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Chronic pain: perception of elderly cancer patients in hospital and their coping strategies

Dor Crônica: compreensão do idoso oncológico hospitalizado e suas estratégias de enfrentamento

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RESUMO | A dor é uma experiência multidimensional que gera desconforto físico e desencadeia muitas respostas afetivas e emocionais. Na população idosa a prevalência de dor é elevada, e dentro da oncologia a dor é o sintoma mais frequente e de difícil controle. Considerando que a dor crônica na população geriátrica evidencia-se enquanto uma situação estressora, e há uma grande variabilidade na forma de enfrentar tais situações, o presente estudo tem como objetivo analisar a percepção do idoso oncológico hospitalizado e as estratégias de enfrentamento utilizadas por este diante da dor crônica. Trata-se de um estudo exploratório, de natureza qualitativa e descritiva, através do qual foi realizado estudo de caso com cinco participantes. Foi utilizada a técnica de entrevista semiestruturada e a análise dos dados foi realizada segundo o método de Análise de Conteúdo de Bardin. Os resultados destacaram que os participantes significam a experiência de dor como uma vivência negativa, gerando e intensificando o isolamento e sentimentos de irritação, bem como evidenciaram a religiosidade e a espiritualidade enquanto principais estratégias para minimizar os impactos negativos advindos do adoecimento e tratamentos contínuos. O entendimento da maneira de enfrentamento da dor pode auxiliar profissionais de saúde na análise de fatores que influenciam na mesma, assim como na adequação de possíveis estratégias de enfrentamento disfuncionais no contexto de saúde, auxiliando o idoso no tratamento e em sua qualidade de vida.

PALAVRAS-CHAVE: Dor crônica. Idoso oncológico. Estratégias de enfrentamento.

ABSTRACT | The pain is a multidimensional experience that generates physical discomfort and triggers many affective and emotional responses. In the elderly population the prevalence of pain is high, and within the Oncology pain is the most frequent symptom and difficult to control. Whereas chronic pain in the geriatric population is evidenced as a estressora situation, and there is a great variability in the shape to face such situations, this study aims to analyze the perception of the elderly hospitalized cancer and coping strategies used by this on chronic pain. This is an exploratory study, qualitative and descriptive in nature, through which was conducted five case study participants. It was used the semi-structured interview technique and the analysis of the data was performed by the method of content Analysis of Bardin. The results highlighted that the participants mean the experience of pain as a negative experience, generating and intensifying the isolation and feelings of irritation, as well as highlighted the religiosity and spirituality while main strategies to minimize negative impacts arising from illness and ongoing treatments. Understanding the way to confront pain can assist health professionals in the analysis of factors influencing on same, as well as the appropriateness of possible strategies of dysfunctional coping in the context of health, assisting the elderly in treatment and in your quality of life.

KEYWORDS: Chronic pain. Elderly cancer. Coping strategies.

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Introduction

According to International Association for the Study of Pain (Associação Internacional para o Estudo da Dor - IASP), pain is an unpleasant sensory and emotional experience due to actual or potential tissue injury in the body (IASP, 2007). It is a subjective manifestation that varies among individuals and presents multiple dimensions (Angerami-Camon, 2012). There are several ways to classify pain, and concerning its duration, it can be divided into acute or chronic.

Acute pain is the pain expressed in short periods, which can last from minutes to weeks. Pain receptors involve nerve endings in the skin and their evolution is, in general, evidenced by gradual reduction of intensity until remission of the algic sensation (Angerami-Camon, 2012; Sallum, Garcia & Sanches, 2012). Chronic pain, in its turn, is characterized by a persistent manifestation, which can range from months to years. Literature indicates a period equal to or greater than three months of painful symptom to be classified as chronic (Angerami-Camon, 2012; Loduca et al., 2014).

Conforming to Dellaroza et al. (2008), as a research objective, the IASP establishes chronic pain as one that lasts longer than six months, either continuous or recurrent. It is usually related to already diagnosed and treated lesions and to diseases considered chronic and even irreversible. In this regard, there may or may not be a correlation between pain and injury. Due to the activation of different neuronal pathways in an extended mode, pain nature can change so that acute pain can become chronic (Sallum, Garcia & Sanches, 2012; Lima & Trad, 2008).

The prolonged period of a chronic pain can make pain as a symptom to become the disease itself, owing to its disturbing nature, causing impacts on lifestyle, mood modification, changes in family, social, work, and leisure relationships (Castro et al., 2011). It also constitutes a public health problem due to its prevalence, high cost, and negative impact that can produced in the quality of life of both patients and their families (Salvetti & Pimenta, 2007). The evaluation of chronic pain is more complex than for acute pain since it involves behavioral, cognitive, affective, social components, beliefs, expectations, values, among other aspects (Sallum, Garcia & Sanches, 2012).

In elderly population, pain prevalence is high, with chronic pain ranging from 29.7 to 89.9%. As in other systems in human body, aging promotes changes in nervous structure, altering pain processing, perception, and treatment. Some complaints among the elderlies related to pain are attributed to the age and considered proper to the aging process, thus, it is not accurately treated, as a result, negatively influencing the quality of life in old age (Celich & Galon, 2009; Pereira et al., 2009).

Among the most common types of pains in elderlies, are those of musculoskeletal origin, followed by neuropathic and oncological pain, that constitute chronic pain (Chiba & Ashmawi, 2011). The distribution of different types of cancer suggests an epidemiological transition in progress. With the exponential growth of elderly population, it is possible to identify an expressive increase in cancer prevalence, which demands that managers of the Brazilian Public Health System (Sistema Único de Saúde - SUS) strive to provide proper care to these patients (Brazil, 2006).

Age becomes a risk factor for cancer development due to the extended carcinogenesis period, tissues vulnerability to environmental carcinogens, and other transformations that favor tumor onset and growth, although malignant neoplasms are prevalent in any age range (Duarte & Nogueira-Costa, 2011). Geriatric oncology patients often present comorbidities, restricted physiological reserve, and functional limitations, requiring health professionals to make planned and individualized therapeutic decisions (Reticena, Beuter & Sales, 2015).

Therefore, professionals responsible for patients with chronic pain should consider the interference of cognitive and psychosocial factors in pain precipitation and maintenance, assessing physical, psychic, and social impacts of the illness and treatment (Duarte & Nogueira-Costa, 2011; Lima & Trad, 2008). Individual may face the events that can develop pain response with notable difficulty, aggravating its intensity and generating stress. Stressor factors are related to the conditions that affect the organism, and pain is one of these conditions, demanding from the patient, adaptive responses to deal with his illness (Angerami-Camon, 2012).

In Lazarus and Folkman (1984)'s perspective, the skills developed to deal with stress and adaptation situations are the coping strategies, which involves a set of cognitive and behavioral strategies used to evaluate and manage internal and/or external demands. Thus, such coping strategies correspond to the process by which the individual manages the demands of the person/environment relationship, and the emotions that they generate. Faced with a hard situation, individuals perform an evaluation of what is occurring, and formulates a response, in an attempt to solve and/or alleviate such situation.

Such strategies allow the individual to adopt new ways of thinking and behave when faced with stressful situations, based on their assessments and reassessments, and this may result in more or less adaptive outcomes when reviewing the initial situation. The coping behavior can be focused in the problem, in which the objective is to change the difficulty in the relation between the person and the environment, directing his action internally or externally; or centered on emotion, whose aim is to alter the emotional state, seeking to reduce the unpleasant sensation of the stress state (Vivan & Argimon, 2009). According to Horta, Ferreira and Zhao (2010), there is a variability in how to deal with disturbing situations. Regarding the experience of chronic pain in geriatric population, especially in cancer patients, the incipience of strategies may lead to loss of quality of life, depression, anxiety, and social isolation.

The present study had the objective to analyze the perception of hospitalized oncological elderly people and their coping strategies to face pain condition. The specific objectives were intended to know the perception of the hospitalized elderly people about chronic pain and to assess the relationship between how the individual perceives the pain and their strategies applied to deal with it.

It is a research of social and academic relevance not only considering the exponential demographic growth of the Brazilian elderly population, but also due to the physical, psychic, and social impacts of chronic pain in this specific population, a fact that demands actions directed to relieve the negative consequences of this chronicity. Furthermore, it is important to consider the perception of the subject, in this case, the elderlies, given that their narratives can provide important aspects about their experiences, and possible strategies that can be applied in pain management, hospitalization, and comprehensive care to cancer patients.

Method

Study Design

It is a qualitative, exploratory, and descriptive study. This type of research has the objective to explore the universe of meanings and feelings, allowing to understand the reality experienced by the participants. Descriptive research observes, records, analyzes, and relates facts or phenomena, aiming to know individual's values, principles, and beliefs (Minayo, 2010).

Location

It was carried out at an oncology unit of a philanthropic hospital for SUS users, in the city of Salvador, Bahia, Brazil. This research field is one of the institutions of practice of the Multiprofessional Residency Program in Health Care of the Elderly Person, in specialization modality, from which it was originated. Data collection was performed between November and December 2016.

Participants

Five elderly participants were selected. This number was set after data saturation criterion. Inclusion criteria were individuals with age equal to or above 60 years old; to be hospitalized in oncological unit of the hospital; to have a chronic pain diagnosis documented in medical records and not to have cognitive impairment that would make it impossible to perform the interviews. All participants selected met the inclusion criteria for participation in the study.

Instruments and procedures

Data collection was obtained through a semi-structured interview technique. It is characterized by a dialogue with the interviewee, based on previously elaborated questions, being complemented by others inherent to the momentary circumstances of the interview and flexible to the interviewee's adaptations (Minayo, 2010).

The first part of the script contained sociodemographic data, followed by issues related to the history of illness, diagnosis, cancer treatment, pain perception, and the coping strategies used. Among the formulated questions were the following concerned to the illness history: "What is your diagnosis?", "How long has the diagnosis been known?", "Have you had any previous treatment?", "What is your current treatment?"," How long have you Sir/Madam been in the hospital? "" Tell me your history of illness. "

When it came to pain, the issues were: "What is pain to you?" "Do you attribute this pain to something specific?" "How long have you been experiencing pain?" "How did the pain start?" "What is the location of the pain?", "Is there any factor that increases/ alleviate the pain?", "What feelings do you have in the moment of pain?". For coping strategies: "In the moment of pain, do you do something to alleviate or diminish it? If yes, what is it? "," Is there any thought that helps you deal with pain? "," Is there any personal/religious belief that helps you deal with the pain experience? ". These questions were supplemented by others, based on participant' responses and the interview progress.

Interviews were carried out individually at the aforementioned oncology unit, and due to the interviewees' clinical condition, they happened in the wards, respecting the norms and routines of the multiprofessional consultations offered to the patients. Each interview was recorded with the aid of a digital recorder, which lasted an average of 30 minutes and was later transcribed in its entirety by the researcher. None of the participants declined to participate in this study.

Data Analysis

The analysis was performed according to the Bardin Content Analysis method, which allows the discovery of the meaning in the text message, resulting in meeting the objectives proposed in the study. Content Analysis is a set of communication analysis techniques that aims to obtain, through systematic procedures, indicators that allow the inference of knowledge regarding the conditions of production/ reception of these messages (Bardin, 2011).

Analysis phases were followed according to the three poles of organization proposed by Bardin: the preanalysis; the exploitation of the material; the treatment of results, inference and interpretation (Bardin, 2011). After data collection and interviews transcription, a floating reading was performed to capture the content in a generic way. In the successive readings, the key points of each participant speech were highlighted, according to pertinence and study's objectives. Then, the speeches were grouped according to representativeness, similarity, and relevance of the content. Finally, analytical categories were organized that were discussed based on the available literature.

Ethical Aspects

In order to guarantee research ethics, the study project was submitted and evaluated by the Ethics and Research Committee (CEP) of the institution that was the field of practice for the present work, with approval under the opinion number 1.813.073 (CAAE 58199816.0. 0000.0047). The research participants were elucidated on the objectives of the work, being free to participate or not, assuring them the freedom to give up at any time. After reading, understanding the objectives of the study and acceptance, the participants signed the informed consent form, respecting the ethical principles contained in Resolution 466/12 of the National Health Council, which regulates research involving human beings (Brazil, 2013).

Participants' confidentiality standards were maintained in order to avoid any exposure or vexatious situation. To ensure anonymity, participants were identified with names of precious stones, thus preserving the information provided. They were informed that this study would not cause physical or chemical risks, however, it could generate discomfort or inconvenience in sharing personal or confidential information in some topics of the questionnaire and that, in this case, they would be assisted by the psychology service of the unit.

Results and discussion

Five elderly people were interviewed, two men and three women, whose ages ranged from 60 to 66 years old. For marital status, two were divorced, one married, one single, and one widow. The participants

were adherents to different religions, among them the Catholic, Evangelical Christianity, Buddhist, and Spiritism. The level of schooling ranged from incomplete elementary school to complete high school. All of them knew about their own diagnostic and the period experiencing chronic pain varied from six months to five years. Participants profile and sociodemographic data can be seen in Chart 1 below:

Chart 1. Participants sociodemographic and health data

Aliases	Gender	Age	Marital status	Children	Schooling	Occupation	Religion	Diagnosis	Pain period	Hospitalized Period (until the interview day)
Amethyst	F	66	Widow	4	Incomplete elementary school	Retired Housekeeper	Catholic	Anal neoplasia	1 year and 2 months	20 days
Emerald	F	62	Divorced	9	Complete high school	Retired Housekeeper	Evangelical Christianity	Uterine cervical neoplasia	6 months	5 days
Uranium	M	64	Single	1	Complete high school	Retired Banker	Catholic and Spiristism sympathizer	Epiglottis and tongue basis carcinoma	2 years	12 days
Magnetite	F	60	Married	7	Incomplete elementary school	Retired Housekeeper	Evangelical Cristianity	Stomach neoplasia (with metastasis to liver and pancreas)	5 years	6 days
Ametrine	M	66	Divorced	5	Incomplete high school	Retired Eletrician	Budhist	Esophageal adenocarcinoma (metastasis to bones and liver)	10 months	50 days

During analysis of the interviews, three main themes that permeated and prevailed in their narratives were identified, which will be presented as analytical categories: "Pain perception and significance: multiple looks"; "Pain, loneliness and isolation: a two-way street" and, finally, "Pain, religiosity, and spirituality: the seek for a way out of science".

Pain perception and significance: multiple looks

The conceptual amplitude of pain involves multidimensional aspects and, therefore, the experienced pain involves body, mind, life history, and is loaded with meanings by those who go through it (Lima & Trad, 2008). Sustaining such meanings is an experience that includes sensations and feelings that influence the relationship between the subject himself and the others (Palmeira, 2015).

Pain experience understanding is important in the approach to pain in collective health practices, since, in such way, it will allow professionals to build knowledge on pain narratives, thus helping in therapeutic behaviors (Santos, Giancomin & Firmo, 2015). The one who experiences pain can suffer rupture with several important dimensions in his life, so, valuing the thoughts reported by those who feel the pain, can help to rescue the dimension of these subjects' autonomy, interfering in their identity and in the pain meanings (Palmeira et al., 2015). In the participants' reports, perceptions about pain, in general, refer to negative connotations, involving the associated losses, as well as the absence of happiness and well-being, as it is expressed in the following statement:

> *Oh ... pain is a bad thing, a very bad thing. It's something that should not exist in anyone, that's what I think, right? Without pain, you are in heaven, you are a happy, healthy person, you feel that you are a human being, I don't know how to explain, you feel everything good (Amethyst, 66).*

In this aspect, the patient Uranium also reinforces the negative nature of the pain when affirming: "Pain hurts, it is very bad". Ametrine further increment to this negative nature, the need to seek solutions to face it: "Pain is a symptom, too much unusual, there is nothing like this, that you are not used to feel and is uncomfortable, forcing us to go get help, you know?".

As discussed by Santos, Giancomin and Firmo (2015), each social group has a unique language through which sick people demonstrate to others the meanings of what makes them suffer. According to the same authors, in the field of elderly speech, it is recurrent that health is related to an experience of absence of pain, and then, the illness is interpreted as the pain felt itself in the aging body. Although the study participants do not convey the notion of aging linked to pain, they point to the dimension of suffering associated to the painful experience and the inconveniences arising from it.

Daily activities earn another connotation in the universe of those who live with chronic pain and it also directly influence the emotional aspects of the subject, as explained by Magnetite patient when affirming that "the pain affects our head", referring to the negative feelings such as nervousness and irritability owing to painful experience. Hence, the relations that are established are mediated by pain sensation and by diverse feelings, including irritation, fatigue, and sadness. (Castro et al., 2011)

These emotional aspects are described by patients who realize how much the pain influences emotions and affections, as expressed by Amethyst: "Sometimes experiencing the pain, I got very nervous, really nervous, I did not want to talk to anyone, I got really sad, feeling down". Magnetite also remarks it when she reports: "I run out of patience, I do not encourage anyone to come in, full house, and talk and make noise, I feel stressed." This aspect is still emphasized in the narrative below:

> *Oh, the pain got me irritated, nervous ... even people voices bother me. And I say: shut up! If anyone keep asking you if you are in pain, if it has alleviated, if it has intensified, will it solve the problem? For example, I'm here with you who just gave me a medicine, so it's like, 'And then, is it better? Is it over?' Then I'll say to shut up because ... will it solve? If I say the pain has increased, will it solve? If I say it has diminished, will it? No, it will not! So be quiet! I'd rather you take my hand and be quiet by my side, understand? (Uranium, 64 years).*

In this sense, chronic diseases, in general, have the characteristic of mediating the connection that the person establishes with the world. Pain can demonstrate how the presence of a persistent disease can generate psychological distress and interfere with the relation we set with the world, imposing daily

challenges on the relationships with oneself and with the others (Santos, Giancomin & Firmo, 2015).

Psychological aspects are also emphasized in painful complaints, as symptoms and disorders of anxiety and depression are really significant throughout the illness process and are aggravated by tension and apprehension before the algic syndrome. Especially people with chronic diseases, who require continuous treatment and for prolonged periods, they exhibited significant changes in mood and quality of life, which directly influence social relations, daily life activities, sleep, and appetite (Castro et al. 2011).

Through patients' reports it was also possible to observe another sense of pain. The established causal link was that unsuccessful interpersonal relationships influence the illness process and chronic pain:

I think that, what also got me here, was a disappointment I had in the last relationship, got me? (...) and that was when I was told about this problem of my cancer disease (Amethyst, 66 years old).

I was a very healthy woman, you know? But after a while, I used to get stressed with my husband, then, I was with diabetes, high blood pressure, then the blood was not going to the leg. I had surgery about one month ago, vascular ... and then after São João festivities, I started to bleed, I bled a lot, it was already cancer. (Emerald, 62 years old)

In patients' narratives, it is observed that the conjugal crisis is a factor directly related to the illness and how much this sickness articulates with several dimensions of life. A diversity of aspects is related to the context of the pain onset. Some disturbing events for the subject such as unemployment, grieving process, as well as family and marital problems can be triggers of an illness process and intensify chronic pain (Palmeira et al., 2015).

Pain experience includes naming the source of suffering, which implies having the conditions to relieve pain and know the direction to take concerned to this suffering. Thus, illness and pain onset is sometimes attributed to aging itself and its organic changes, but it also finds expression in blaming persons and/or life events, as observed in previous reports (Santos, Giancomin & Firmo, 2015). Seeking for an answer or causative agent, a search is set, not always verbalized by the individual, for a possible cause of the illness. Hence, symbolization and the search for meaning the illness are constant among people with chronic pain, referring to life events that represent losses (Santos, Giancomin & Firmo, 2015).

Pain, loneliness and isolation: a two-way street

Chronic pain influences not only the relationship that each person establishes with himself, but also generates effects in social and family relations, alters daily life, and can produce a sense of loneliness and generate isolation (Pereira et al, 2014). In this context, pain leads to new ways for this subject to relate to the world as now there is a complete change in the way of dealing with their routine, altered by the presence of the disease, treatments, and pain, which can guide the person to have a life more restricted in their usual activities.

Such a situation can conduct the subject to an intense questioning of his own identity, considering that society is very little structured in the matter of participation and inclusion of people who have become ill and who need more specific ways to get involved in the work, in reorganization of their daily activities, and in autonomy recovery. Thus, the subject can suffer not only from the pain, but from isolation that this circumstance creates (Pereira et al, 2014; Sallum, Garcia & Sanches, 2012).

Isolation and loneliness dimensions came out in the speeches of some of the interviewed patients, with different meanings. In Amethyst's report, loneliness is emphasized as an intensifying factor for the pain:

The pain increases when you are alone, with a kind of contempt, seeing yourself isolated, understand? That's sad, I think that's when we end up faster, when we feel like we've got abandoned for someone, you know? (Amethyst, 66 years old)

While in other narratives, social distancing and isolation response may be suggestive of a passive strategy (dysfunctional) to deal with pain:

(...) while feeling pain I prefer to be silent, in silence, that people do not talk to me, leave me quiet, understand? (...) someone can even stay with me, I don't insist, but if stay, do not ask me bullshit (Uranium, 64).

I drive pain in silence. I spend all day long feeling pain but I don't tell anyone. I spend all day feeling pain,

working, doing everything quietly. I like to be alone. It is a serious problem, isn't it? I want to be alone all day when I'm in pain (Magnetite, 60).

The use of coping strategies emerges from the occurrence of stressful events. Such events alone do not determine the negative consequences for people, as they depend on the cognitive assessment, on the demand that these events exert on the subject's life. In elderly population, there is significant variability in coping with stressful events, since they are exposed to different circumstances of their personal context, besides having different levels of resilience and a particular way of interpreting and dealing with the disturbing situations in which they are inserted (Horta, Ferreira & Zhao, 2010; Fortes-Burgos, Neri & Cupertino, 2008).

Thus, the choice of coping strategies depends on the perception and evaluation of the hard situation in which the subject is and can result in better or worse outcomes than the initial condition. Among the repertoire of coping strategies used by individuals, one can fall back on confrontational coping, the search for social support or social distancing, dodge/avoidance, emotions inhibition, positive reassessment, religious coping, search for information, among others (Ottati & Campos, 2014).

In Uranium and Magnetite's the reports, the silent response to the pain and the desire to be alone and not to be disturbed evidences how they deal with the difficult event regarding the painful process in which they live. Such a strategy seems to be functional for both; however, it is important to be aware of the psychosocial impacts of such strategies and the repercussions on routine and family dynamics, as these are not functional and adequate alternatives and produce significant consequences that corroborate the pain worsening. Considering that each stage of the cancer treatment is a stressful event, and how the patient deals with the problem influences the adaptation to the new phase, it is important that the therapeutic practices are directed to assist individuals' adaptation to the new reality as well as in the appropriate use of coping strategies (Ottati & Campos, 2014).

As discussed by Palmeira (2015), the difficulty in sharing about pain experiences and their social delegitimation are aspects that literature conveys in studies on meanings, emphasizing the dimension of pain individualization and also the idea of solitude, isolation and uncertainties about the future. Pain can restrict the person to himself, configuring as a solitary experience, without social mediation, impoverishing the interlocution with other people. This fact generates the feeling of isolation and compromises his language and the capacity for communicating the pain in the social field (Santos, Giancomin & Firmo, 2015).

In view of the possible impacts of social isolation of the individuals with pain, therapeutic goals should consider the importance of recovering daily activities, establishing a new social function, so that it can minimize the social isolation, despite the pain permanence. These aspects displace pain as the central aspect of life and put it in a perhaps controllable margin (Lima & Trad, 2007). It is important to be attentive to these aspects, so that care directed to the chronic patient to be effective, thus minimizing the impacts of their loneliness and creating spaces for symbolization and meaning of the painful experience in old age and oncological context.

Pain, religiosity and spirituality: a seek for a way out of science

Spirituality and religiosity as a coping strategy in health and illness contexts of individuals has been widely discussed in literature. Spirituality is the peculiar dimension of the human being that propels him in the search for the sacred, of the transcendent experience, in the attempt to give meaning and response to the fundamental aspects of life; involves the possibility of diving into oneself. Religiousness, in turn, is the expression or practice that can be related to a religious institution and is configured as a manifestation of spirituality itself (Gomes, Farina & Dal Forno, 2014).

Religiousness and spirituality are the most used coping strategies in crisis situations caused by health problems and, in general, have beneficial effects in diseases control and cure. For an expressive part of the elderly population, issues related to the divine and the sacred represent relevant means of dealing with hard events, especially facing the possibility of complete dependence on other people (Pereira, Firmo & Giancomin, 2014).

The concept of religious coping, defined from the cognitive study of stress and coping, is understood

as an interactive transaction in which person and environment establish dynamic and reciprocal relationships. (Santos, Giacomin, Pereira & Firmo, 2013). Such strategies can be classified as positive or negative, depending on the effects generated in physical and mental health, and according they contribute to the adherence to the therapeutic treatment. The significant use of these approaches may reveal the lack of other resources and concrete alternatives for support and intervention in health problems (Pereira, Firmo & Giancomin, 2014).

Religiosity and spirituality dimensions were the aspects revealed by all participants as a coping strategy used in the experience of the illness and pain, corroborating to what the literature points out about the relevance and expressiveness of religious coping.

Well, at the time that pain seems to ate me, I prayed my prayers, I asked God a lot, I put my knee on the floor and asked ... I said to God that I did not accept what I was going through, understand? I always asked in such way, with all my heart, in my way of asking. I used this as a way to get better, and God, whenever I ask, thanks God, everything in life that I've asked for, I achieved. I think I seek Him with too much faith, that it happens, understand? (Amethyst, 66 years old)

I have great faith in God! I have already passed through the heart one, now comes this other of the lump (...) then Jesus will heal me; if I've been through two, I will beat three, you know? (Emerald, 62 years old)

A study by Folkman, Lazarus, Pimley & Novacek (1987), based on the theory of stress and coping, showed that older people tend to use more coping strategies that focus on their emotions compared to other age groups. Other studies reveal that from middle age onwards individuals value the internal aspects of the self, allowing them to meet their feelings and strengthen religious behaviors (Santos, Giacomin, Pereira & Firmo, 2013).

Thus, religious coping acts as a mediator between afflictions, fear, tragedies, and the reality of those who grow old, and especially of the ones who live with current incapacity or with fear that it will occur in the future (Vivan & Argimon, 2009).

Through this coping technique, the subjects seek explanations that extrapolate the biological and scientific knowledge, and refer to supernatural aspects. In these cases, the expectation of healing may fail to rely on the technical and scientific means to be directed to a healing provenient from a religious/ spiritual dimension, through which the patient seeks the sacred in order to control something that cannot be controlled as the proximity of finitude becomes more evident (Reis, Farias & Quintana, 2017).

Besides these elements, the culture of society reinforces the non-straight facing of the suffering; In this sense, religiosity intensifies this aspect, since, with no other alternatives, it produces passivity and conformism (Santos et al., 2013). This is implicit in the statements that present the idea that is God who wants things to happen in such way, naturalizing the process of illness and associating aging with incapacity. This aspect is emphasized by Esmeralda when reporting: "But so it is, right? It's God's will! " It is also emphasized in the following narrative:

You have to have faith in God, because Jesus is wonderful ... In this world, we have to endure everything, very calmly, with a lot of faith in God. God's will, we can only accept, can't we? (Magnetite, 60 years)

Spirituality in coping with cancer and its influence on quality of life are discussed by Miranda, Lana and Felippe (2015). These authors approach researches performed with elderly cancer patients, where spiritual well-being meant a positive protective factor in combating the disease and anxiety in patients who said to have some religious faith. Therefore, it is important to value the spiritual dimension in the hospital environment, so that it enable improvements in the health condition and quality of life of patients who use this strategy. The patient Ametrine highlights his meditation routine in the hospital and reports decrease in anxiety caused by his religious practice, as well as the support from professionals and other patients:

(...) I have a philosophy of not getting stressed. As I told you, Buddhist thinking leads me to relaxation, meditation, calmness. I can usually concentrate here in the hospital ... then when I wake up, I make my prayers, my mantra, and keep quiet, and then I become less anxious. It helps me to keep walking, because living with cancer and pain is not easy. And everybody here already knows, and respects my schedules (Ametrino, 66 years).

Uranium patient also explains the importance of his religious belief as a coping strategy in the cancer treatment process.

> *Look ... I've been praying a lot, you know? When I am going to have radiotherapy sessions, which is another moment that bothers me a lot, I pray a lot when I'm lying there ... I'm Catholic, and then I pray a lot, I pray my Our Father, my Hail Mary, my Hail Holy Queen, my 'I believe in God The Father', and one and another pray, and I feel better (Uranium, 64).*

He also emphasizes the importance of family support and the relevance of having some belief, something superior for holding, as a means of strengthening and coping.

> *At home we keep praying all day, television on Catholic channel, mass, novena. A lot of people in the family pray a novena, there are a lot of evangelical members who also ask the pastor to pray, and all belief is welcome and helps me. I also practice Spiritism (...) You have to believe in something. It strengthens you, knowing that there is something for you that gives you comfort. I always talk to Sister Dulce, for example (Uranium, 64).*

In this context, it is observed that religiosity and spirituality occupy a place of importance in patients' life, composing the reality of their illness and contributing to alleviate the negative impacts arising from the chronicity of illness.

Therefore, understanding on the role of religious coping in cancer treatment is relevant, since it can allow health professionals to enable and operate the subjects' beliefs through the facilitation of his religious practices that are functional to the treatment. This may be a health strategy that increases quality of life, adherence to treatment and contributes to the individual subjective well-being.

Final remarks

Chronic pain, due to its specificities, can influence different dimensions in the human being life who experiences it, including social and family relationships, mood, daily activities, and work. Thus, individuals can have difficulty in facing their illness and painful experience, requiring attitudes and strategies of adaptive coping. In this regard, this study aimed to understand the perceptions and subjectivity of hospitalized elderly people about chronic pain and how they deal with the difficulties imposed by their condition.

From analysis of the narratives, it is observed that the participants mean pain as a negative experience, which affects them directly and influences, above all, social relations, generating and intensifying isolation and feelings of irritation. As a resource for coping with such situations, religiosity and spirituality stand out, being a way of minimizing the negative impacts arising from the illness and continuous treatments.

Therefore, to investigate these aspects is important as the understanding on the way of facing the pain by the elderlies can help health professionals in the analysis of factors that affect it, as well as in the adequacy of possible dysfunctional coping strategies within health context, assisting their treatment and quality of life. Hence, in health practices, in the management and treatment of chronic pain, multiple aspects of the patient's life should be appraised, considering that patient's pain is not a single phenomenon, but is always multidimensional, with numerous affective, emotional, cognitive and behavioral variables interacting among them.

Author contributions

Castro, M. M. C. participated as a research advisor, instructing and guiding on the literature review, the data collection process, as well as in article edition and orthographic revision. Santos, N. R. P. took part as a researcher, collecting research data, transcribing and interpreting them in the light of the theoretical reference mentioned throughout the article. She also carried out the writing and the literature review indicated by the advisor, and was responsible for submitting the scientific article to the present journal.

Competing interests

No financial, legal or political competing interests with third parties (government, commercial, private foundation, etc.) were disclosed for any aspect of the submitted work (including but not limited to grants, data monitoring board, study design, manuscript preparation, statistical analysis, etc.).

References

Angerami-Camon, V. A. (2012). Psicossomática e a psicologia da dor. São Paulo: Pioneira Thomson Learning.

Bardin, L. (2011). Análise de Conteúdo. São Paulo: Edições 70.

Castro, M. M. C., Quarantini, L. C., Daltro, C., Pires-Caldas, M., Koenen, K. C., Kraychete, D. C., & Oliveira, I. R. (2011). Comorbidade de sintomas ansiosos e depressivos em pacientes com dor crônica e o impacto sobre a qualidade de vida. *Rev. psiquiatr. clín*., 38(4), 126-129. Recuperado de http://www.scielo.br/pdf/rpc/v38n4/a02v38n4.pdf. doi: 10.1590/S0101-60832011000400002

Celich, K. L. S., & Galon, C. (2009). Dor crônica em idosos e sua influência nas atividades da vida diária e convivência social. *Revista Brasileira de Geriatria e Gerontologia,* 12(3), 345-359. Recuperado de http://www.scielo.br/pdf/rbgg/v12n3/1981-2256-rbgg-12-03-00345.pdf. doi: 10.1590/1809-9823.2009.00004

Chiba, T. & Ashmawi, H. (2011). Diagnóstico e tratamento da dor. In E. V. Freitas, L. Py, F. A. X. Cançado, J. Doll, M. L. Gorzoni, *Tratado de Geriatria e Gerontologia* (pp. 1706-1721). São Paulo: Guanabara Koogan.

Dellaroza, M. S. G., Furuya, R. K., Cabrera, M. A. S., Matsuo, T., Trelha, C., Yamada, K, N., ... Pacola, L. (2008). Caracterização da dor crônica e métodos analgésicos utilizados por idosos da comunidade. *Revista da Associação Médica Brasileira,* 54(1), 36-41. Recuperado de http://www.scielo.br/pdf/ramb/v54n1/18.pdf. doi: 10.1590/S0104-42302008000100018

Duarte, R. C., & Nogueira-Costa, R. (2011). Tratamento do Paciente Geriátrico Portador de Câncer. In: E. V. Freitas, L. Py, F. A. X. Cançado, J. Doll, M. L. Gorzoni, *Tratado de Geriatria e Gerontologia* (pp. 1706-1721). São Paulo: Guanabara Koogan.

Folkman, S., Lazarus, R.S, Pimley, S., & Novacek J. (1987). Age Differences in Stress and Coping Processes. *Psychol Aging*, 2(2), 171-184.

Fortes-Burgos, A. C. G, Neri, A. L., & Cupertino, A. P. F. B. (2008). Eventos estressantes, estratégias de enfrentamento, auto-eficácia e sintomas depressivos entre idosos residentes na comunidade. *Psicologia: Reflexão e Crítica*, 21(1), 74-82. Recuperado de http://www.scielo.br/pdf/prc/v21n1/a10v21n1.pdf. doi: 10.1590/S0102-79722008000100010

Gomes, N. S., Farina, M., & Dal Forno, C. (2014). Espiritualidade, Religiosidade e Religião: Reflexão de Conceitos em Artigos Psicológicos. *Revista de Psicologia da IMED*, 6(2), 107-112. Recuperado de https://seer.imed.edu.br/index.php/revistapsico/article/view/589/484. doi: 10.18256/2175-5027

Horta, A. L. M., Ferreira, D. C. O., & Zhao, L. M. (2010). Envelhecimento, estratégias de enfrentamento e repercussões na família. *Revista Brasileira de Enfermagem*, 63(4), 523-528. Recuperado de http://www.scielo.br/pdf/reben/v63n4/04.pdf. doi: 10.1590/S0034-71672010000400004

Internacional Association for the Study of Pain (2007). Recuperado de http://www.iasp-pain.org.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping.* New York: Springer Publishing.

Lima, M. A. G., & Trad, L. A. B. (2007). A dor crônica sob o olhar médico: modelo biomédico e prática clínica. *Cadernos de Saúde Pública*, 23(11), 2672-2680. Recuperado de http://www.scielo.br/pdf/csp/v23n11/14.pdf. doi: 10.1590/S0102-311X2007001100015

Lima, M. A. G., & Trad, L. A. B. (2008). Dor crônica: objeto insubordinado. *História, Ciências, Saúde Manguinhos*, 15(1), 117-133. Recuperado de http://www.scielo.br/pdf/hcsm/v15n1/07.pdf. doi: 10.1590/S0104-59702008000100007

Loduca, A., Müller, B. M., Amaral, R., Souza, A. C. M. S., Focosi, A. S., Samuelian, C., ... Batista, M. (2014). Retrato de dores crônicas: percepção da dor através do olhar dos sofredores. *Revista Dor*, 15(1), 30-35. Recuperado de http://www.scielo.br/pdf/rdor/v15n1/1806-0013-rdor-15-01-0030.pdf. doi: 10.5935/1806-0013.20140008

Minayo, M. C.S. (2010). O desafio do conhecimento: pesquisa qualitativa em saúde. São Paulo: HUCITEC.

Ministério da Saúde. Secretaria de Atenção à Saúde. Instituto Nacional de Câncer. Coordenação de Prevenção e Vigilância (2006). A situação do câncer no Brasil. Recuperado de http://bvsms.saude.gov.br/bvs/publicacoes/situacao_cancer_brasil.pdf

Miranda, S. L., Lanna, M. A. L., & Felippe, W. C. (2015). Espiritualidade, Depressão e Qualidade de Vida no Enfrentamento do Câncer: Estudo Exploratório. *Psicologia: Ciência e Profissão*, 35(3), 870-885. Recuperado de http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-98932015000300870. doi: 10.1590/1982-3703002342013

Ottati, F., & Campos, M. P. S. (2014). Qualidade de vida e estratégias de enfrentamento de pacientes em tratamento oncológico. *Acta Colombiana de Psicología*, 17(2), 103-111. Recuperado de http://www.scielo.org.co/pdf/acp/v17n2/v17n2a11.pdf. doi: 10.14718/ACP.2014.17.2.11

Palmeira, A. T., Iriart, J., Castellanos, M., Lima, M. A. G., Barros, N, F., & Menezes, P. F. A. (2015). Narrativa sobre dor crônica: da construção do adoecimento à organização da vida com dor. In M. E. P. Castellanos, L. A. B. Trad, M. S. B. Jorge, & I. M. T. A. Leitão (Orgs.). *Cronicidade: experiência de adoecimento e cuidado sob a ótica das ciências sociais* (pp. 300- 338). Fortaleza: EdUECE.

Palmeira, A. T. (2015). Experiência de enfermidade em pessoas com dor crônica atendidas em um serviço especializado de saúde (Tese de doutorado). Universidade Federal da Bahia, Salvador, BA, Brasil. Recuperado de https://repositorio.ufba.br/ri/bitstream/ri/17921/1/TESE.%20Aline%20Palmeira.%202015.pdf

Pereira, J. K., Firmo, J. O. A., & Giacomin, K. C. (2014). Maneiras de pensar e de agir de idosos frente às questões relativas à funcionalidade/incapacidade. *Ciência & Saúde Coletiva*, 19(8), 3375-3384. Recuperado de http://www.scielo.br/pdf/csc/v19n8/1413-8123-csc-19-08-03375.pdf. doi: 10.1590/1413-81232014198.11942013

Pereira, L. V., Vasconcelos, P. P., Souza L. A. F., Pereira, G. A., Nakatani, A. Y. K., & Bachion, M. M. (2014). Prevalência, intensidade de dor crônica e autopercepção de saúde entre idosos: estudo de base populacional. *Revista Latino-Americana de Enfermagem,* 22(4), 662-669. Recuperado de http://www.scielo.br/pdf/rlae/v22n4/pt_0104-1169-rlae-22-04-00662.pdf. doi: 10.1590/0104-1169.3591.2465

Resolução 466/12, de 12 de dezembro de 2012. Dispõe sobre as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Recuperado de http://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html

Reis, C. G. C., Farias, C. P., Quintana, A. M. (2017). O Vazio de Sentido: Suporte da Religiosidade para Pacientes com Câncer Avançado, *Psicologia: Ciência e Profissão*, 37(1), 106-118. Recuperado de http://www.scielo.br/pdf/pcp/v37n1/1982-3703-pcp-37-1-0106.pdf. doi: 10.1590/1982-3703000072015

Reticena, K. O., Beuter, M., & Sales, C. A. Vivências de idosos com a dor oncológica: abordagem compreensiva existencial. *Revista da Escola de Enfermagem da USP*, 49(3), 419-425. Recuperado em http://www.scielo.br/pdf/reeusp/v49n3/pt_0080-6234-reeusp-49-03-0419.pdf. doi: 10.1590/S0080-623420150000300009

Sallum, A. M. C., Garcia, D. M., & Sanches, M. (2012). Dor aguda e crônica: revisão narrativa da literatura. *Acta Paul Enferm*., 25(1), 150-154. Recuperado de http://www.scielo.br/pdf/ape/v25nspe1/pt_23.pdf. doi: 10.1590/S0103-21002012000800023

Salvetti, M. G., & Pimenta, C. A. M. (2007). Dor crônica e a crença de auto-eficácia. *Revista da Escola de Enfermagem da USP*, 41(1), 135-140. Recuperado de http://www.scielo.br/pdf/reeusp/v41n1/v41n1a17.pdf. doi: 10.1590/S0080-62342007000100018

Santos,W. J., Giacomin, K. C. & Firmo, J. O. (2015). A Alteridade da dor nas práticas de Saúde Coletiva: implicações para a atenção à saúde de pessoas idosas. *Ciência & Saúde Coletiva*, 20(12), 3713-3721. Recuperado de http://www.scielo.br/pdf/csc/v20n12/en_1413-8123-csc-20-12-3713.pdf. doi: 10.1590/1413-812320152012.19382014

Santos, W. J., Giacomin, K. C., Pereira, J. K., & Firmo, J. O. A. (2013). Enfrentamento da incapacidade funcional por idosos por meio de crenças religiosas. *Ciência & Saúde Coletiva*, 18(8), 2319-2328. Recuperado de http://www.scielo.br/pdf/csc/v18n8/16.pdf. doi: 10.1590/S1413-81232013000800016

Vivan, A. S., Argimon, I. I. L. (2009). Estratégias de enfrentamento, dificuldades funcionais e fatores associados em idosos institucionalizados. *Caderno Saude Publica*, 25(2), 436-44. Recuperado de http://www.scielo.br/pdf/csp/v25n2/22.pdf. doi: 10.1590/S0102-311X2009000200022