






ORIGINAL ARTICLE

Hope, spirituality and quality of life: a study with chronic kidney patients on peritoneal dialysis*

HIGHLIGHTS

1. Average HHS score: 38.78 of 48.
2. Average score WHOQOL-SRPB: 17.28 out of 20.
3. Correlation between HHS and WHOQOL-SRPB scales: ($p = 0.01$).
4. Better quality of life is associated with greater hope.

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ABSTRACT

Objective: Analyze the level of hope, spirituality, and perception of the quality of life of chronic renal patients on peritoneal dialysis. **Method:** Transversal analytical study conducted in a nephrology center between January and April 2024. A clinical-demographic questionnaire, the Herth Scale of Hope and Quality of Life - Spirituality, Religiousness and Personal Beliefs, were applied. For the analysis of correlation between scales, Pearson and Spearman tests were used; for comparisons between groups, Mann-Whitney and Kruskal-Wallis tests were used. **Results:** 69 individuals participated, with average scores of 38.78/48 and 17.28/20 for hope and quality of life, respectively. Significant correlation was identified between the scales ($p = 0.01$), indicating that higher hopeful scores are associated with a higher quality of life. **Conclusion:** Despite treatment limitations, participants demonstrated hope and spirituality at satisfactory levels, with a positive impact on quality of life.

DESCRIPTORS: Public Health; Indicators of Quality of Life; Nephrology; Renal Dialysis; Renal Insufficiency, Chronic.

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INTRODUCTION

Chronic kidney disease (CHD) is a condition of global relevance, with increasing prevalence and incidence, representing a challenge to public health. Its etiology is associated with systemic arterial hypertension, diabetes *mellitus*, and glomerulonephritis, requiring effective strategies for prevention, early diagnosis, and proper management^{1,2}.

In the advanced stages (glomerular filtration rate below 15 mL/min), the functional loss becomes significant, with the need for renal replacement therapy. In this stage, hemodialysis (HD) is the preferred approach due to its efficacy in removing toxins. As an alternative, peritoneal dialysis (PD) is an equally effective option, offering greater autonomy and the possibility of being conducted at home^{3, 4}.

PD is a method that involves the infusion, retention, and drainage of fluids and toxins via a Tenckhoff catheter inserted into the peritoneal cavity. This is a procedure that can be performed at the patient's home⁵. There are two approaches to its initiation: the planned PD, which includes pre-preparation, training, and catheter use after 15 days of implantation; and the unplanned PD, initiated within 72 hours of implantation as an emergency, without prior HD^{6,7}.

According to the Brazilian Dialysis Census of 2024, the total number of patients on chronic dialysis reached 172,585. There was an estimated growth of 52,944 new cases, reflected in the prevalence and incidence rates per million inhabitants, which were 812 and 249, respectively. Among the prevalent, 87.3% were in conventional HD, while only 5.6% were in PD⁸.

Despite the benefits associated with PD, CHD patients undergoing dialysis therapy face various physical and emotional limitations that negatively impact their vivacity and functionality. These restrictions undermine the ability to maintain productive and social activities, directly affecting the quality of life⁹.

However, across dialectical modalities, PD has been associated with better indicators of quality of life, particularly by providing greater autonomy and flexibility in everyday life. A comparative study among patients with HD and PD shows that individuals with PD report higher satisfaction with treatment and greater stimulation from the healthcare team, possibly due to the lower frequency of direct contact and exposure to potentially stressful situations, common in the environments of HD¹⁰.

This positive perception is directly related to the concept of quality of life adopted by the World Health Organization (WHO), which defines it as the perception that the individual makes of their position in life, considering the cultural context, the value systems into which they are inserted, as well as their goals, expectations, patterns, and concerns¹¹. In this sense, PD can foster greater alignment with the subjective and social dimensions that comprise this definition, contributing to a more satisfying and meaningful treatment experience.

In this context, it becomes necessary to develop situation-based tackling strategies, among which stands the support offered by spirituality and religiousness, which gives hope for better management of the disease¹².

Spirituality is perceived as the search for understanding the meaning of life and its connection with the sacred, and may or may not result in religious practices. While religious practice refers to the level of belief and practice of a religion, it can be organizational (participation in institutional religious activities) or non-organizational

(without institutional bond), manifesting itself in individual practices, such as prayer, meditation, reading religious texts, or even in the expression of faith in daily activities¹².

It can be inferred that spirituality and religiousness promote hope, translated in the context of health as a continuous and essential process to foster favorable actions, face crises, preserve quality of life, plan healthy goals, and promote health improvement¹³. In clinical practice, it is observed that in the care of renal patients, there is a significant discrepancy between the spiritual needs of these individuals and the techniques offered, representing a challenge¹².

Additionally, greater adaptation to HD may result in economic benefits, since this modality presents lower costs than HD and better adherence tends to expand the vacancy pool and reduce waiting lists in HD, provided that it is accompanied by public policies that encourage home treatment and ensure adequate technical support¹⁴.

Based on the reflections presented, this study aimed to analyze the level of hope, spirituality and perception of the quality of life of chronic renal patients in peritoneal dialysis. To this end, the following guiding question was raised: To what extent do hope and spirituality impact the quality of life of CHD patients in PD?

METHOD

This is a cross-sectional analytical study with a quantitative approach, conducted at a nephrology center in a hospital in the Federal District, from January to April 2024.

The inclusion criteria were: individuals with CHD, of both sexes, aged over 18 years, and undergoing PD treatment for more than three months. Patients with acute renal impairment (IRA), those with limited ability to understand and communicate, physical incapacity to attend the research site, and those who refused to participate in the study were excluded.

The subjects of the study were selected from the universe of 96 individuals inserted into the PD program during the collection period. Of the total individuals, four were excluded due to limited ability to understand and communicate, three due to death, two due to hospitalization elsewhere, one due to transfer to HD, one due to transfer to another program, 11 due to absences from monthly consultations, and five who refused to participate in the study. Thus, 27 patients were excluded, leaving 69 individuals who composed the final sample of the study.

A clinical-demographic questionnaire, the Herth Hope Scale (HHS), and the instrument Quality of Life - Spirituality, Religion and Personal Beliefs (WHOQOL-SRPB) were applied.

The clinical-demographic questionnaire covered questions relating to profile, religiousness, spirituality, and therapy. With multiple choice questions and Likert questions ranging from 1 to 5 (nothing, very little, more or less, quite or extremely).

HHS is a self-reporting psychometric instrument of the Likert type, with scores ranging from 1 to 4 (completely disagree, disagree, agree, completely agree), developed to measure hope in individuals, especially those with chronic diseases. With 12 items, your total score ranges from 12 to 48, being proportional to hope level^{4,15}.

The WHOQOL-SRPB is an additional module of the WHOQOL instrument, developed by the World Health Organization (WHO) to assess the quality of life in the field of spirituality, religiousness, and personal beliefs. Integrated into WHOQOL-100 as domain 6, it consists of 32 items distributed in eight facets: spiritual connection, sense of life, admiration, totality and integration, inner strength, inner peace, hope/optimism, and faith. Each facet is scored independently, with scores ranging from 4 to 20, where higher values indicate better perception of quality of life in the respective dimension. Domain 6 is calculated by the average of the result of the facets multiplied by four^{16,17}.

The data was tabulated in Microsoft Excel spreadsheet and analyzed in the program Statistical Package for Social Science (SPSS), version 23.0. For the correlation analysis, the Pearson and Spearman tests were used, according to the distribution of the variables.

In addition, to compare the independent variables between groups, the Student t test, Mann-Whitney test, and Kruskal-Wallis test were used. The chi-square test was used for the categorical variables, and statistical significance was assessed at $p < 0.05$.

This study was approved by the co-founded opinion of the Research Ethics Committee by opinion nº 6.424.369.

RESULTS

The sample was composed of 69 (100%) participants, 37 female (53.60%), with an average age of 56 years; 30 (43.47%) older than 60 years, married 31 (44.93%), and had children 55 (79.71%), who, in the majority, resided with them. Regarding racial self-declaration, 41 (59.40%) identified as purple. Catholicism was the most mentioned religion, representing 38 (55%) of the sample.

In the socioeconomic profile, 33 (47.82%) were retired, 21 (30.43%) had elementary education, 32 (46.37%) had income up to a minimum wage, and 26 (37.68%) received some government aid. Among the comorbidities, systemic arterial hypertension was the most prevalent, present in 60 (86.96%) subjects, followed by diabetes mellitus 29 (42.03%), and anxiety in 20 (28.99%). Absence of physical activity practice was a commonly reported condition, 50 (72.46%).

Regarding religiousness, 29 (42.03%) participants stated that they attended church or religious temple at least once a week, 27 (39.10%) considered themselves very religious, and 18 (26.10%) extremely religious. Regarding spiritual beliefs, 27 (39.13%) considered them very important, while 29 (42.03%) considered them extremely important.

The duration of treatment ranged from 3 to 192 months, with an average of 38 months, of which 37 (53.62%) were on dialysis for less than 24 months. It was observed that 32 (46.38%) were on the waiting list for transplantation. As for the start of therapy, 13 (18.84%) entered unplanned and 56 (81.16%) carried out prior planning.

Descriptive statistics and the Mann-Whitney test indicated no significant difference between the groups' scores (planned and unplanned). However, there was a tendency towards significance in the variables' integrity ($p = 0.056$) and faith ($p = 0.070$) (Table 1).

Table 1. Descriptive measurements of scores (WHOQOL and HHS domains) with planned and unplanned. Brasília, DF, Brazil, 2024

Variable	Unplanned	Planned	P. value
Connection	4.15(1.04)	4.43(0.66)	0.373
Meaning	4.23(0.75)	4.48(0.54)	0.241
Admiration	4.19(0.99)	4.4(0.58)	0.757
Integrity	3.77(0.81)	4.15(0.76)	0.056
Force	4.31(1.08)	4.48(0.61)	0.783
Peace	4.04(0.75)	4.16(0.84)	0.399
Hope	4.12(0.83)	4.19(0.73)	0.777
Faith	4.27(0.89)	4.58(0.68)	0.070
WHOQOL Domain 6	16.54(3.12)	17.44(2.22)	0.307
Hope and Herth Scale	40.54(5.08)	41.61(4.96)	0.428

Source: The Authors (2024).

As for HHS, only one participant obtained a score of 26; 18 presented values between 31 and 39; and 50 remained between 40 and 48, of the four reached the maximum score. The total average was 38,78, indicating high levels of hope among the participants (Table 2).

Table 2. Descriptive statistics of HHS scores by items and total. Brasília, DF, Brazil, 2024

Question	Media	PD	Median	Minimum	Maximum
I am optimistic about life	3.49	0.72	4.00	1.00	4.00
I have short and long-term plans	3.29	0.88	4.00	1.00	4.00
I feel very alone(a)	1.99	1.01	2.00	1.00	4.00
I can see possibilities in the midst of difficulties	3.14	0.93	3.00	1.00	4.00
I have a faith that comforts me	3.70	0.63	4.00	1.00	4.00
I'm afraid of my future	1.70	0.77	2.00	1.00	3.00
I can remember happy and pleasant times	3.67	0.59	4.00	1.00	4.00
I feel very strong	3.33	0.83	4.00	1.00	4.00
I feel able to give and receive affection/love	3.70	0.58	4.00	2.00	4.00
I know where I want to go	3.38	0.82	4.00	1.00	4.00
I believe in the value of every day	3.64	0.57	4.00	1.00	4.00
I feel that my life has value and usefulness	3.75	0.55	4.00	1.00	4.00
Total	38.78		43.00	13.00	47.00

Source: The authors (2024).

Regarding future expectations, 62 (89.85%) showed optimism for life, 56 (81.15%) had short- and long-term plans; 65 (94.20%) claimed to have faith that offers comfort; 45 (65.21%) valued every day; and 47 (68.11%) did not feel alone. Only seven (10.14%) said they were not optimistic about life, and three (42.86%) said they felt very lonely.

As for the WHOQOL-SRPB scale, the results ranged from 8.5 to 20, with an average of 17.28. The average scores were high, indicating that participants maintain a strong connection with spirituality and believe that these dimensions positively impact their

lives. The total score concludes this perception, with the predominance of the summed scores close to the maximum (Table 3).

Table 3. Descriptive statistics of instrument scores WHOQOL-SRPB by items and in total. Brasília, DF, Brazil, 2024

Question	Media	PD	Median	Minimum	Maximum
Connection	4.37	0.74	4.50	1.25	5.00
Meaning	4.43	0.59	4.50	2.25	5.00
Admiration	4.36	0.67	4.50	1.50	5.00
Integrity	4.09	0.78	4.25	1.75	5.00
Force	4.45	0.71	4.75	1.50	5.00
Paz	4.15	0.82	4.50	1.25	5.00
Hope	4.18	0.74	4.25	2.00	5.00
Faith	4.53	0.72	4.75	1.75	5.00
Domain 6 (Total)	17.28	2.41	18.12	8.50	20.00

Source: The authors (2024).

There was no statistical significance between HHS and WHOQOL-SRP scores and the profile, expressing that gender, age group, civil status, religion and time of therapy did not significantly influence the scores. In relation to the WHOQOL-SRPB, the Mann-Whitney test showed a tendency to significance ($p = 0.080$) in the sex scores in the connection domain.

In the scores by age group, by the Kruskal-Wallis test, it was identified that participants aged between 60-69 years had higher scores in both HHS and WHOQOL-SRPB, compared to those aged 20-29.

In the analysis of the Spearman correlation between the scales applied, a moderate positive and statistically significant association between the HHS scores and the WHOQOL-SRPB scores was observed, indicating that higher levels of hope are related to better perception of spiritual quality of life (Table 4).

Table 4. Correlation between HHS and WHOQOL-SRPB. Brasília, DF, Brazil, 2024

Correlation	HHS	HHS			WHOQOL-SRPB	
		Correlation coefficient	1.000		.545**	
		Sig. (2 ends)	.		.000	
	WHOQOL-SRPB	N	69		69	
		Correlation coefficient	.545**		1.000	
		Sig. (2 ends)	.000		.	
Spearman r		N	69		69	

** The correlation is significant at level 0.01 (2 extremities).

Source: The authors (2024).

Among the four participants who obtained the maximum score in the HHS (48 points), three presented 20 points and one recorded 19,625 points on the WHOQOL-SRPB scale. These values indicate that these individuals with peak levels of hope also achieved high scores in assessing quality of life related to spirituality, religiousness

and personal beliefs. This pattern suggests that, in this specific group, high hopes are associated with positive perceptions of subjective aspects of quality of life.

Figure 1 shows a positive correlation between the scales, indicating that as quality-of-life scores increase, hopeful levels tend to be higher. Most participants had high scores on the WHOQOL-SRPB, ranging from 16 to 20, with corresponding high hopeful levels of 40 to 50. However, there is a greater dispersion in hope scores for participants with lower quality of life values, suggesting greater variability of hope in these cases.

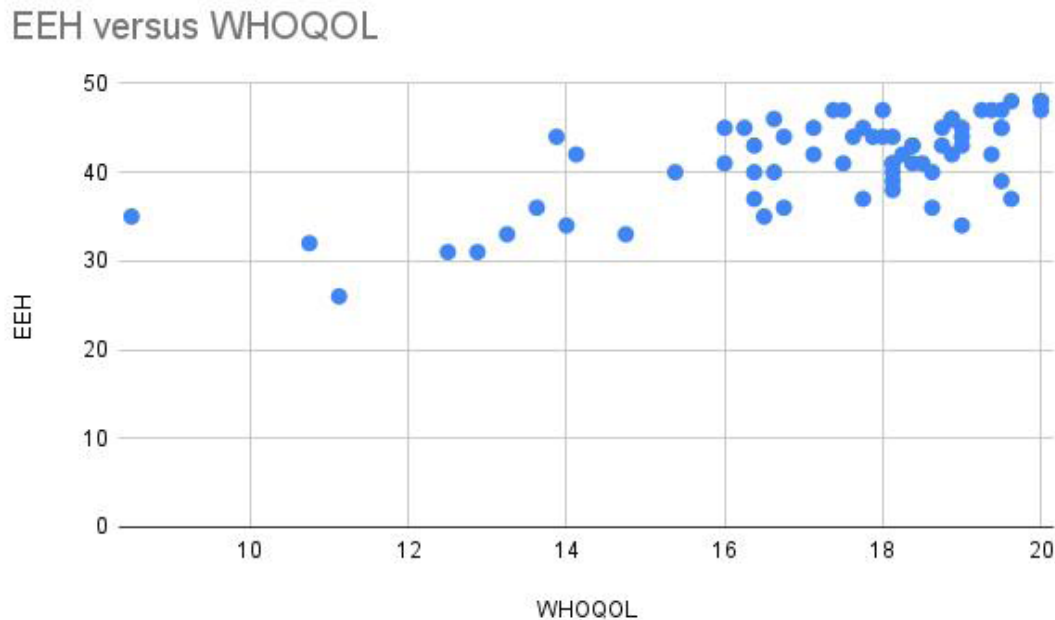


Figure 1. Dispersion of correlation between HHS and WHOQOL. Brasília, DF, Brazil, 2024

Source: The authors (2024).

DISCUSSION

In the sociodemographic analysis, female predominance was observed, aligned with the recent analysis, contrasting with international data and the Brazilian Census of Dialysis of 2024, which point to a male majority among the dialysis patients^{8,18,19}. This discrepancy may reflect variations in population cut-offs and sample characteristics. Factors such as increased female search for preventive care, the cultural role of caregiver and greater engagement with self-care can influence the indication of peritoneal dialysis¹⁹.

Cohabitation with a spouse and the presence of children constitute an essential support network for the effectiveness of peritoneal dialysis. This modality requires joint adaptation between the patient and family, which promotes the patient's well-being, and many report not feeling alone. The family actively participates in the treatment, offering emotional and financial support and assisting with therapeutic adherence, especially in cases where it directly takes over the management of dialysis²⁰.

As for comorbidities, HAS and DM were the most prevalent, in accordance with epidemiological data from the Brazilian Dialysis Census of 2024, in which HAS (29%) and DM (29%) constituted more than half of the underlying diseases for kidney disease⁸.

In this study, the predominance of brown differs from previous research, which showed the prevalence of white^{2,9}. There was also a wide variation in educational

attainment, with primary education predominant, indicating a profile of lower formal education. Evidence indicates that race/color and education act as protective factors for the CHD, and the probability of diagnosis is lower among self-declared white or brown individuals with complete secondary or higher education².

Occupational diversity was observed among the participants, with informal ties predominating among those who worked, while almost half were retired. Although the CHD and dialysis treatment do not render work impossible, they impose limitations that justify such ties and the most vulnerable socioeconomic profile observed²¹.

This occupational reality is directly related to the financial context of these individuals. About half received up to a minimum wage, demonstrating the functional impact of the CHD. In a comparative study, 82.8% of individuals had income equivalent to a minimum wage of ²¹.

The average 38-month treatment duration observed in this study was considerably greater than the 16.68 months reported in another Brazilian study²². Regarding survival, the literature indicates stability, with 59% of patients still alive after 96 months of follow-up¹⁸. In the international context, it was found that 48% of patients remained in PD after five years, suggesting that factors such as the predominant modality of therapy, the clinical profile of patients, and the available care structure directly influence the duration of stay in renal replacement therapy²³.

Recent data from the Brazilian Dialysis Census 2024 reinforce that strategies aimed at the prevention of complications such as anemia, hyperphosphatemia, and cardiovascular diseases are fundamental to broaden survival and improve the quality of life of these patients^{8,23}.

More than half of the participants declared to profess the Catholic religion, corroborating a previous study, in which 60% were Catholics, and faith was considered an important factor in dealing with the CHD²⁴. Spirituality and religiousness are relevant dimensions for emotional strengthening, helping in dealing with daily difficulties. Hope, in addition, helps to maintain motivation and the prospect of a better future. Thus, healthcare professionals should consider these dimensions in the comprehensive care of chronic kidney patients²¹.

The difference between the planned and unplanned groups is justified by the recent implementation of the unplanned modality in the hospital, with low adherence in the DF. Emergency dialysis has been spread worldwide, considered a viable and safe alternative, contributing to broadening the prevalence of PD among patients with CHD²⁵⁻²⁷.

This distinction can impact both adherence to treatment and emotional and spiritual aspects. There was a tendency towards significance in the fields of integrity and faith, indicating greater emotional and spiritual balance among those who started therapy in a planned way. These findings suggest that prior planning supports clinical adjustment and emotional resilience in the face of the challenges posed by the disease.

In this context, faith proved essential in the confrontation, promoting strength, comfort and well-being. Faith and spirituality have been identified as foundations in the search for existential meaning and resilience strategies, evidencing the relevance of the spiritual dimension in the care of the person with CHD²⁴.

This internal strengthening appears to directly influence how patients perceive their condition, as many did not consider themselves ill, demonstrating well-being and

optimism. Studies indicate that positive self-perception favors clinical evolution and can directly impact mortality².

In this perspective, the HHS results indicate that, despite adversities, most participants achieved high scores, demonstrating that hope is a predominant feeling, consistent with another study that obtained comparable results using the same scale⁹.

The positive results of the WHOQOL-SRPB indicate that spirituality, religiousness, and personal beliefs have a favorable impact on patients' quality of life. Similar studies reinforce this evidence in patients with HD. While those in PD presented superior quality of life, with better physical and emotional performance compared to those in HD^{21,28}.

There was no statistical significance between the variables gender, age, civil status, religion and time of therapy and scores on the scales, indicating that such factors did not influence the results. However, a tendency to significance was observed in the field of gender connection, with greater involvement among women. This finding suggests that women tend to be more open to religious and spiritualized practices, reflecting greater spiritual connection²⁹.

This study observes that older individuals demonstrate higher levels of hope and quality of spiritual life, possibly related to resilience, appreciation of the present, and internalization of spiritual dimensions. While other studies point to clinical profile and vulnerability as influencers of hope, life experience stands out as a positive factor⁷.

A correlation between HHS and WHOQOL-SRPB was verified, showing that high levels of hope positively impact on quality of life. Hope is a fundamental human resource for adapting to adversity, and it is important to foster strategies that stimulate confrontation and well-being³⁰. Despite the scarcity of research on spirituality and hope in patients with PD, evidence from HD has shown positive associations between WHOQOL-SRPB and HHS, corroborating the findings of this study²¹.

Finally, the short interval between consultations, the dengue epidemic in the period, the change of unit location, and the loss of follow-up (transfers, hospitalizations, deaths) were highlighted as limitations of the study, which impacted data collection.

CONCLUSION

The present study showed that chronic renal patients on peritoneal dialysis exhibit high levels of hope and spirituality, which are positively associated with perceptions of quality of life. The scores obtained on the HHS and WHOQOL-SRPB scales indicate that, despite the limitations imposed by the disease and dialysis treatment, participants maintain significant internal resources to manage the clinical condition. The statistically significant correlation between hope and quality of life reinforces the role of the spiritual dimension as a protective factor and promoter of well-being.

Spirituality, expressed through faith, a sense of life, and inner strength, contributed to emotional balance and resilience to the challenges imposed by renal replacement therapy. Hope, in turn, proved to be a central element in fostering positive perspectives, promoting treatment adherence, and preserving quality of life. Such findings reinforce the importance of incorporating approaches that value the spiritual dimension in integral care for kidney patients, thereby promoting more humanized and effective therapeutic strategies.

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