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Religiosity and spirituality in women with breast cancer: integrative review of the literature.

Religiosidad y espiritualidad en mujeres con cáncer de mama: revisión integrativa de la literatura

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Abstract

Breast cancer represents 16% of all female cancers worldwide. The religious and spiritual values of patients can have different meanings and even cause spiritual suffering. The present literature review explores the place of spirituality and religiosity in the way in which a group of women with breast cancer assume, signify and face their disease. For this, the documentary analysis was carried out in different specialized databases. It was observed that spirituality and religious sense significantly affect decision making in advanced stages of the disease and influence the quality of life, socio-family relationships and the treatment of patients. Spirituality and religiosity are perceived as an emotional and psychological support to face the disease. Therefore, it is important to strengthen the spiritual dimension of the patient so that they face the disease, that of the family so that they face the suffering caused by the patient's disease, that of the health professionals

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so that they carry out an ethical, humanized and excellent in terms of biopsychosocial approach.

Keywords: Religiosity; Spirituality, Breast Cancer, Women, Diagnosed patients, Surviving patients.

Resumen

El cáncer de mama representa el 16% de todos los cánceres femeninos a nivel mundial. Los valores religiosos y espirituales de los pacientes pueden tener distintos significados e inclusive causar sufrimiento espiritual. La presente revisión de la literatura explora el lugar que ocupa la espiritualidad y religiosidad en la manera en la que un grupo de mujeres con cáncer de mama asumen, significan y enfrentan su enfermedad. Para ello se efectuó el análisis documental en distintas bases de datos especializadas. Se observó que la espiritualidad y el sentido religioso afectan de manera importante la toma de decisiones en etapas avanzadas de la enfermedad e influyen en la calidad de vida, las relaciones socio-familiares y el tratamiento de las pacientes. La espiritualidad y religiosidad son percibidas como un soporte emocional y psicológico para afrontar la enfermedad. Por ello, es importante fortalecer la dimensión espiritual del paciente para que afronte la enfermedad, la de la familia para que afronte el sufrimiento que le produce la enfermedad del paciente, la de los profesionales de la salud para que realicen una práctica ética, humanizada y excelente en cuanto al enfoque biopsicosocial.

Palabras clave: Religiosidad; Espiritualidad, Cáncer de Mama, Mujeres, Pacientes diagnósticadas, Pacientes sobrevivientes.

Introduction

Breast cancer is the most common cancer among women worldwide. It accounts for 16% of all female cancers. According to WHO, there are 1.38 million new cases and 458,000 deaths from breast cancer each year. The National Cancer Institute warns that religious and spiritual values are important in patients facing cancer, as they can have different meanings and even cause spiritual suffering. Based on these data, the question arises as to the place of spirituality and religiosity in the way women with breast cancer assume, understand and face their disease, considering that they have an important impact on decision making in advanced stages of the disease and influence the quality of life, socio-family relationships and treatment of patients. Spirituality and religiosity are perceived as an emotional and psychological support for

coping with the disease. Therefore, it is important to explore the spiritual dimension of the patient in coping with the disease, the support of the family in coping with the suffering that the disease produces in the patient, and that of the health professionals in carrying out an ethical and humanized practice.

Studies on the relationship between religiosity and spirituality in women with breast cancer have shown three main lines of study. The first one locates coping strategies in the face of the disease. Feher & Maly (1999), Gall, Charbonneau & Florack (2011), Gamboa Romero, M. A., Barros Morales, R. L., & Barros Bastidas, C. (2016). Thuné-Boyle et al. (2013), Veit & Kern de Castro (2013) and Khodaveirdyzad et al. (2016) have inquired that the main strategies employed by women to cope, internalize and accept the diagnosis of cancer and minimize the emotional impact on patients' behavior. At par, Morgan, Gaston-Johansson & Moc (2006) and Gaston-Johansson et al. (2013) prioritized their look at the relationship with spiritual well-being during the treatment process identifying that patients' quality of life correlates directly with coping strategies. Other authors such as Mesquita et al. (2013) and Manning & Radina (2014) particularly inquired about coping during chemotherapy and the post illness period, respectively. A second block of studies has been driven by the inquiry between religiosity, spirituality, well-being and mental health. Mickley, Soeken & Belcher (1992) used the concept of spiritual well-being in order to explore the notion of spiritual health, a concept developed to make explicit individual and socio-religious notions related to the body, health and illness. Meanwhile, Cotton, Levine, Fitzpatric, Dolda & Targ (1999) observed the efficacy of psychosocial support on the well-being and quality of life of diagnosed women identifying that social networks play a fundamental role in the social construction of illness and well-being. And, Khoramirad, Mousavi, Dadkhahtehrani & Pourmarzi (2014) showed for their part the existing relationship with sleep quality. And, the third line of research addresses the quality of life from the religious and spiritual dimensions of women with breast cancer. Purnell & Andersen (2009), Jung-Won & Jaehee (2009) and Wildes. Miller, San Miguel de Majors & Ramirez (2009) looked at the relationship between social support and quality of life by identifying factors of success and failure in the coping strategies employed by breast cancer survivors.

From this theoretical-empirical look at the relationship between religiosity, spirituality and breast cancer in women, a question arises about how studies on this field have been developed in the last thirty years and to understand the theoretical and methodological advances that have occurred in this period of time in order to generate, from a review of the literature, possible theoretical and methodological trajectories for future research.

Materials and methods

This paper is an integrative literature review conducted during December 2018 to February 2019. The central question that guided the study was: what is the existing evidence in the literature on the relationship between spirituality and religiosity in women with breast cancer, for which the following databases were used: APA PsycNET® (APAPN), EBSCO, JSTOR, ProQuest (PQ), Wiley, Web of Sciences (WOS) and Scopus (SP). The descriptors were Religiosity (Religion/Religious/Religiosity), Spirituality (Spiritual/Spirituality), Breast Cancer (Breast Cancer/Breast Cancer), with the Boolean operator "AND" between terms.

The following inclusion criteria were used to identify a document as valid: scientific articles in indexed journals and conference papers and proceedings in English, Spanish or Portuguese reviewed under the double-blind peer-review system, published between 1992 and 2018, which are available for full-text review. Three reviewers, at different times, performed the document search in the identified databases using the proposed descriptors in order to triangulate, verify and validate the results obtained.

Meta-analyses, review studies, books, book chapters, dissertations, theses, reports, journal articles and non-scientific texts were not considered, nor were any other document where the three inclusion descriptors were not found within the keywords, objectives, results and conclusions.

Once the search procedure and verification of the results obtained in accordance with the established methodology had been carried out, a sample of 29 documents was obtained.

The final sample of identified documents was categorized according to the following criteria: author, main objective and study population or sample.

Table 1.

Synthesis of articles published in databases from 1992 to 2018.

Author(s)	Central Objective	Population/ Sample
Mickley, Soeken & Belcher (1992)	To shed light on spiritual health by examining the role of spiritual well-being (SWB), religiosity and hope in spiritual health.	175 women diagnosed with breast cancer.

Feher & Maly (1999)	To identify and examine coping strategies among women with a past and recent diagnosis of breast cancer.	33 women diagnosed with breast cancer.
Cotton, Levine, Fitzpatric, Dolda & Targ (1999)	To examine the relationship between spiritual well-being, quality of life, and psychological adjustment to compare the effectiveness of two psychosocial support programs.	142 women diagnosed with breast cancer.
Choumanova, Wanat, Barret & Koopman (2006)	Examine how patients changed the roles of religion and spirituality in coping with the disease.	03 female breast cancer survivors.
Morgan, Gaston-Johansson & Mock (2006)	To examine the spiritual well-being, spiritual coping strategies, and quality of life of African American women during breast cancer treatment.	11 women diagnosed with breast cancer.
Purnell & Andersen (2009)	To investigate the relationship between religious practices, spirituality, quality of life, and stress in breast cancer survivors.	130 women diagnosed with breast cancer.
Jung-Won & Jaehee (2009)	To examine the differences between religiosity, spirituality, and quality of life among Korean American and Korean breast and gynecologic cancer survivors, as well as to investigate the effects of religiosity, spirituality, and social support on quality of life.	169 women diagnosed with breast cancer
Wildes. Miller, San Miguel de Majors & Ramirez (2009).	To evaluate the association between religiosity/spirituality and health as a quality of life in Latina breast cancer survivors in order to determine the positive correlation between R/E and Health as a quality of life and whether it influences quality of life.	117 female breast cancer survivors.
Gullate, Brawley, Kinney, Powe & Moone (2010)	To examine the influence of religiosity, spirituality, and cancer fatalism on delayed diagnosis of breast cancer in women with self-detected symptoms.	129 women diagnosed with breast cancer.

Barboza & Forero (2011)	To analyze and compare spiritual and religious beliefs, as well as anxiety and depression levels between healthy women and women diagnosed with breast cancer.	61 female breast cancer survivors.
Muhammad & Abdullah (2011)	To reveal the meaning of experience through the stories of women breast cancer survivors, to better understand the deep meanings that inform their experiences with spirituality and religiosity as they cope with those of breast cancer.	03 female breast cancer survivors.
Thune-Boyle, Stygall, Keshtgar, Davidson & Newman (2011).	To examine the impact of breast cancer diagnosis on the spiritual and religious practices and beliefs of UK patients.	202 women diagnosed with breast cancer.
Gall, Charbonneau & Florack (2011).	To investigate the salient role of religion, god image and religious coping strategies in relation to the perception of the development of breast cancer diagnosis.	87 women diagnosed with breast cancer.
Lagman, Yoo, Levine, Donnell & Lim (2012).	Examining the spiritual and religious adherence of Filipino women diagnosed with breast cancer.	10 women diagnosed with breast cancer.
Veit & Kern de Castro (2013)	To examine the relationship between religious coping, clinical variables, and subjective perception of who god is in women diagnosed with breast cancer.	83 women diagnosed with breast cancer.
Veit & Kern de Castro (2013)	To understand, in women with breast cancer with high levels of positive religious/spiritual coping, the place that religiosity/spirituality has in their lives, the forms of coping used during diagnosis and treatment, and the possible changes that occurred during the disease.	07 women diagnosed with breast cancer.
Mesquita, Lopes, Valcanti, Denismar, Alves, Gerhke & Campos de Carvalho (2013)	To investigate the use of religious/spiritual coping by people with cancer in chemotherapy.	101 women diagnosed with breast cancer.

Hurtado & Finck (2013)	To establish whether the Post-Critical Beliefs Scale (PCBS), developed by Hutsebaut et al (1996,1997), is a valid instrument in the study of the religiosity and spirituality of breast cancer patients in Colombia.	84 women diagnosed with breast cancer.
Thuné-Boyle, Stygall, Keshtgar, Davidson & Newman (2013).	To examine the benefits and container effects of religious/spirituality coping strategies in the adjustment process of the first year of diagnosis.	155 women diagnosed with breast cancer.
Gaston-Johansson, Haisfield-Wolfe, Reddick, Goldstein & Lawal (2013).	To examine coping capacity, psychological distress, spiritual well-being, positive and negative spiritual coping, and coping strategies in African American women diagnosed with breast cancer.	17 women diagnosed with breast cancer.
Lynn, Yoo & Levine (2013).	Examining the role of spirituality and religiosity in African American women with breast cancer.	47 female breast cancer survivors.
Schreiber (2014)	To examine the impact of breast cancer diagnosis on religion/faith and behavioral changes as well as the relationships or achievements between these.	28 women diagnosed with breast cancer.
Sanchez, Sierra & Zarate (2014).	Establishing whether spirituality and religiosity are independent dimensions	251 women diagnosed with breast cancer.
Puentes, Urrego & Sánchez (2014).	To explore the place of spirituality and religiosity in the way a group of women with breast cancer assume, signify and face their illness.	04 women diagnosed with breast cancer.
Khoramirad, Mousavi, Dadkhahtehrani & Pourmarzi (2014).	To determine the relationship between sleep quality and spiritual well-being and religious practices in Muslim women diagnosed with breast cancer.	80 women breast cancer survivors.

Manning & Radina (2014)	To examine how mothers of breast cancer survivors managed the adversities associated with the disease.	30 women diagnosed with breast cancer.
Khodaveirdyzad, Rahimi, Rahmani, Ghahramanian, Kodayari & Eivazi (2016).	To examine the relationship between spiritual coping, adjustment to breast cancer diagnosis in Iranian women.	266 women diagnosed with breast cancer.
Borges, Caldeira Loyola-Caetano, de Magalhaes, Areco & Panobianco (2017).	To examine the level of spiritual/religious coping in women with breast cancer.	94 women diagnosed with breast cancer.
Park, Waddington & Abraham (2018).	To examine the relationship between religiosity/spirituality in breast cancer survivors and their healthy behavior.	172 female breast cancer survivors.

Results

Twenty-nine articles met the inclusion criteria established according to the proposed methodology. A greater number of publications were identified in the databases Wiley (32), Web of Science (25), ProQuest (19), APA PsycNET® (19), Scopus (18), followed by Springer (12), EBSCO (11) and JSTOR (07), to a lesser extent.

Regarding the methodological approach, 20 quantitative and 09 qualitative articles were identified. The quantitative articles were developed under a descriptive-correlational-retrospective (12), descriptive-transversal (07) and comparative-retrospective (01) methodological design. In the case of qualitative designs, descriptive-cross-sectional (06), comparative-cross-sectional (02) and exploratory-cross-sectional (01) were identified. The main publication language of the articles was English (22), Spanish (05) and Portuguese (02).

Research was conducted in the United States (15), Colombia (05), Brazil (04), Iran (02), followed by Chile, Malaysia and the United Kingdom, with one study each.

Most studies were conducted in the years 2013 (07), 2014 (05), 2011 (04), 2009 (03), 1999 (02), 2006 (02), and the rest in 1992, 2010, 2012, 2016, 2017, and 2018, each with one publication.

It was identified that all qualitative studies (09) worked with samples of ≤50 cases: x≤10 (05 cases), 11≥x≤20 (01 case), 21≥x≤30 (02 cases), 41≥x≤50 (01 case). While those of quantitative character, 02 did so with samples ≤50 cases (17 and 33 cases, respectively) and, the remaining ranged from 51≥x≤266: 51≥x≤100 (06 cases), 101≥x≤150 (05 cases), 151≥x≤200 (04 cases) and 201≥x≤266 (03 cases). Along the same lines, overall, 06 studies focused on female breast cancer survivors and 23 studies on diagnosed women. However, the quantitative studies had a particularity: 19 studies focused on diagnosed women and 01 on survivors. Meanwhile, in those with a qualitative approach, a certain similarity was observed: survivors (04) and diagnosed (05).

With respect to the use of research techniques and instruments, it was identified that all the qualitative studies used the in-depth interview technique and 01 study in particular also used focus groups. On the other hand, in the case of the quantitative studies, to measure religious coping and spirituality they mainly used three evaluation instruments: Religious Coping Scale (RCOPE) by Pargament (1997), Multidimensional Measurement of Religiousness/Spirituality (MMRS) by the Fetzer Institute (1997) and Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being Scale (FACIT-Sp) by Peterman et al. (2002). The same instruments were repeated in several studies.

The relationship between the variables religiosity and spirituality as central elements for coping with the disease in female patients with breast cancer has been a general criterion in all the articles identified that have been part of this integrative review. It was observed that the topic addressed has been of interest to professionals in the social and health sciences, especially during the last decade, due to the increase of patients diagnosed with this type of cancer worldwide and the search for new ways of coping, understanding and resilience in the face of the impact of diagnosis, treatment, therapy (including chemotherapy), body mutilation (removal of the breast) and the proximity to death.

In the last decade, increased attention has been given to the study of spirituality/religiosity as a coping strategy used by people with cancer, given its protective role against psychological morbidity. Each individual relates spirituality to the hope of surviving cancer. However, the review of the literature specifies a conceptual ordering/differentiation between religiosity and spirituality as independent theoretical concepts (Sanchez, Sierra, & Zarate, 2014), the same that is situated from the approach to the modes of agency and interpretation of the events of the disease, which, in turn, are crossed by conceptions and practices related to "the spiritual" and "the religious" (Puentes, Urrego, Sanchez, 2015). Then, religiosity is understood as a social dimension that includes theological beliefs, practices, commitments and

congregational activities as an institutional organization (Plant & Sherman, 2001). On the other hand, religiosity is also defined as the personal meaning that individuals attribute to a particular system of beliefs, values, rules of conduct and rituals (Mickey, Soeken & Belcher, 1992). Meanwhile, spirituality relates more to an individual and private experience with "the sacred" that suggests a sense of transcendence and may or may not be embedded within a particular religious tradition (Breitbart, 2005). Additionally, spirituality is shown to be a felt connection to a non-mental, non-emotional, and non-physical aspect of the self (Hiatt, 1986), which includes elements of meaning, purpose, and connection to a Higher Power or something greater than the self (Targ & Levine 2002). Some authors have divided spirituality into two factors: intrinsic and extrinsic, with the intrinsic factor originating from within the person, while extrinsic factors are seen outside the person (Donahue, 1985) and (Allport, 1967).

After reading the articles, extracting and analyzing the relevant information to answer the guiding question, the data were organized into two categories: positive or negative CRS use in diagnosed patients and by survivors.

R.1. Use of positive CRS in diagnosed patients.

Religiosity in women diagnosed with breast cancer is expressed in most cases as a coping resource towards the disease (religious coping). That is, in a more functional sense in terms of subjective well-being, but not as the underlying structure that governs their daily actions based on religious norms and values (Mickley, Soeken & Belcher (1992). Thus, faith and religiosity are coping tools in women with breast cancer (Feher, & Maly, 1999). This coincides with the findings reported by Cotton, Levine, Fitzpatric, Dolda, & Targ (1999) where it was evidenced that spiritual well-being and quality of life have a positive correlation and that it is related to five psychological adjustment styles (fighting spirit, helplessness/hopelessness, fatalism, anxious preoccupation and cognitive avoidance), clarifying the intimate relationship between psychological adjustment and spirituality. In addition, a strong relationship between spiritual well-being and quality of life was evidenced, resulting in an associated increase in physical, emotional and functional well-being (Morgan, Gaston-Johansson & Mock, (2006).

Likewise, Barboza, & Forero-Forero (2011) observed a tendency, in women with breast cancer, to be more spiritual/religious than those without breast cancer. They reported a greater commitment to belief in god and a sense of responsibility to try to alleviate suffering in the world. Thus, Gall, Charbonneau, & Florack (2011) have concluded that various aspects of religiosity/spirituality have different positive implications for the experience of breast cancer perception, growth, and clinical follow-up.

For example, some women use spirituality/religiosity as a coping resource (Lagman, Yoo, Levine, Donnell, & Lim, 2012), with prayer being the most commonly used

practice of religiosity and spirituality, as it was reported to help them cope positively with their daily lives. In other cases, it was reported that some women expressed a firm belief that the prayers they prayed contributed to their healing process (Lagman, Yoo, Levine, Donnell, & Lim, 2012).

Additionally, Thuné-Boyle, Stygall, Keshtgar, Davidson & Newman (2013) found that the time at which the illness is detected and how RS coping resources are effected at the onset of the patient's illness and how the illness is perceived is also important.

The literature review in this particular leads to the notion of religious coping. Mesquita, Lopes, Valcanti, Denismar, Alves, Gerhke, & Campos de Carvalho (2013) reported that breast cancer patients, with a greater religious sense, consider spirituality and religiosity as a very important factor for coping with the disease so they use more positive coping strategies, different from patients who did not consider themselves religious, as the latter tend to use negative spiritual/religious coping.

It has also been identified that, in other cases, diagnosed women use more positive religious/spiritual coping strategies than negative CRE. Positive (CRE) (perceiving god as a presence or condition of existence/survival) helps patients cope with the stress of the disease, and may serve as a potential resource during treatment (Veit, & Kern de Castro, 2013). In addition, a strong relationship was found between diagnosed women and a higher power (God): the practice of faith helped in the elaboration of a meaning of the disease, which favored a greater control of their condition and the mobilization of a sense of hope towards healing. The social support of the religious community also appears as a positive coping tool, as all participants established good relationships with those who helped them, they felt more valued and loved through these friendships (Mesquita, Lopes, Valcanti, Denismar, Alves, Gerhke, Campos de Carvalho, 2013).

It is also important to pay attention to the mechanism by which religious coping strategies become highly recurrent in their practical use. Thuné-Boyle, Stygall, Keshtgar, Davidson, & Newman (2013) suggest examining individual coping strategies rather than taking them as a set of a priori strategies, as high coping ability may be beneficial and have a relationship/link to less psychological distress, negative religious coping strategies, and catastrophic thinking. Women with fewer negative religious coping strategies have higher levels of spiritual well-being and less distress (Gaston-Johansson, Haisfield-Wolfe, Reddick, Goldstein & Lawal, 2013). Here, it is observed that the use of self-affirming coping strategies is related to high spiritual well-being development and less negative religious coping. In sum, catastrophic thinking has negative effects on psychological distress and spiritual well-being.

R.2. Use of negative CRSs in diagnosed patients

Interesting findings have been reported on the use of negative religious coping resources. Thuné-Boyle, Stygall, Keshtgar, Davidson & Newman (2013) reported cases of women who manifest feeling abandoned and punished by god being this a predictor of negative depressive mood. In other cases, some patients may use religious coping in a negative way because the religious theme is simply a rejection, that is, they are not religious/spiritual people and make use of other types of non-religious coping strategies such as acceptance/denial, instrumental support, planning, self-blame, distraction and venting (Staton, Danoff-Burgh & Hugging, 2002).

Cases were found where negative religious coping strategies can have a negative impact on the development of the disease as they affect women's ability to maintain a positive perception of their health, triggering a process of internal spiritual struggle with feelings of anger, confusion and uneasiness as they question their religious practices and beliefs and their relationship with God when they feel that their life is in danger (Sheerman & Simoton, 2001). In addition, Choumanova, Wanat, Barrett & Koopman (2006) found that not all patients are optimistic when cancer is very advanced because it is difficult to have faith in those circumstances.

Gullate, Brawley, Kinney, Powe, & Moone (2010) identified that when there are very high levels of religiosity and spirituality these can affect the period of symptom detection in some women by physicians, as some women only told God at the time of discovering a symptom.

It was also found that negative religious coping is directly related to the feeling of physical well-being, impairing it and slowing down the process of clinical intervention. According to Fiala, Bjork & Gorsuch (2002) this is aligned with the anxiety, depression and stress suffered by the patient.

R.2. Use of CSR in survivors

The use of CSRs was positively manifested by providing survivors with primary coping resources of psychological (subjective well-being) and religious (prayer) coping with illness, as well as an enhanced emphasis on the importance and significance of religion and spirituality in their lives (Choumanova, Wanat, Barret, & Koopman, 2006): the practice of prayer as a coping resource was used to generate peace of mind, distracting emotional stress and negative thoughts about illness such as death or loss. A state of relaxation is generated as a symptom reduction technique (Choumanova, Wanat, Barret, & Koopman, 2006).

In other cases, positive aspects were observed, showing that women breast cancer survivors improved the different dimensions of quality of life (HQQL) such as social well-being, functional well-being and the patient-doctor relationship, being good predictors of these (Wildes, Miller, San Miguel de Majors, & Ramirez, 2009).

Ahmad, Muhammad, & Abdullah (2011) demonstrated a significant influence of spirituality and religiosity in coping with illness by developing in women a positive acceptance of illness, being more aware of life, and developing a sense of it as preparation for the afterlife. That is, an optimism for life motivating their behaviors beyond the disease.

Other religious practices most used by survivors were attending religious services, prayer/meditation, Bible readings. Relying on god highlights different agency practices to provide oneself with positive coping resources: going to church, being heard by a clergy person, asking for prayer and prayers for/to oneself, enabling better management of stress and fears (Lynn, Yoo, Levine, 2013).

In other cases, it was evidenced that some women, being more aware of life, realized that their personal life possesses a fleeting nature. This positively influences their behavior as a source of motivation for personal development, as well as awakening the altruistic sense (Schneider, Edward (2014). From egocentrism to a sense of altruism.

In this regard, Manning, & Radina (2014) observed that, with respect to mothers of survivors, stress management is related to developing a sense of the unknown and maintaining hope. Serving as a resource to caregivers of breast cancer patients.

Finally, religiosity and spirituality have significant associations in survivors' healthy behaviors (Park, Waddington, & Abraham, 2018), with quality of life and post-traumatic stress (Purnell, & Andersen, 2009) and, specifically, spiritual identity and coping are established as practices more related to healthy behavior rather than prayer in some cases (Park, Waddington, & Abraham. (2018).

Conclusions

Religiosity and spirituality in breast cancer patients can be analyzed in the whole process of the development of the disease from diagnosis, during treatment and after recovery and also from the positive and negative religious spiritual coping. In positive CSR, for diagnosed patients, religiosity/spirituality is a way in which women cope with their disease, because in it they find emotional, social and meaningful support. Patients place their trust in a supreme being in the hope of obtaining help and strength to manage the situation in the face of the worry, fear and uncertainty caused by the disease when it is detected. In the context of the patients' well-being and quality of life, the spiritual element is interpreted as a factor that influences the state of health, as well as the recovery and improvement of pain levels, contributing to the quality of life of the patients that allows them to incubate positive thoughts, to have faith and to

search for the meaning of life, all this related to the hope of recovery and with a feeling of hope and optimism towards the future.

On the other hand, in negative coping, diagnosed patients may feel the disease as a divine punishment, generating in them feelings of abandonment, frustration and uneasiness, even rethinking their relationship with God. Religious practice is questioned for some patients who do not profess a religion and instead use other mechanisms such as acceptance to cope with the disease. On the other hand, there are some religions such as Islam where anger towards God is not accepted, but one must accept his design. Studies should also analyze other aspects such as the pessimism that leads patients to expect bad results, believing in advance that things will not go well.

The patients who have recovered from their cancer experience have made use of the spiritual element as a support, generally through prayer, feeling that there was always someone to trust and feel supported when the treatments were traumatic and they had moments of fragility, finding comfort in religious and spiritual faith. Another aspect that has helped them to overcome the disease has been the support received from religious communities that encouraged them to endure suffering and trust in God, so that many of the patients have transformed their lives in the face of the disease.

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