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Spiritual Problems of Women with Breast Cancer in Iran: A Qualitative Study

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Abstract

Background and Objectives: A developing body of evidence has demonstrated the detrimental effects of spirituality and religion on the well-being of patients with cancer. This necessitates the need to explore the content of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V (code 62.89). The present study aimed to identify the spiritual problems of Iranian patients with breast cancer concerning their religious beliefs and cultures.

Methods: A qualitative content analysis with an abductive approach was used and data were gathered using individual semi-structured interviews. The participants were selected by purposive sampling which continued until data saturation after 12 interviews. Data were analyzed using the Graneheim and Lundman thematic approach.

Results: The themes extracted from the data were "Questioning spiritual values" and "loss or questioning of faith". The three categories in the first theme included "Find spiritual cause of illness", "Question God's justice", and "Deal with God". Moreover, "Lack of intimacy with God", "Giving up rituals" and "Losing religious faith" were the categories of the second theme.

Conclusion: As evidenced by the obtained results, awareness of religious/spiritual problems of the patients with breast cancer may be of great help to healthcare professionals to manage the patients who need a referral, further assessment, and appropriate intervention. In addition, the assessment of spiritual/ religious problems is of paramount importance in designing cultural and spiritual care and interventions.

Keywords: Spirituality, Religion, DSM-V, Breast cancer.

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Introduction

A breast cancer diagnosis is often realized as a traumatic and life-changing event and a stressful experience (1). Questioning one's religious/spiritual beliefs and spiritual struggle is one of the life challenges people face (2). Being diagnosed with cancer, women feel severe distress, encounter religious conflicts, and cannot use meaning-making coping strategies (3,4). Kamala Devi, M and Karis Cheng Kin Fong (5) studied the spiritual experiences of Singaporean women with breast cancer in the first year of diagnosis. They reported that spiritual needs are common and Harrison et al. (6) documented patients indicated through survey responses that they had unmet spiritual needs. The spectrum of spirituality encompassed spiritual despair (alienation, loss of self, and dissonance), spiritual practice (forgiveness, self-exploration, search for balance), and spiritual well-being (connection, self-actualization, consonance). According to the World Health Organization and the US National Quality Forum, spiritual and religious dimensions of a patient's life should be considered in holistic, multidimensional care (7,8). Based on the structure of spirituality in Iran, it is defined as

"the noble dimension of human existence which all humans have been endowed to follow the path of transcendence that is proximity to God" (9). There is an increasing interest in the role of spirituality as a part of well-being and supportive care of patients with cancer (10-12). A growing body of evidence documented that spirituality can play a leading role in healing and quality of life (4,13) since spirituality confers inner power, tranquility, welfare, and wholeness and influence the way people cope with cancer (13-15). Although race, culture, and personal experience may affect the expression of spirituality, everyone has their unique interpretation of spirituality (16).

Despite the importance of spirituality in patients with cancer (17) as a coping strategy (Whether positive or negative) (18), there is a paucity of studies on negative spiritual experiences of women with breast cancer. Furthermore, women's perception of spirituality and their cancer experience has implications for long-term mental health and coping (19). The majority of studies have explored cancer patients' spiritual needs or distress (5, 20), While the content of them is underestimated. According to the American Psychiatric Association and Diagnostic and Statistical Manual of Mental Disorders (DSM–5), recognizing and understanding spirituality in the cultural texture of society is pivotal to the provision of culturally appropriate care (21). To this end, it is of utmost importance to identify the spiritual problems of patients according to their religious beliefs and culture (22). Furthermore, the present study was targeted at exploring the spiritual problems of women with breast cancer.

Methods

Qualitative content analysis with an abductive (combined) approach was used to identify the spiritual problems of women with breast cancer (23) under the ethical code: IR.IUMS.REC.1398.489). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist was applied to describe the research methodology (24).

Purposeful Random Sampling was used in the current study. The inclusion criteria entailed: 1) taking chemotherapy therapy for at least 6 months, 2) breast cancer stages of 0-3, 3) age range of 30-65, and 4) ability to speak and communicate in Persian. On the other hand, the exclusion criteria included: 1) psychotic or bipolar disorders, 2) intrusive suicidal thoughts, and 3) current drug abuse. Patients were recruited from the Hematology and Oncology Department of Rasoul-e-Akram Hospital in Tehran. Audio-recorded interviews were conducted from August 2018 until February 2019. Table 1 demonstrates the demographic characteristics of the participants. All interviews were conducted by the first author who was trained in conducting qualitative studies (items 1-5 in COREQ checklist). The patients were provided with research subject, objectives, and identity of the researchers. Subsequently, the researcher fully explained the study procedure to all those who agreed to participate and informed consent was obtained from all of them (6-8 in COREQ checklist).

Table 1. Demographic characteristics of patients

Patient code	Age	Educational level	Religion	Employment status	Marital status
1	53	Secondary	Islam	Housewife	Married
2	30	Bachelor	Islam	disabled	Single
3	45	Associate degree	Islam	disabled	Married
4	32	Diploma	Islam	Housewife	Married
5	40	Secondary	Islam	Housewife	Married
6	56	Associate degree	Islam	Employee	Married
7	51	Diploma	Islam	Housewife	Married
8	39	Associate degree	Islam	Housewife	Married
9	48	Primary	Islam	Housewife	Married
10	56	Secondary	Islam	Housewife	Married
11	65	Primary	Islam	Hairdresser	Married
12	57	Diploma	Islam	Teacher	Divorced

Data were collected by individual semi-structured with the stance of friendship interviews. The interview guide was designed for the study. It was based on reviewing texts and consulting three spiritual care experts. Open-ended questions were crafted to gather the patients' problems about spirituality and challenges they face concerning religious/spiritual values, as well as coping

with cancer. Some general questions were proposed to start the interview process, and the interview was based on self-response. Sample questions entailed: “Have you experienced any change in spiritual/religious issues after being diagnosed with cancer?” “How do you evaluate yourself on religion/spirituality now?” “What are the effects of this illness on your religious/spiritual beliefs?” “Is the cause of your illness related to spiritual/religious issues?” “Do you perform religious or spiritual practices? Are they affected by the illness?”

To ensure that the questions were clear for patients and study purpose is fulfilled, the guide was reviewed after the first several interviews. In this regard, some questions were added, for instance: “What effect do you think this disease has on your meaning in life?” “Did you complain to God during your illness?” “How is your relationship with God?” More detailed questions about their feelings and thoughts along with exploratory ones were also asked (e.g., "Can you explain more about this?"). It is worthy to note that given the stance of friendship interviews, the researchers expressed empathy for the feelings of patients. In this respect, if the patient became disturbed or sad while expressing her experiences, the interview process ended with positive notes. For instance, the patient was asked to describe the advantages of this illness, summarize the experience of her illness that can be instructive for others, and describe her plans for recovery and discharge.

The patients were interviewed in the time and place convenient to them. The interviews lasted within 35-70 min, with 50 min being the average. The sampling continued until data saturation was achieved when no new data were emerging. After the conduction of 12 interviews, no new code was developed for creating categories and themes; however, two additional interviews were administered (17-22 in COREQ checklist).

All transcribed interviews were reviewed, coded, and immediately analyzed. A conventional content analysis, followed by Graneheim and Lundman's method, was used for data analysis (23). Firstly, each interview was thoroughly read to get a sense of the overall content and an accurate perception of the statements. Meaning units were extracted from the interview texts and condensed into a description of their manifest and literal content and an interpretation of their latent content. Subsequently, the meaning units were condensed and initial codes were generated. The categories were abstracted based on the content similarities of codes available in the descriptions and interpretations.

The researchers of the present study reflected on the categories and revised them before the whole text was analyzed. The fifth author read one-third of the interview texts and checked the codes and categories. Through a process of reflection and discussion, the authors agreed upon a set of themes. On a final note, the categories were reflected on and seemed related to DSM-5 which includes a new V code entitled "Religious or Spiritual Problem": Given that V code focuses on religious or spiritual problems, it was considered relevant headings would unify the categories to themes.

The initial content of interviews and analysis was not reviewed by the patients; however, the researcher took her notes and comments into account after each interview. All processes were performed by one person who spent an extensive amount of time on data collection and analysis. Manual data management was used and no software was used for data analysis. Direct quotations of interviews are provided in the results section to clarify codes, categories, and themes (items 23–32 in the COREQ checklist).

Lincoln & Guba's trustworthiness criteria were used to evaluate the credibility, dependability, conformability, and transferability of the obtained data (25). Credibility was realized through sufficient cooperation and interaction with the patients, prolonged involvement, and immersion in the subjects. Transferability and dependability were insured by correcting any error made by the external supervisors and arriving at a consensus. The researchers were provided with the research details to decide on the application of the findings. Triangulation of data resources was performed to review the opinion of experts (psycho-oncologist,

chaplain, and oncologist) through interviews. In addition, opposed evidence for a comprehensive description of subjects was confirmed by purposeful sampling on individuals with positive spiritual coping strategies.

Result

The analysis of data revealed that women with breast cancer lose or question their faith and spiritual values. The themes are presented below, and illustrative codes for each can be found in Table 2.

Theme 1: Questioning spiritual values

Most of the women in the present study pointed to how spiritual values have been questioned following the breast cancer diagnosis. They seek spiritual causes for their illness and question God's justice.

Patients explain the cause of their cancer concerning God and seek a spiritual reason, and check their religious practices to find some spiritual lapses that led to this illness. Women asked the question “why me?” and declared that God’s will or God’s punishment was effective. They believed that God was testing their faith or saw their suffering as retribution for the sins of their past life. In this regard, participant#1 said: “I used to think that sinners get cancer; however, I was diagnosed with this illness and it was a blow to me. I did not hurt a soul. Why did I get this disease? I am still wondering why God did this to me”. Not only did they expect their good deeds to protect them from illness, but also they were waiting for rewards, the lack of which has been challenging to them. They had gone through hard times in the past and being diagnosed with breast cancer seemed a miscarriage of God’s justice. Patient #6 explained: “I shouldered the responsibility of the whole family. I cried out to God why he gave this terminal disease to me and complained to him”. When their illness-centered prayers are not answered, they lose their trust in God. Participant # 7 said in this regard: “I prayed so much, went on pilgrimage, and pledged for a negative pathology. However, God liked me this way”.

Table 2. Themes, categories, and codes

Themes	Categories	codes
Questioning spiritual values	Find the spiritual cause of illness	Question God's purpose of illness Why me? Challenge God’s retribution Non-sinful cause of illness Test of Faith with cancer Compensation for sins with illness
	Question the justice of God	Lack of eligibility for illness Review the past difficulties in life Lack of God 's fairness Being oppressed Blamed God for the disease
	Deal with God	Safety expected of disease Pray for health Waiting for rewards Health in exchange for prayer Recovery for worship
loss or questioning of faith	lack of intimacy with God	Abandonment by God Anger at God Negative image of God Blaming God for experiencing cancer
	Relinquishing rituals	Leaving religious communities Regarding religious practices and worship as ineffective Reluctance to perform usual religious practices Giving up prayer Failure to observe religious practices Separation from religious gatherings
	Loss of religious faith	Verbalized inner conflicts about religious beliefs Conflicts between religious beliefs Doubt about religious values Shaken faith Question religious values Nonreligious beliefs

Theme 2: loss or questioning of faith

Participants pointed to isolation and disconnection as the primary result of a spiritual problem. Lack of intimacy with God, giving up rituals, and losing religious faith was reported to be an unmet experience for these patients.

Having experienced cancer, patients reported a troubled spiritual relationship and detached themselves from God. Some were even annoyed at God, avoided him and even lost their friendly and intimate spiritual relationship. Patient #11 asserted: “I had a close and friendly relationship with God and constantly remembered him. Nonetheless, this disease took its toll leading to the breakdown of our relationship”. Breast cancer sufferers expressed religious uncertainty and doubt, challenged their past beliefs and religious values, and even discontinue the religious rituals since they were not meaningful to them

anymore. Some even left the religious community or maintained distance from religious gatherings they attended before. Their faith is sometimes shaken to the point that they give up prayers. Patients #8 reported: “After this disease, I gave up prayer since I lost my trust in God”. Participant # 9 claimed that “There exist no God, Prophet, and Imams in the world. If they even existed, I would not believe them.

Discussion

As illustrated by the results of the current study, questioning spiritual values and losing or questioning faith are the most spiritual/religious problems posed to breast cancer patients. To make matters worse, these problems get intertwined while being simultaneously in contact with each other. These results were in accordance with spiritual problems in DSM 5 (V code 62.89). The first theme consisted of three categories, including the search for a spiritual cause of disease, questioning divine justice, and dealing with God. Since breast cancer sufferers held God responsible for their sufferings, they blame God by asking why me? Why now? Although these ‘why’ questions have been addressed in previous studies (26-28), the content of God-oriented questions was illustrated in this research. God's plan for testing patients' faith or punish them is the sensible answer to most of these questions. Nonetheless, cancer sufferers consider this contrary to God's righteousness and promises. In this regard, affliction with this disease seemed unfair to several women with hard times in life. This problem and such a spiritual perception of the disease leads to spiritual crisis and discontent (29) which can be explained by passive spiritual resources reported by Holt et al. (30). They indicated that patients consider God's will as a cause of illness and recovery. They do not have a specific role, and through this, attribution adapts to stressful situations.

Another result related to this theme is contrary to the expected outcomes of religious practices. Patients expected protection from daily prayers, reading scriptures, and attendance at religious services. They used a variety of religious and spiritual practices in order to prevent diseases or promote healing; nonetheless, the desired outcomes were not bestowed on them by God (31). Taylor et al. suggested that patients performed religious rituals with specific purposes, such as health, and questioned the existence of God after being diagnosed with cancer (32). In the same vein, in the study conducted by Jors et al., disease-centered prayer was the most common after the diagnosis of cancer (14). Gall et al. regarded these challenges as the coping strategies to find meaning in disease which ultimately leads to spiritual growth (33). However, the anger at God and the simultaneous mobilization of the spiritual and religious powers for healing leads to internal conflicts in the patient, which creates more frustration and spiritual challenges (33).

The second theme of this study is loss or questioning of faith with three categories, including lack of intimacy with God, relinquishment of religious rituals, and losing religious faith. Being diagnosed with breast cancer, women in this study lost their inner, sincere, and friendly relationship with God, and started blaming him. They were reluctant to talk to God and lost their hope and trust in God which was consistent with the argument of Penson et al. They suggested that the pain of the disease may take its toll on the patients and distort the spiritual relationship (26). Therefore, the patients avoid God since they regard him as the source of all their sufferings (34). Having lost their love of God, they feel isolated and lonely (31,35). In the present study, the patients stated that they did not adhere to their past religious beliefs, doubted the existence of God, and were confronted with spiritual questions, especially in painful situations. These findings confirmed the results of previous studies concerning spiritual struggles (4,34-36). This change in patients' attitudes is accompanied by the abandonment of previous religious and ritual practices. Cancer poses challenging questions about the benefits of religious practices which can exert adverse effects on spiritual beliefs.

Researchers reported that religious struggles affect rituals and the discontinuity of religious

practices might make it more likely (11,37). The findings of this category were in line with the research carried out by Salsman et al. In the mentioned study, the spiritual and religious dimensions of cancer patients were categorized as emotional, behavioral, and beliefs which affect each other (12). Pargament noted that stressful events in life, such as cancer, could challenge people's spiritual beliefs and lead to spiritual disruption (2). Therefore, the negative attitude to God and spiritual challenges are considered red flags for these patients and threaten the quality of life of affected women (38). It is noteworthy that negative religious coping is associated with lower life satisfaction, distress, and depression among patients with cancer and predicted suicide (37).

Limitations of the study

Every study has some limitations that should be addressed in the paper. One of the limitations of this study was the purposeful sampling method. Therefore, the generalization of the findings should be carried out with caution. Since the statistical population of the present study included women with breast cancer in Tehran (22), the generalizations of the research may be affected by cultural differences among different ethnic groups in Iran. Despite these limitations, the results of the present study provide some promising areas for future research.

Most importantly, longitudinal studies are required to investigate how various aspects of spiritual problems affect short- and long-term quality of life in different stages of breast cancer among women. Longitudinal research will be also of great help to determine the adaptive and maladaptive aspects of these problems. Finally, based on these results, health care providers should assess and attend to the spiritual problems of patients, especially in a stressful situation, since such factors may have implications for adjustment.

Conclusion

The findings of the present study highlighted the spiritual problems posed to women in the face of breast cancer. They hold God responsible for their cancer and seek the spiritual cause of the disease. The tone of their voice demonstrated that cancer is unfair and opposed to fairness of God which conflicts with their religious beliefs. They questioned their religious values and relinquished religious practices which were previously important to them. Researchers and therapists need to turn their close attention to these problems from the beginning of the process of cancer diagnosis and treatment since these problems may lead to a lower quality of life and poorer health outcomes. These patients need emotional support and care from clinicians and nurses along with their treatment process and spiritual care providers should attend to patients' spiritual problems.

Conflict of interest

The authors declare that they have no conflict of interest regarding authorship, and/or publication of the current article.

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