions of the questionnaires[8-9]. The data will be exposed through the minimum and maximum values, mean and standard deviation (SD±).

For the analyzes between the RSC Scale indices and the domains of the FACT-B+4 questionnaire, two statistical tests were applied: the Shapiro-Wilk test and the Spearman correlation. Analyzes were performed using the Software Statistical Package Social Science (SPSS) 20.0. First, the Shapiro-Wilk test was applied to verify the normality of the data and, thus, allow for the adequate choice of tests. The analyzed variables presented $p<0.05$, indicating that the data did not follow the normal curve, being classified as non-parametric. According to the normality test, Spearman's correlation was performed, indicated for non-parametric data. Variables that presented $p<0.05$ were considered correlated and the intensity of the relationship was classified as high between 0.5 to 1 and -0.5 to -1[10].

The research project was approved by the Research Ethics Committee (REC) of the Hospital de Cancer de Pernambuco, with Opinion number 4.354.126 and Certificate of Ethical Appreciation Presentation number 28749320.3.0000.5205. The guidelines and regulatory standards of Resolution No. 466/2012 of the National Health Council (NHC) on research involving human beings were followed.

Results

Due to the new coronavirus pandemic and refusals, the sample consisted of 39 women diagnosed with breast cancer undergoing cancer treatment.

Table 1 presents sociodemographic profile data. The sample had an average of 52.8 years, with a minimum age of 25 years and a maximum of 71 years. Most had an inactive profession/occupation. Among them, 9 participants were retired and 8 women received some benefit due to cancer.

Table 1 – Sociodemographic characterization of women with breast cancer undergoing cancer treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39) (continued)

Variables	Category	Absolute Frequency (n)	Relative Frequency (%)
Age range (years)	Adult	31	79.5
	Older adult	8	20.5

Table 1 – Sociodemographic characterization of women with breast cancer undergoing cancer treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39) (continued)

Variables	Category	Absolute Frequency (n)	Relative Frequency (%)
Skin color	White	10	25.6
	Black	7	18
	Yellow	2	5.1
	Brown	20	51.3
Marital status	Single	11	28.2
	Married/Stable Union	19	48.7
	Divorced/Separated	7	18
	Widow	2	5.1
Who do you live with	Alone	4	10.3
	Family	35	89.7
Monthly income	no income	1	2.6
	<1 minimum wage	5	12.8
	1 to 2 minimum wages	26	66.7
	3 to 4 minimum wages	5	12.8
	> 4 minimum wages	2	5.1
Education	Literate	1	2.6
	Incomplete Elementary School	12	30.7
	Complete primary education	3	7.7
	Incomplete high school	4	10.3
	Complete high school	12	30.7
	Incomplete Higher Education	1	2.6
	Complete Higher Education	3	7.7
	Full Graduate	3	7.7
Profission/Occupation	Primary Sector	6	15.4
	Secondary Sector	3	7.7
	Tertiary Sector	25	64.1
	Housewife	5	12.8
Profession/Occupation Status	Inactive	27	69.2
	Active	12	30.8
Inactive Status	with benefit	23	82.1
	no benefit	5	17.9
Religion	Without religion	1	2.6
	catholic	21	53.8
	Evangelical	14	35.9
	spiritist	2	5.1
	Christian – Church of Jesus Christ of Latter-day Saints (Mormons)	1	2.6

Table 1 – Sociodemographic characterization of women with breast cancer undergoing cancer treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39) (conclusion)

Variables	Category	Absolute Frequency (n)	Relative Frequency (%)
Active in religion	Yes	29	76.3
	More or less	3	8
	No	6	15.7
Before cancer, I had religion	Yes	38	97.4
	No	1	2.6
Religion/Spirituality helps in coping	Not even a little	1	2.6
	Very	3	7.7
	Very much	35	89.7

Source: created by the authors.

Table 2 reveals the clinical profile. Regarding the presence of cancer dissemination, one participant (2.6%) had visceral (hepatic and adrenal), pleural, lymph node and muscle involvement. As for treatment, at the time of the interviews, five participants (12.8%) had not undergone chemotherapy, six (15.4%) had not undergone radiotherapy and four (10.3%) had not used hormone therapy.

Table 2 – Clinical characterization of women with breast cancer undergoing oncological treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39) (continued)

Variables	Category	Absolute Frequency (n)	Relative Frequency (%)
No. of breast cancer diagnoses			
	1	32	82
	> 1	6	15.4
	Recurrence	1	2.6
Histopathological classification			
	in situ	2	5.1
	Invasive	34	94.9
Diagnosis time			
	< 6 months	1	2.6
	6 to 12 months	5	12.8
	> 12 months	33	84.6
Treatment time			
	< 6 months	4	10.3
	6 to 12 months	5	12.8
	> 12 months	30	76.9
Surgical procedure			
	Partial breast removal	9	23.1
	Total breast removal	9	23.1
	Total breast removal + Lymphadenectomy	21	53.8

Table 2 – Clinical characterization of women with breast cancer undergoing oncological treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39) (conclusion)

Variables	Category	Absolute Frequency (n)	Relative Frequency (%)
In course of chemotherapy			
	Yes	10	29.4
	No	24	70.6
In course of radiotherapy			
	Yes	7	78.8
	No	26	21.2
Undergoing hormone therapy			
	Yes	33	94.3
	No	2	5.7

Source: created by the authors.

Table 3 presents the minimum and maximum values, mean and standard deviation (SD±) of the domains of the quality-of-life questionnaire for women with breast cancer, the FACT-B+4.

Table 3 – Descriptive analysis of the variables of the FACT-B+4 questionnaire applied to women with breast cancer undergoing cancer treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39)

Subscales	Minimum value	Maximum value	Mean	Standard deviation
Physical well-being	3	28	19.87	6.08
Social/family well-being	6	28	22.56	5.16
Emotional well-being	8	24	19.69	4.32
Functional well-being	2	28	20.48	5.24
Breast concerns	12	36	24.07	5.63
Arm concerns	4	20	14.28	4.96
Final Score	53	160	120.97	21.77

Source: created by the authors.

Table 4 reveals the minimum and maximum values, mean and standard deviation (SD±) of the variables of the Religious-Spiritual Coping Scale (RSC)[9].

Table 4 – Descriptive analysis of the variables of the Religious-Spiritual Coping Scale applied to women with breast cancer undergoing cancer treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39) (continued)

Variables	Minimum value	Maximum value	Mean	Standard deviation
Positive Religious-Spiritual Coping	1.32	4.65	3.73	0.61
Negative Religious-Spiritual Coping	1.19	2.19	1.56	0.27
Negative Religious-Spiritual Coping Ratio/ Positive Religious-Spiritual Coping	0.29	1.16	0.44	0.15
Total Religious-Spiritual Coping	2.90	4.54	4.21	0.33
Factor P1 – Transformation of Yourself and/or Your Life	1.00	5.00	3.98	0.72
Factor P2 – Actions in Search of Spiritual Help	1.00	4.50	3.21	0.78
Factor P3 – Offer to Help Others	1.43	4.86	3.84	0.78

Table 4 – Descriptive analysis of the variables of the Religious-Spiritual Coping Scale applied to women with breast cancer undergoing cancer treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39)

(conclusion)

Variables	Minimum value	Maximum value	Mean	Standard deviation
Factor P4 – Positive Position Before God	1.73	4.64	4.04	0.47
Factor P5 – Personal Pursuit of Spiritual Growth	1.00	5.00	3.78	0.75
Factor P6 – Actions in Search of the Institutional Other	1.00	5.00	3.71	1.06
Factor P7 – Personal Quest for Spiritual Knowledge	1.20	4.80	3.03	1.06
Factor P8 – Withdrawal through God, Religion and/or Spirituality	1.00	5.00	4.15	0.87
Factor N1 – Negative Reappraisal of God	1.00	2.38	1.31	0.47
Factor N2 – Negative Position Before God	1.00	3.00	2.10	0.60
Factor N3 – Negative Reassessment of Meaning	1.00	3.40	1.50	0.57
Factor N4 – Dissatisfaction with the Institutional Other	1.00	2.00	1.61	0.47

Source: created by the authors.

The arbitrary parameter used for the analysis of the values of the averages of Total RSC before its use comprises: Negligible or None (1 to 1.5), Low (1.51 to 2.5), Medium (2.51 to 3, 5), High (3.51 to 4.5) and Very High (4.51 to 5)[9]. Two participants (5.1%) had a mean value (3.09, SD ± 0.28) of Total RSC, 36 women (92.3) had a high mean (4.12, SD ± 0.22) of RSC Total and only one participant (2.6%) obtained a very high average RSC Total (4.54). The average obtained from this sample was 4.21. Thus, it is considered a high value.

Tables 5a and 5b reveal the correlations between the main indices of the RSC Scale and the domains of the FACT-B+4 questionnaire. A weak positive correlation was verified between the Social/family well-being domain of the FACT-B+4 questionnaire between the items RSC Positive (ρ=0.445; $p<0.05$) and RSC Total (ρ=0.412; $p<0.05$) of the RSC Scale. Other positive and negative correlations were found within the two instruments.

Table 5a – Correlation between the main evaluation indices of the Religious-Spiritual Coping Scale and the domains of the FACT-B+4 questionnaire, according to Spearman's correlation test, applied to women with breast cancer undergoing cancer treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39)

(continued)

Variables	Social well-being	Emotional well-being	Functional well-being	Concerns – Breast	Concerns – Arm	Final Score - FACT
Physical well-being	0.081 0.624	0.431 (2) 0.006	0.321 (1) 0.046	0.631 (2) -	0.676 (2) -	0.785 (2) -
Social well-being		0.413 (2) 0.009	0.491 (2) 0.002	0.282 0.082	0.039 0.814	0.513 (2) 0.001

Table 5a – Correlation between the main evaluation indices of the Religious-Spiritual Coping Scale and the domains of the FACT-B+4 questionnaire, according to Spearman's correlation test, applied to women with breast cancer undergoing cancer treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39)

(conclusion)

Variables	Social well-being	Emotional well-being	Functional well-being	Concerns – Breast	Concerns – Arm	Final Score - FACT
Emotional well-being			0.425 (2)	0.649 (2)	0.124	0.713 (2)
			0.007	0.000	0.451	-
Functional well-being				0.342 (2)	0.118	0.601 (2)
				0.033	0.473	-
Concerns - Breast					0.493 (2)	0.790 (2)
					0.001	-
Concerns – Arm						0.578 (2)
						-
Final Score – FACT						
Positive Spiritual Religious Coping						
Negative Spiritual Religious Coping						
Negative Spiritual Religious Coping / Positive Spiritual Religious Coping						

Source: created by the authors.

Note: Conventional signal used:
- Numerical data equal to zero not resulting from rounding up.

(1) Significant Spearman correlation ($p<0.05$).
(2) Highly significant Spearman correlation ($p<0.01$).

Table 5b – Correlation between the main evaluation indices of the Religious-Spiritual Coping Scale and the domains of the FACT-B+4 questionnaire, according to Spearman's correlation test, applied to women with breast cancer undergoing cancer treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39)

(continued)

Variables	Positive Spiritual Religious Coping	Negative Spiritual Religious Coping	Negative Spiritual Religious Coping / Positive Spiritual Religious Coping	Total Spiritual Religious Coping
Physical well-being	-0.015	-0.100	-0.064	0.040
	0.928	0.545	0.700	0.810
Social well-being	0.445 (2)	0.041	-0.233	0.412 (2)
	0.005	0.806	0.154	0.009
Emotional well-being	0.204	-0.082	-0.188	0.273
	0.214	0.621	0.251	0.093
functional well-being	0.213	-0.141	-0.213	0.309
	0.194	0.390	0.192	0.056

Table 5b – Correlation between the main evaluation indices of the Religious-Spiritual Coping Scale and the domains of the FACT-B+4 questionnaire, according to Spearman's correlation test, applied to women with breast cancer undergoing cancer treatment at the Cancer Hospital of Pernambuco. Recife, Pernambuco, Brazil – 2020. (N=39)

(conclusion)

Variables	Positive Spiritual Religious Coping	Negative Spiritual Religious Coping	Negative Spiritual Religious Coping / Positive Spiritual Religious Coping	Total Spiritual Religious Coping
Concerns – Breast	0.135	-0.119	-0.153	0.200
	0.412	0.472	0.351	0.222
Concerns – Arm	-0.039	-0.002	0.119	-0.066
	0.816	0.991	0.471	0.690
Final Score – FACT	0.187	-0.181	-0.224	0.275
	0.255	0.271	0.171	0.091
Positive Spiritual Religious Coping		0.123	-0.528 (2)	0.867 (2)
		0.457	0.001	-
Negative Spiritual Religious Coping			0.665 (2)	-0.321 (1)
			-	0.046
Negative Spiritual Religious Coping / Positive Spiritual Religious Coping				-0.806 (2)
				-

Source: created by the authors.

Note: Conventional signal used:
- Numerical data equal to zero not resulting from rounding up.

(1) Significant Spearman correlation ($p<0.05$).
(2) Highly significant Spearman correlation($p<0.01$).

Discussion

The results of this research showed significant oscillations in the responses (descriptive analysis) of some dimensions obtained with the application of instruments for assessing quality of life and spirituality. Among the causes of this finding is the diversity of information in the sample, which presented different sociodemographic and clinical characteristics. However, understanding the sociodemographic profile of women with breast cancer is essential to provide individual and comprehensive care, according to each period of the therapeutic itinerary[4].

Regarding sociodemographic characteristics, there were similar results in other studies. In the validation study of the FACT-B+4 questionnaire itself, with one hundred women diagnosed with breast cancer treated or undergoing treatment, in a private hospital, the mean age was 56.5 years, 64% were married and 69% were catholic[8]. Research with 83 women with breast cancer, linked to two non-governmental institutions during diagnosis and treatment, in which the RSC Scale was applied, also showed similar characteristics, such as a mean age of 52.3 years, 55.4% were married/ lived together, most had incomplete primary education, 84.3% were inactive at work. Among these, 55.4% had cancer as justification and 63.9% were Catholic[7].

Despite the findings arising from research carried out in a private institution[8], and with part of the treated patients, the profile of women with breast cancer in this study also follows the same pattern seen in society. Part of this female population, when impacted by the diagnosis and treatment, is in its active, productive phase, building and supporting family, with personal,

spiritual and religious practices and beliefs. They also have a lower level of education and need more attention and care for their health, from prevention practices to the rehabilitation process. In this way, cancer entails, at first and especially, personal impacts, being irreparable potential years of life, but also family, labor and economic impacts. When these are added to the impacts on society, considering disability, morbidity, mortality and costs, they become relevant factors in the repercussion of cancer as a public health problem.

As most participants in this study reported living with partners or living with family members, it was observed that family and social support were recognized as important resources for these women, who may suffer from reduced self-esteem and body image. This finding was also found in another study with women survivors of this type of cancer[11]. In this research, the Social/family well-being domain had the second highest mean and the Emotional well-being and Physical well-being domains had the lowest means, as shown in Table 3.

This suffering with self-esteem and body image may be due to the therapeutic path that women with breast cancer face. Mastectomy is considered the main surgical therapeutic approach[12]. In this study, it was predominant along with lymphadenectomy. This surgical procedure can interfere in several fields of women's lives, including affecting their perception of sexuality, body image and health-related quality of life. Depression, fear of recurrence, physical discomfort, decrease in activities, sleep disturbance and sexual difficulties are the main effects resulting from this type of treatment[12]. All these factors, mentioned during the interviews, arising not only from the surgery, but from the entire process from the discovery of the disease to the follow-up period, affect and can reduce the HRQoL of these women.

As for the assessment of the quality of life of women with breast cancer, the FACT-B+4 applied in this research showed results similar to those of the validation study of the same questionnaire, in which the domains with the highest average were: Concerns-Breast, physical well-being, social/family well-being. The domains with the lowest scores were: Concerns-Arm, Emotional well-being and Functional well-being[8].

Most women claimed to be using hormone therapy. This type of therapy is very important for the transition from active treatment to survival care, as it significantly improves long-term survival outcomes[13]. Furthermore, as they are oral medications, they can provide better quality of life related to the health of patients, with a greater sense of control over the treatment and less interference in their social life[14].

Although functional capacity and physical limitation are related to breast surgeries, as well as chemotherapy and radiotherapy treatments – and most women are inactive in their profession/occupation and at home as well –, the participants in this study showed and revealed optimism, hope, faith and belief. About 97% of them had a religion, 76% considered themselves active in their religion and 94% believed that religiosity/spirituality helped in coping with cancer. In addition, they presented positive averages in the evaluation items of the RSC Scale.

Regarding this scale, a study with 83 women with breast cancer obtained very similar results, including the total RSC was considered high compared to its average 3.78. The positive RSC was 3.52, the negative RSC was 1.94 and the average RSCN/RSCP ratio was 0.56[7].

These results associated with the spirituality/religiosity domain are coping strategies used to experience adversity, anguish, and doubts in the illness process. The strength achieved by spirituality, from the connection with the Sacred and the Transcendent, is revealed in facing the adverse circumstances of life[15].

Spirituality plays an important role in the individual's life and can be essential in the relationship with the experience with cancer, as it provides the search for a new meaning and restructuring of life. This type of confrontation can also be a very significant tool for the health team, especially for the Nursing team, in view of their direct and continuous participation in the care given to the individual and in the

establishment of bonds with patients and family members.

Despite the existence of a positive, albeit weak, correlation between the two instruments, the Social/family well-being domain of the FACT-B+4 questionnaire and the RSC Positive and RSC Total items of the RSC Scale, it is evident that HRQoL correlates with positively with spiritual and emotional well-being (see Tables 5a and 5b). In this way, it allows a possible interpretation of the existence of a relationship between the sense and the meaning that the patient attributes to her existence in a phase of illness and her consequent choices related not only to the religious aspect but also to social and affective bonds, in the resolution of interpersonal conflicts and also with oneself, physical and psychological health care and its adequacy and bond with the environment[16].

In view of this correlation, it is important to emphasize that the Social/family well-being domain of the FACT-B+4 questionnaire contains statements regarding support from partners, family and friends. Therefore, social and family support are fundamental factors for bringing the individual closer to religion, spirituality, belief or faith, and the search for spiritual help during this coping process.

The results of research with 22 cancer patients showed that, when they received support from family, friends and members of their Churches, their HRQoL was generally improved. As for spirituality, for most of these patients, it represented a primordial function, as many stated that the disease directed them towards spiritual growth and brought them closer to God[17].

Social support refers to the tools made available by other individuals under conditions of need, and can be measured by the individual perception of the degree to which interpersonal relationships are equivalent to functions, such as emotional, material and affective support[18].

Studies show that the perception of social support has a direct impact on psychological well-being; therefore, it interferes with the patient's ability to employ relevant coping strategies[19]. Therefore, it is possible to understand that the existence of timely social support has a consequence in the choice of positive religious-spiritual coping[20]. Likewise, the existence of religious beliefs and religious-spiritual coping are associated with an increase in the perception of social support[21-22].

Research with 120 women under follow-up, in which 80 participants had a diagnosis of breast cancer and 40 had gynecological cancer, aimed to evaluate the religious-spiritual coping and verify the relationship of this factor with the presence of psychological symptoms, with the perception of support social and with QVRS. The results showed an association between being a religious practitioner and all dimensions of social support, in which the participants, when claiming to practice their religious belief, demonstrated a greater perception of social support in all the indexes obtained. Equivalently, the variable time devoted to religion also showed a relationship with all dimensions of social support. The data revealed that the greater daily time dedicated to religious activities increased the perception of social support. Positive RSC also showed a significant association with all dimensions of social support. Thus, the greater the use of positive RSC strategies, the greater the perception of social support[23].

Another study with similar results, with a sample consisting of women with breast cancer, revealed that patients who declared participating in religious and spiritual activities had higher levels of social support[24].

Given this, it is possible to state that the use of total and positive religious-spiritual coping strategies is significantly associated with a greater perception of social support. Likewise, it is necessary to highlight the importance of spirituality/religiosity and social/family support as strategies for coping with cancer[23].

Although there was a positive correlation between social/family well-being and levels of positive and total religious-spiritual coping, and the influence of these two supports on the HRQoL of women with breast cancer was evident, it is worth mentioning the importance of changing individual behavior and/or disposition

for this type of coping, which first happens to the individual when exposed to the diagnosis of cancer. Therefore, the behaviors resulting from the positive religious-spiritual coping strategy used (arranged in eight factors in Table 4) indicate the need for and importance of strengthening the relationship with God or with any other Higher Being, to overcome adversity. Also under the gaze of faith and hope, it may be possible, through spiritual and personal growth and knowledge, the internal and life transformation.

In this way, it is understood that the coping strategies need to be worked on in the first contact of the woman with the diagnosis of breast cancer, so that a new process of re-signification of life, which comprises the illness and the therapeutic itinerary until its rehabilitation can be started. This form of guidance can help in the search for an ideal condition of well-being in the face of each need and moment of this process.

Women with breast cancer need comprehensive care. Therefore, the practices of nursing professionals must achieve a balance between the physical, emotional, social and spiritual domains, with a focus on HRQoL, which must be maintained even with the adverse effects of treatment[25].

The research presented some limiting factors, mainly the coronavirus pandemic (SARS-CoV-2), which restricted the number of participants, since the interviews were suspended at a certain point. Consultations, exams and treatment sessions for these patients also competed, which took place concurrently with the interviews, as well as refusals, due to personal reasons or lack of time, since the interviews had a moderate duration.

It is believed that the results of this study can stimulate new approaches, especially religious-spiritual coping strategies during care for women with breast cancer, which can cooperate with essential interventions during the health-disease process. In addition, it can contribute to this type of strategy associated with the assessment of HRQoL in cancer patients, given their complexity and needs, since care must be directed and comprehensive, in the personal, family and collective spheres.

Conclusion

The present study showed positive and associated results between HRQoL and spirituality/religiosity. Therefore, the use of these strategies while coping with cancer positively influences the perception of better HRQoL and/or its domains and, for a better HRQoL, the search for and greater use of spirituality/religiosity. Furthermore, the association between these two factors allowed us to corroborate the importance of discussing and expanding the role of both in the setting of care for cancer patients.

Care in the spiritual dimension and, consequently, in other dimensions of health-related quality of life, brings benefits to women with cancer, who need to deal with the effects and changes in their bodies and in all areas of their lives. It also suggests establishing and valuing family ties and health professionals.

As a way to encourage more studies in this area, it is important to develop and validate more HRQoL instruments that address the spirituality/religiosity domain, to make it possible to obtain even more expressive associations, in order to guarantee the evaluation, follow-up and fundamental interventions during the health-disease process of individuals with cancer.

Collaboration:

1 – conception and planning of the project: Renata Ramos Menezes, Simone Yuriko Kameo and Natália Fernandes dos Santos;

2 – analysis and interpretation of data: Renata Ramos Menezes, Simone Yuriko Kameo and Natália Fernandes dos Santos;

3 – writing and/or critical review: Renata Ramos Menezes, Simone Yuriko Kameo and Natália Fernandes dos Santos;

4 – approval of the final version: Renata Ramos Menezes, Simone Yuriko Kameo and Natália Fernandes dos Santos.

Conflict of interest

There are no conflicts of interest.

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