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PSYCHOPATHOLOGICAL ANALYSIS, SUICIDALITY AND SPIRITUALITY IN ELDERLY PEOPLE WITH CANCER

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ABSTRACT

Objective: The objective of this study was to analyze the relationship between psychopathology, suicidality and spirituality and religiosity (R/S) of elderly people with cancer. Methods: To this end, a cross-sectional study was conducted at a High Complexity Care Center in Oncology (CACON, as per its Portuguese acronym) in the State of Pernambuco (Brazil). The sample consisted of 60 people over 60 years of age admitted to the oncology ward from September 2019 to January 2020. Sociodemographic and clinical data (oncology and mental health) were collected, where psychopathological aspects and R/S indexes were analyzed. For statistical analysis, the SPSS 13.0 software was used. **Results:** Controlled levels of psychopathology (4.75 ± 5.68) were found, in addition to high levels of spirituality (22.35 ± 6.06) and organizational (2.68 ± 1.54), non-organizational (2.20 ± 2.89) and intrinsic (4.87 ± 2.89) religiosity. There was a statistically significant association between psychopathology and suicidality ($p = 0.023$). **Conclusion:** The significant potential of R/S in the lives of elderly people with cancer was noted, and then it is suggested to include this perspective in multidisciplinary care practices. The association between psychopathology and suicidality reinforces the need for greater articulation between psychiatry and psychology in the care of people with chronic and threatening conditions such as cancer.

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INTRODUCTION

Epidemiological surveys show that 11% of the world's population is 60 years old or older, with a projected increase of 22% by 2050 (Newgard, 2013). Such age restructuring entails several challenges for health systems around the world. To give you an idea, 80% of elderly citizens have a chronic condition and 50% of them have two.[1] Among chronic diseases, cancer is linked to aging, since more than 50% of all neoplasms take place in people over 65 years of age, more than 60% of new cases and more than 70% of deaths from the disease happen in people aged 85 and over (Ferlay, 2018). Concerning the complexity of comprehensive care for elderly people with cancer, the American Society of Clinical Oncology (ASCO) recommends that, since the beginning of the disease and concurrently with treatment with a curative focus, these people have access to so-called palliative care (PC), whether they are hospitalized or not (Ferrell, 2017). These prioritize the proportionality of care and comfort strategies in the face of diseases or conditions that predispose the finitude of life.

Such conditions predispose the person to experience a myriad of symptoms resulting from the progression of the disease and also from its treatment. Dong, Butow and Costa highlighted the presence of four common groupings of symptoms present in the trajectory of advanced cancer, namely: anxiety-depression, nausea-vomiting, nausea-inappetence and fatigue-dyspnea-drowsiness-pain (Dong *et al.,* 2014). In most cases, these groups of symptoms were not stable longitudinally and their refractoriness can threaten the quality of life and dignity of thousands of people and their families (Kelley *et al.,* 2015). The complexity and multidimensionality of human distress in the PC setting, in addition to the physical aspect, contemplates the psychological, social and spiritual instances (Miccinesi, 2020). When it refers specifically to the presence of mental distress in the environment of PC, numerous psychological aspects can be touched and a series of fears, anxieties and other feelings can gain space. Lloyd-Williams *et al*. point to a 30% prevalence of psychological distress (experiencing stress, anxious symptomatology and depressive symptomatology, for example) in people under PC and correlates this distress with functional loss, decreased treatment adherence and increased institutionalization (Lloyd-Williams, 2009).

Furthermore, the onco-geriatric population has indicators of depression about three times higher than the general population. Ghanmi *et al.* found a prevalence of depression of 48% in hospitalized elderly citizens and drew attention to the correlation of this fact with single or widowed marital status, lesser degree of autonomy, fatigue, pain and a history of mental disorders in the family. The loss of functionality and the consequent increase in dependence were indicated as strong predictors for the diagnosis (Ghanmi, 2020). As an alternative to manage distress in its multiple expressions, people diagnosed with threatening conditions can find tools for maintaining self-esteem in spirituality and religiosity (R/S), developing a sense of hope and understanding in relation to the meaning and the purpose of life, as well as of the fact of getting sick (Nejat, 2016). Koenig *et al.* defined religion as an organized system of beliefs, rituals and symbols historically elaborated to facilitate proximity to the sacred or transcendent (God, higher power, ultimate truth, etc.). Spirituality, on the other hand, would be characterized by a personal search to understand the final questions of life, about its meaning and relationship with the sacred or transcendent and which may or may not lead to the development of religious rituals (King, 2009). There is increasing evidence that R/S is related to several aspects linked to health, both physical and mental, and quality of life (Lucchetti, 2014). The knowledge of how R/S influences the mental health of people with cancer can help in the development of preventive measures and guidelines to drive the practice of health professionals. Therefore, the present study has the objective of performing a psychopathological and R/S analysis in elderly people followed-up by a High Complexity Care Center in Oncology (CACON, as per its Portuguese acronym) in Pernambuco.

METHODS

Study design: A descriptive cross-sectional study was conducted.

Sample: The study was conducted with a consecutive, non-probabilistic sample. Which included 60 people aged 60 or over who had a cancer diagnosis and were admitted to the oncology ward of the Prof. Fernando Figueira Integral Medicine Institute (IMIP, as per its Portuguese acronym) between September 2019 and January 2020, excluding those with significant organic impairment (such as severe hearing loss or aphasia) that prevented the interview.

Procedure: After authorization from the coordination of the IMIP oncology service, the elderly were approached in their beds and, after reading the Free and Informed Consent Term, they were invited to participate in the study. Those who accepted, proceeded with the signature of the term in two copies followed by the data collection that was carried out through the instrument to be described below.

Variables and data collection instrument: Data collection took place through a guided interview and response to a structured questionnaire. It encompassed sociodemographic variables (sex, age, race/color, education, origin, income, religion and family history of mental illness), clinical variables (oncology and mental health) and R/S variables, through validated instruments, namely: Palliative performance scale (PPS): translated and valid for Brazilian Portuguese in 2009, it is a scale for assessing functionality that takes into account deambulation, evidence of disease activity, self-care, oral intake and level of consciousness, determining a level of functionality ranging from 100% to 0 (death).[12] In this study, the PPS greater than or equal to 70% was considered as an indicator of preserved functionality. Palliative prognostic index (PPI): it has variables (physical performance, oral intake, edema, dyspnea at rest and delirium) that must be scored between 0 and 4, with a score ranging from 0 to 18 (best prognosis and worst prognosis) and that, subsequently, three subgroups should be allocated: Group A): PPI <2; Group B): PPI between 2 and 4; and Group C): PPI greater than 4, which represents, in perspective, the estimated survival greater than six weeks; estimated survival between three and six weeks; and survival less than 3 weeks, respectively.[13]

a)Brief Psychiatric Rating Scale (BPRS): it has 18 items referring to various aspects of symptomatology (psychopathology) that are distributed in four subscales or dimensions (anxiety/depression, retraction and psychomotor retardation, thought disorder and activation) that can have individual scores. The total BPRS score is obtained by adding all the items and can be categorized in the absence of syndrome (0-9 points), minor syndrome (10-19 points) and major syndrome (20 points or more) (Bech, 1986). For analysis purposes, in this study, it was chosen to combine the results of minor syndrome and major syndrome in "presence of syndrome". In this research, the version by Bech *et al*, adapted for Brazilian Portuguese, was used. The reliability of the global scale was evaluated in terms of internal consistency, with a value of cronbach's alpha coefficient equal to 0.65, and in terms of temporal stability, obtaining an intraclass correlation coefficient of the test-retest equal to 0.91 ($p < 0.05$) (Zuardi *et al.,* 1994). Spirituality Self-Report Scale (SSRS): it is a scale composed of six questions related to the dimension and individual application of spirituality presented in Likert format, ranging from "1 = totally agree" to "5 = totally disagree". The responses of the 6 items are added to produce the total score (ranging from 6 to 30), and this, in turn, represents the index of spiritual guidance (Galanter, 2007). SSRS has Cronbach's alpha ranging from 0.82 to 0.91. The Brazilian version of the SSRS presented similar internal consistency values to the original English version and can be considered good (Gonçalves, 2009).

Duke religion index (DUREL): it is a measure of five items of religious involvement that assesses the three main dimensions of human religiosity: organizational religious activity (ORA, frequency of institutionalized religious activities), non-organizational activity (NORA, private and non-religious activities) organizational aspects such as prayer and reading) and intrinsic religiosity (IR, religiosity as the ultimate meaning of life). The IR subscale (three items) has its response options offered in a decreasing direction and has a score ranging from 3 to 15 points. In order to classify it as high or low, a cutoff point of 6 points or less was used. The ORA and NORA scores, whose scores can range from 1 to 6, follow the same logic of interpretation of the IR score. In order to classify them as high or low, a cutoff point of 3 points or less was used (Koenig, 1997). The translated and validated version of DUREL into Portuguese has adequate internal consistency (cronbach's α > 0.80) and test-retest reliability (correlation coefficient intraclass > 0.90) (Taunay, 2012).
Furthermore, the suicidality of the patients was analyzed. For this purpose, a structured question on a Likert scale was used, which included the following answers: absent; thinks that life is not worth living; would like to be dead, or any thoughts about possible death for oneself; suicidal ideas or gestures or suicide attempt. The last two responses were encompassed and interpreted as 'presence of suicidality'. The understanding of the health situation was also validated through a question whose answers ranged, on a Likert scale, from: i understand perfectly; i understand almost everything; i understand reasonably; i don't understand why nothing; i do not understand anything.

Statistical analysis: For statistical analysis, the SPSS 13.0 and Excel 2010 programs were used. The results are presented in tables, with respective absolute and relative frequencies. In order to check the existence of an association between psychopathology and suicidality and R/S, the Chi-square and Fisher's exact tests were used for categorical variables, and all tests were applied with 95% confidence. For statistical purposes, a value of $p<0.05$ was considered.

Ethical aspects: This research was submitted for analysis by the IMIP Human Research Ethics Committee (entry nº: 864), being approved under CAAE 04278818.2.0000.5201, and was carried out complying with all ethical aspects required by the institution. Eligible patients were informed about the objective of the study, its duration and the non-mandatory participation, and then signed a free and informed consent form.

RESULTS

It was attended by 60 elderly people, mostly men (55.0%), white (51.7%), with four years of schooling (32.7%), married (61.0%), with an average age of 68.48 ± 6.43 years old and originating from the Recife metropolitan region (Pernambuco, Brazil). Most (58.3%) had about 1 minimum wage per month, which is equivalent to US$ 205.00 and had male or female partners (61.0%). The most prevalent religion was Catholic (53.3%), followed by Evangelical (38.3%), as shown below (Table 1).

Table 1. Sociodemographic data of the elderly people with cancer admitted to the oncology ward of the Prof. Fernando Figueira Integral Medicine Institute. Recife, 2020

Variables	N	%
Gender		
Male	33	55,0
Female	27	45,0
Race		
White	31	51,7
Black	18	30,0
Brown	10	16,7
Indigenous	1	1,7
Schooling level		
Illiterate	9	15.5
Elementary School I	19	32.7
Elementary School II	7	12.1
High School	16	27.6
Higher Education	7	12.1
Origin		
RMR*	31	51.7
*ZM**	12	20.0
Agreste (harsh)	3	5.0
Sertão (hinterland)	5	8.3
Other states	9	15.0
Marital status		
With partner	36	61,0
Without partner	23	39,0
Religion		
Catholic	32	53.3
Evangelical	23	38.3
Spiritist	1	1.7
Atheist	1	1.7
Without religion	3	5.0
Age		
Average ± SD		68.48 ± 6.43
Minimum – Maximum		60 – 87

(*) Recife metropolitan region; (**) *Zona da Mata*

The most prevalent primary cancer sites were prostate (33.3%) and breast (16.7%). A total of 21.7% had some metastasis and 40.0% had undergone neo-adjuvant surgery. Almost half (46.7%) of the participants had been ill for less than six months and 80.0% started cancer treatment within 60 days after diagnosis as determined by Brazilian Law nº 12.732 (Table 2). Chemotherapy was performed by 65.0% of the total (Table 2). In general, the participants in this research had preserved functionality (73.3%) and a prognosis greater than six weeks (80.0%). The data from the psychopathological analysis obtained through the BPRS are described in Table 2. The subscales of anxiety and depression, followed by the subscale of retraction and psychomotor retardation, were those with the highest scores: 2.8 ± 3.8 and 1.42 ± 3.21 respectively. The domains of thought disorder and activation had scores <0. The average of the total BPRS score was 4.75 (SD ± 5.68), and 76.7% of participants did not have significant psychopathology, while 21.7% and 1.7% had minor syndrome and major syndrome at the time of assessment, respectively (23.4% with the presence of syndrome). Of the total participants, 88.3% claimed they had not received any psychiatric diagnosis during the follow-up at the institution's oncology service and only 18.3% reported the existence of some psychiatric diagnosis, including depressive, anxiety and /or psychotic syndromes, in first or second degree relatives (Table 2).

Table 2. Clinical variables (oncology and mental health) of the elderly people with cancer admitted to the oncology ward of the Prof. Fernando Figueira Integral Medicine Institute. Recife, 2020

Variables	n	%
Cancer		
Colorectal	8	13.3
Cervical	5	8.3
Breast	10	16.7
Prostate	20	33.3
Lung	10	16.7
Other	7	11.7
Metastasis		
Yes	13	21.7
No	47	78.3
Treatments		
Chemotherapy	39	65.0
Radiotherapy	26	43.3
Brachytherapy	3	5.0
Surgery	24	40.0
Family history of mental illness		
No	49	81.7
Yes. Depressive syndrome;	6	10.0
Yes. Anxiety syndrome	1	1.7
Yes. Psychotic syndrome	4	6.7
Suicidality		
Present	6	10.0
Absent	54	90.0
Psychopathology*		
Absence of Syndrome	46	76.7
Presence of Syndrome	14	23.4
Average ± SD		4.75 ± 5.68
Minimum – Maximum		0 – 24

(*) Index obtained from the Brief Psychiatric Rating Scale (BPRS)

As for the communication regarding illness, most (53.3%) reported not having a good understanding of their clinical situation and, of these, 21.7% chose not to be informed. Regarding the experience of total distress, physical distress (43.3%) and social distress (40.0%) were the most prevalent (Table 3).

Table 3. Communication and total pain variables of the elderly people with cancer admitted to the oncology ward of the Prof. Fernando Figueira Integral Medicine Institute. Recife, 2020

Variables	N	%
Understanding about illness		
With good understanding	28	46.7
Without good understanding	32	53.3
Sphere of greatest concern or distress		
Physical	26	43.3
Emotional	8	13.3
Social	24	40.0
Spiritual/existential	2	3.3

As for the spiritual and religious dimensions of the participants, the spirituality index was 22.35 ± 6.06, while the organizational, non-organizational and intrinsic religiosity indexes were 2.68 ± 1.54, 2.20 ± 2.89 and 4.87 ± 2.89, respectively (Table 4). The relationship between psychopathology, R/S and suicidality is found in Table 5. An association was found between the presence of psychopathological syndrome (major or minor) and suicidality, identified here through suicidal ideas or gestures or a report of attempted suicide (p-value = 0.023). The relationship between R/S and suicidality was also tested, but no statistically significant results were found.

DISCUSSION

The present study provides information and can signal the direction of new more detailed investigations that contemplate the psychological instance of distress and the potential for positive coping provided by R/S. Its results show a majority of men, white, with a low schooling level, from Recife and the metropolitan region and with an average age of less than 70 years.

Table 4. Spirituality and religiosity indexes of the elderly people with cancer admitted to the oncology ward of the Prof. Fernando Figueira Integral Medicine Institute. Recife, 2020

Variables	n	%
Spirituality index*		
High	52	86.7
Low	8	13.3
Average ± SD	22.35 ± 6.06	
Minimum – Maximum	6 – 30	
Organizational religiosity index**		
High	43	71.7
Low	17	28.3
Average ± SD	2.68 ± 1.54	
Minimum – Maximum	1 - 6	
Non-organizational religiosity index**		
High	50	83.3
Low	10	16.7
Average ± SD	2.20 ± 2.89	
Minimum – Maximum	1 - 6	
Intrinsic religiosity index**		
High	51	85.0
Low	9	15.0
Average ± SD	4.87 ± 2.89	
Minimum – Maximum	3 - 15	

(*) Index obtained from the Spirituality Self Rating Scale; (**) Duke Religion Index

Table 5. Relationship among psychopathology, spirituality, religiosity and suicidality of the elderly people with cancer admitted to the oncology ward of the Prof. Fernando Figueira Integral Medicine Institute. Recife, 2020

	Psychopathology		
Variables	Presence of Syndrome n (%)	Absence of Syndrome n (%)	p-value***
Spirituality index*			
High	13 (25.0)	39 (75.0)	0.667
Low	1 (12.5)	7 (87.5)	
Organizational religiosity index**			
High	11 (25.6)	32 (74.4)	0.737
Low	3 (17.6)	14 (82.4)	
Non-organizational religiosity index**			
High	12 (24.0)	38 (76.0)	1.000
Low	2 (20.0)	8 (80.0)	
Intrinsic religiosity index**			
High	13 (25.5)	38 (74.5)	0.671
Low	1 (11.1)	8 (88.9)	
Suicidality			
Present	4 (66.7)	2 (33.3)	0.023
Absent	10 (18.5)	44 (81.5)	

(*) Index obtained from the Spirituality Self Rating Scale; (**) Duke Religion Index; (***) Fisher's Exact Test

High R/S rates and a controlled index of psychopathology were found, as well as a significantly statistical association. The majority of men may have favored a higher prevalence of prostate cancer over other primary cancer sites. Considered as a disease typical of elderly men, prostate cancer can affect from physical functions, such as sexual, to psychological, cognitive and social functions, factors that negatively interfere with quality of life and that point to the need to know and evaluate the living conditions, social support, as well as to grasp the understanding of illness experienced by these men (Fervaha *et al.,* 2020). Estimates indicate that one (1) out of six (6) men with prostate cancer has depression. Suicidal ideation, in turn, is also not uncommon in this population and, although the choice of definitive treatment (radiotherapy or surgery) does not seem to affect depressive symptoms, the accomplishment of androgen deprivation therapy seems to exert a cumulative effect and intensify even more the experience of psychological distress. In addition, depressive symptoms can also adversely affect cancer outcomes (Araújo, 2017).

Regarding communication, it was noted that most elderly people denied good understanding about their illness, which includes everything from information about the diagnosis to questions about the prognosis and care planning proposed by the health team. Objectivity, clarity, completeness and compassion are basic requirements for the development of effective communication.

The good understanding on the part of the receiver decreases the risks of errors and occurrences, provides comfort, safety and quality in the relationship of the health team with the person in illness and the family/ community of reference (Machado, 2019). On the other hand, information can be hidden, especially in conflicting circumstances, at the initiative of the health team and/or the family/community of reference in a process called Conspiracy or Pact of Silence. This would be defined as an implicit or explicit agreement that would have the objective of altering or filtering information provided to the person, in relation to diagnoses, prognoses and also about attitudes towards treatment. The Conspiracy of Silence is considered a barrier to the truth in clinical practice (Espinoza-Suárez, 2017). Evidence suggests that most people with diseases or threatening conditions like cancer know they are going to die and want to talk to their family about this matter. A survey carried out by the Reference Center for the Elderly Person in a Brazilian capital shows that, in a situation of serious illness, with less than an estimated year of life, most elderly people (74.0%) would always like to be informed about their limited life prognosis. This population also stated that they would like to be informed about symptoms and health problems (89.3%) and about the options available for care, if they received any threatening diagnosis (96.3%) (Espinoza-Suárez, 2017).

In the same vein, a European population-based study that interviewed 9,344 people from different European Union countries concluded that 73.9% of these expressed the desire to always be informed about issues of illness and prognosis, with a variance of 67.6% (Italy) up to 80.7% in a Belgian region. Only a minority (21.1%) stated that they preferred not to be aware of such information, (Harding, 2013) a data similar (21.7%) to that obtained by the present study. This fact predicts that the desire for an effective and non-violent communication, strengthening the autonomy of the person, does not depend on culture or nationality. Such results reinforce the need to foster knowledge, skills and attitudes in difficult communication by multidisciplinary health teams. In addition, it is suggested that they are equipped to identify and manage critical cases, such as those in which people choose not to be informed and when there are family conflicts (Espinoza-Suárez, 2017). Family conflicts, loss or threat of social role, financial, labor or beneficiary concerns are events that can characterize social distress or pain. In this study, the experience of social pain is equated with the experience of physical pain (40.0% and 43.3%, respectively), overcoming psychological and spiritual distress. In contrast, social support, often performed by the family, reference community, religious institution and other community groups, seems to positively influence the experience in question. A survey carried out with more than 12 thousand people with cancer showed that social support would be a coping factor that would reduce, even, the negative impact caused by the symptoms of anxiety and depression in pain, in other words: the effect of depression on pain differed according to the degree of social support, even after controlling for all clinical-epidemiological variables (Galloway, 2019).

The difficulty in expressing spiritual and psychological distress may be the result of non-recognition, prejudice and difficulties in dealing with ultimate and intimate issues of distress, which may answer the result found by this study, where less than 20% of surveyed people pointed to psychological and spiritual distress as their biggest nuisance. Especially regarding spiritual distress, there is a lack in the literature that highlights its real prevalence, which makes it difficult for health teams to develop identification and management strategies. With regard to psychological distress, the cancer diagnosis has been constantly associated with several mental disorders that can potentiate self-destructive tendencies and, ultimately, lead to suicide.[26] In addition to discussing specific diagnostic perspectives, this study focused on the analysis of psychopathology. It is understood that psychopathology is a science that studies mental illness and is based on its manifestation (signs and symptoms) in certain psychological functions (mood, affectivity, reality judgment, psychomotricity, etc) (Dalgalarrondo, 2019). Controlled psychopathology indexes were found in this study, only the domains of anxiety and depression and retraction and psychomotor retardation had average scores greater than zero, but, even so, low scores were found. The same happened, consequently, with the total BPRS score. Notably, the anxiety and depression score, assessed by one of the domains of the instrument, strengthens the premise that dysfunctional mood may represent a pathogenic substrate common to depression, cancer and the aging process, which may have important implications for the treatment itself. Studies point to a higher prevalence of mild depressive symptoms (23%) compared to significant depressive symptoms in elderly citizens (8 to 16%). For those with cancer, the prevalence range is even greater, which may reflect the diversity of measurement strategies, psychopathological presentations, ages, treatment status and other peculiarities of mental illness in this population (Krebber, 2014). Identifying and treating depression in cancer patients has been considered an effective strategy to decrease morbidity and mortality, especially in situations where there is an increased risk of suicide, which determines a decisive planning of interventions (Whisenant, 2020). Surveys reported several risk factors associated with suicidality in the elderly population, such as male gender, economic vulnerability, educational level, physical activity, interpersonal trust, social support, discrimination, loss of social status, mistreatment and loss of functionality (Choi *et al.,* 2019). Furthermore, several psychiatric syndromes are also indicated as an independent risk factor for suicide in elderly people with cancer, which corroborates this

study (Rossom, 2019). An American case-control and population-based study showed an association between suicide and cancer (OR 2.62, 95% confidence interval [95% CI] 1.84–3.73) to the detriment of possible associations with other morbid conditions such as acute myocardial infarction, hip fracture or stroke. Moreover, in this study, the likelihood of suicide declined among elderly people with a spouse (OR 0.61, 95% CI 0.43–0.88) and/or who had one or more indicators of social support (OR 0.27, 95% CI 0.19–0.39) (Cole, 2014). On the other hand, a factor that potentially decreases the incidence of depression and anxiety and improves the quality of life of people with cancer is spirituality. An observational study conducted with 115 Lebanese undergoing cancer treatment showed that spiritual well-being correlated significantly and positively with the overall quality of life status and with emotional and cognitive functions; conversely, it was negatively correlated with fatigue, dyspnea and loss of appetite (Abou Chaar, 2018).

In this study, the spirituality index was considered satisfactory, as well as the ORA, NORA and IR indexes, data analogous to those of similar publications (Leimig, 2018). A study conducted in Brazil with 140 elderly people admitted to a hospital service in the Brazilian Federal District used the same religiosity measurement instrument as this study and highlighted a significantly statistical correlation between IR and the absence of depressive symptoms (Nery, 2018). An observational study that analyzed the influence of spirituality on decision-making in people under PC showed that spiritual well-being was associated with fewer decision conflicts, less uncertainty, a feeling of being more effectively informed and supported and greater satisfaction with the decisions. Moreover, spiritual well-being also correlated significantly with physical, emotional and functional well-being and a better quality of life (Rego, 2020). In this sense, it is necessary to understand that the inclusion of spiritual and religious instances would improve the quality of comprehensive care for people with threatening conditions. A survey carried out at the same health institution of this study highlighted that most (89.7%) professionals working in PC support consider that R/S has a strong influence on the lives of the people under their care and that this, in most times, it would be a positive influence (70.7%). These professionals feel motivated to approach R/S in clinical practice; however, they considered themselves little prepared for such procedure (Ferreira, 2015). Some limitations of the present study must be taken into account. First, it is a cross-sectional study, and therefore cause-effect relationships cannot be obtained from this methodology. Moreover, it was conducted only at an oncology service; thus, the results found should not be extrapolated or generalized to other populations. The small sample population, determined by the short time interval in which the study was held, also strengthens the fact that the results found should not be generalized. Further studies including a larger sample size and with other methodological designs that enable the establishment of cause-effect relationships between exposure and outcome variables are necessary, in this case, R/S and psychopathology. It is believed that this study may serve as a basis for this purpose, since it can raise interesting data. It is also suggested that factors such as social support and suicidality can be further studied and analyzed based on sociodemographic characteristics and clinical variables (such as time of illness, history of mental illness, marital status, etc.).

CONCLUSION

The results of this study show high levels of R/S in elderly people with cancer and, consequently, strengthen the significant potential of R/S in human life and the need to include this perspective in multidisciplinary care practices. Despite controlled levels of psychopathology, there was an association between it and suicidality, which reinforces the need for greater articulation between psychiatry and psychology in the care of people with chronic and threatening conditions such as cancer.

conflict of interest. This research was submitted for analysis by the IMIP Human Research Ethics Committee (entry nº: 864), being approved under CAAE 04278818.2.0000.5201, which guarantees the safety of data and materials. Eligible patients were informed about the objective of the study, its duration and the non-mandatory participation, and then signed a free and informed consent form.

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