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Effect of an intervention based on basic Buddhist principles on the spiritual well-being of patients with terminal cancer

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ABSTRACT

Purpose: To evaluate the effect of an intervention based on basic Buddhist principles on the spiritual well-being of patients with terminal cancer.
Methods: This quasi-experimental research study had pre- and post-test control groups. The experimental group received conventional care and an intervention based on basic Buddhist principles for three consecutive days, including seven activities based on precept activities, concentration activities and wisdom activities. The control group received conventional care alone.
Results: Forty-eight patients participated in this study: 23 in the experimental group and 25 in the control group. Their mean age was 53 (standard deviation 10) years. The spiritual well-being of participants in the experimental group was significantly higher than that of participants in the control group at the second post-test ($P < 0.05$).
Conclusions: An intervention based on basic Buddhist principles improved the spiritual well-being of patients with terminal cancer. This result supports the beneficial effects of implementing this type of intervention for patients with terminal cancer.

1. Introduction

Spiritual well-being is a sense of meaning and peace of mind (Murata and Morita, 2006). Spiritual well-being is not a religion; however, religion can increase spiritual well-being. In Thailand, 94% of the population are Buddhists (National Statistical Office, 2014). Therefore, from a Thai perspective, spiritual well-being can be defined as a multidimensional concept of wisdom, or a mental state, in relation to a religious view that could lead to peace, happiness and enlightenment (Chaiviboontham et al., 2016). Worldwide, cancer challenges patients, families, caregivers and societies. It is a leading cause of death and the number of new cases is expected to increase by approximately 70% over the next two decades (World Health Organization, 2015). In Thailand, the number of patients with cancer is increasing every year (National Cancer Institute, 2014), and cancer remains the leading cause of death. In 2015, the cancer mortality rate in Thailand was 112.8 patients per 100,000 population. Between 2011 and 2015, liver cancer, lung cancer and leukaemia were the cancer types with the highest mortality rates in Thailand (Bureau of Policy and Strategy, Ministry of Public Health, 2015).

Cancer is a chronic disease that requires long-term, intimate treatment and care because of worsening symptoms that cannot be cured completely. Eventually, patients often face a terminal stage with symptoms of both physical and psychological suffering (Department of Medical Services, 2014). When patients recognise that death is coming closer, they may be depressed, lose hope for living, feel that their lives are worthless, fear death and, most of all, feel afraid about being parted from their loved ones (Wisesrith et al., 2013). These feelings create spiritual grief and diminish spiritual well-being. Previous studies have found that patients with low spiritual well-being are more likely to experience depression (Stutzman and Abraham, 2017) and a lower quality of life (Bai and Lazenby, 2015). Jafari et al. (2013) found that the spiritual well-being of Iranian women with breast cancer was poor. Similarly,

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Martoni et al. (2017) reported a low level of spiritual well-being among Italian patients with advanced cancer. In Thailand, Rattanil and Kespichayawattana (2016) found that the spiritual well-being of patients with terminal cancer in a tertiary hospital was moderate, while the spiritual well-being of patients with terminal cancer in two hospices that include religious practice in their palliative care was high (Tantitrakul and Thanasilp, 2009). This result was in agreement with the study of Chaiviboontham et al. (2016) in three tertiary hospitals.

O'Brien's (2008) conceptual model of spiritual well-being in illness states that a sick individual has the ability to find spiritual meaning in the experience of illness, which can ultimately lead to an outcome of spiritual well-being for the individual. This ability is influenced by personal faith, spiritual contentment, religious practice, severity of illness, social support and stressful life events (O'Brien, 2008). Koenig (2015) found that beliefs and religious activities led to better spiritual well-being. Moreover, Tantitrakul and Thanasilp (2009) found that practising religious activities (e.g. almsgiving, precept observation and/or chanting) was a crucial predictor of spiritual well-being among cancer patients at the terminal stage.

A systematic review of adults with terminal cancer found that several multidisciplinary palliative care interventions and meditation had been used to improve spiritual well-being in terminal patients. For multidisciplinary palliative care interventions, the main activities were palliative care team consultations, enhancing comfort, managing symptoms, psychosocial support and family caregiver training, but no significant difference in spiritual well-being was found between the experimental and control groups (Candy et al., 2012). However, a meta-analysis of patients with cancer showed that spiritual interventions had a moderate effect on spiritual well-being (Oh and Kim, 2014). Olver and Dutney (2012) found that intercessory prayer can improve spiritual well-being in patients with cancer. Moreover, two studies found that spiritual therapy rooted in Islam improving spiritual well-being significantly in patients with breast cancer (Jafari et al., 2013; Zamaniyan et al., 2016). Therefore, it might be better to use Buddhist principles to create an intervention. Rattanil and Kespichayawattana (2016) examined the effects of Buddhist spiritual care based on a conceptual model of spiritual well-being in illness, and found that this intervention could increase spiritual well-being. However, their results were limited as they performed a quasi-experimental study with a single-group design, and only involved elderly patients with terminal cancer. Thus, there is a need for further study with an adult group in order to test the effects of basic Buddhist principles on spiritual well-being.

Patients need psychological care as much as physical care. For patients with terminal cancer, taking care of their psychological state is particularly important because, although their physical health continues to decline, their psychological health is still able to recover from illness and agitation, and they can remain calm even at the end of their lives (Visalo, 2014). Thus, during the terminal stage of cancer, religious practices, for those who are religious, may help to promote spiritual well-being, and these practices must develop their wisdom in order to understand the law of nature and the truth of life in order to accept what is happening at that moment, let everything go, and perceive their value. Therefore, one of the basic crucial principles of dharma, the law of nature, which is called 'three-fold training' in the Buddhist religion, could be applied to create an intervention that can improve spiritual well-being among patients with terminal cancer across a wide range of ages. This three-fold training includes precept training, concentration training and wisdom training. The aim of this study was to evaluate the effects of a new intervention based upon basic Buddhist principles on spiritual well-being among patients with terminal cancer. It was hypothesised that this intervention based upon basic Buddhist principles would improve spiritual well-being among patients with terminal cancer.

2. Methods

2.1. Study design

This quasi-experimental research study had pre- and post-test control groups. The research was approved by the Research Ethics Committee of the Hospital of Excellence in Thai Traditional and Complementary Medicine for Cancer in Sakonnakhon (IRB No. 2/2015). The researchers introduced themselves and informed the participants of the objectives of the research, data collection procedures, duration of research implementation and expected benefits. Participants had the right to leave the study at any time. A signed consent form was obtained from each participant.

2.2. Participants and setting

The participants were recruited at the Hospital of Excellence in Thai Traditional and Complementary Medicine for Cancer in Sakonnakhon, where palliative care services are provided.

Patients were recruited if they met the following criteria: (1) diagnosed with terminal cancer with symptomatic treatments, and aware of their diagnosis; (2) Buddhist; (3) aged $\geq$18 years; (4) conscious and literate in the Thai language; and (5) willing to participate in the research.

Participants who were unwilling or unable to participate in all sessions of the intervention were excluded from the study. The sample size was calculated using G*Power Version 3.1.9.2 (Faul et al., 2007) based on an effect size of 0.82 from the study by Rattanil and Kespichayawattana (2016). The estimated sample size was at least 11 subjects per group, with alpha of 0.05 and power (1-b) of 0.80. However, in order to achieve more reliable results, 25 patients were recruited for each group. Ultimately, there were 25 participants in the control group and 23 participants in the experimental group (two were eliminated from the latter group because they did not participate in all sessions of the intervention).

2.3. Intervention

2.3.1. Intervention based on basic Buddhist principles

The intervention based on basic Buddhist principles included: (1) precept training (i.e. the training of morality of conduct for good moral behaviour); (2) concentration training (i.e. mental study for a peaceful mind and great quality of the mind); and (3) wisdom training (i.e. intellectual study to live happily with recognition of the world and real life). The intervention comprised three sessions over three consecutive days (2–3 h/day) delivered by the researchers. The participants were divided into groups of six to eight participants for the convenience of activities and discussion. The details are as follows.

2.3.1.1. Day 1. precept activities. The intervention started by building relationships and self-introduction of the researchers. This session took 30 min. In the first activity, the participants introduced themselves through art. They were instructed to design their own name tags by writing their names or drawing/painting colours that signified themselves. Personal notebooks were distributed to the participants. Participants gave their names, addresses, three of their good points/skills, three things about themselves that they wanted to develop, and the meaning of their own name tags. The self-introduction was conducted in three pairs of participants. In total, the first activity lasted for 45 min.