

The Effectiveness of Religious-Spiritual Psychotherapy on the Quality of Life of Women with Breast Cancer

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ABSTRACT

BACKGROUND AND OBJECTIVE: Breast cancer is one of the most common cancers around the world that leads to a decreased quality of life. Since one of the supportive measures is the use of spiritual teachings, the present study was conducted to investigate the effect of religious care on the quality of life of women with breast cancer.

METHODS: This quasi-experimental study was conducted in 2017 among women with breast cancer who referred to Qom health centers at least two months after their diagnosis. Seventy subjects were selected through convenience sampling and were randomly assigned to intervention and control groups. For the intervention group, 6 sessions of religious – spiritual psychotherapy were held with the focus of communication with God, other people, self and environment. The quality of life of the subjects was evaluated before the intervention, immediately after the intervention and two months after that using The World Health Organization Quality of Life (WHOQOL) with mean score of 0 – 100.

FINDINGS: The results showed a significant difference between the dimensions of quality of life in the control and intervention groups: total health and quality of life (57.61±9.42) vs. (60±19.51) (p=0.002), physical health (46.22±19.53) vs. (61.35±13.36) (p=0.016), mental health (57.85±24.16) vs. (67.55±13.24) (p=0.005), social health (54.88±24.44) vs. (62.79±18.35) (p<0.001), and environmental health (62.05±3.55) vs. (67.33±33.43) (p=0.048), indicating that the results were stable over time.

CONCLUSION: The results of the study showed that religious–spiritual psychotherapy increases the quality of life of women with breast cancer.

KEYWORDS: *Breast Cancer, Quality of Life, Religious, Spiritual Psychotherapy.*

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Introduction

Cancer is one of the leading causes of death worldwide, with breast cancer accounting for 1.7 million new cases (11.9%) and 522,000 (6.4%) deaths in the world. Breast cancer is the second most common cause of death from cancer among women (1, 2). The diagnosis and treatment of breast cancer confronts women with difficult situations in life, and even if they are treated, they suffer from more fatigue and anxiety compared with healthy women, and they experience a high level of anxiety, stress and depression (3, 4), which reduces the level of health and quality of life (5). With a survey of 126,685 cancer patients and healthy people, researchers at The National Cancer Institute have reported a lower quality of life among these patients compared with healthy people (6).

Quality of life is an abstract concept that is not visible or measurable by others and is based on the perception of a person from different aspects of life in four dimensions of physical, psychological, social, and cognitive functioning (7). The importance of measuring the quality of life is to the extent that some consider the improvement of this aspect as the most important goal of therapeutic interventions (8). There is also evidence that the quality of life can be an important prognosis in therapeutic situations. Therefore, measuring the quality of life in is highly important in difficult – to – treat diseases (9, 10).

Cancer causes multiple changes in quality of life, which is why the reduction in the quality of life in cancer patients is quite evident (11). Research has shown that the use of prayer in cancer patients can improve the quality of life of these patients. Spirituality and religion are new paradigms for responding to the challenges of the future, so that satisfying the transcendent needs of individuals can be sought in the model of spirituality and religion. The greatest source among spiritual and religious sources is prayer. It seems that repeated use of spiritual experiences along with therapeutic methods has positive effects on cancer patients (8). In a study aimed at investigating the relationship between religiosity and quality of life in women with breast cancer, there was a significant direct correlation between all subscales of religiosity and quality of life (11).

The study by Ahmadifaraz et al. showed that Quran and prayer increase the spiritual health of patients with cancer (12). Another study showed that religious and spiritual teachings, including prayer in patients, could be effective in increasing their satisfaction with quality of life. Research findings indicate that religious and

spiritual calmness may be even more important than physical and mental health in cancer patients who are at the final stages of their disease (13). According to Newton et al., most cancer patients use religious practices as a strategy to adapt to their circumstances, and thus religion can be considered as a mechanism for moderating and reducing the psychological problems of cancer patients (14).

According to the studies, spirituality and spiritual interventions such as prayer and religion recitations affect the quality of life and improve the quality of life of people with cancer (15 – 17). Therefore, according to the presented principles indicating that cancer is a stressful event that decreases the quality of life, and given the high prevalence of breast cancer and significant increase in the number of women with breast cancer, and on the other hand, the increasing need of these patients for supportive and spiritual care, this study was conducted to investigate the effectiveness of religious – spiritual psychotherapy on the quality of life of women with breast cancer.

Methods

This quasi-experimental double-blinded study was approved by the ethics committee of Nursing and Midwifery School, Shahid Beheshti University, in Tehran with ethics code PHNM.SBMU.IR.1395.644. It was registered at the Iranian Registry of Clinical Trials with code IRCT20171106037279N2. It was conducted as pretest-posttest with two-month follow-up with a control group among women with breast cancer referring to selected health centers in Qom.

The sample size was determined based on the study by Bolhari et al. with a confidence interval of 95% and a statistical power of 80%. Thirty-two samples were considered in each group (totally 64 samples) (18), and considering the sample loss (10%), 35 samples were assigned to each group. Among the referring patients, 35 patients were selected for each group using convenience sampling based on medical records and clinical interviews and according to the inclusion criteria. Hence, interventional factors such as income level and belief in the basic principles of Islam were controlled and the selected individuals were randomly assigned to control and intervention groups. Iranian patients with minimum age of 18 and maximum age of 65 years, definitive diagnosis of breast cancer (at stages 1 to 4) with pathological tests, at least 2 months after diagnosis, lack of severe mental diseases such as psychotic disorders or bipolar disorder that may require

hospitalization, non-exposure to another stressful event such as divorce and death of a close relative during the past year, being aware of time and place, having reading and writing ability, ability to speak Persian, lack of physical disability and Islam religion were included in the study. In case of dissatisfaction to continue the study, patient's death, absences for more than two sessions, patients were excluded from the study (Fig 1).

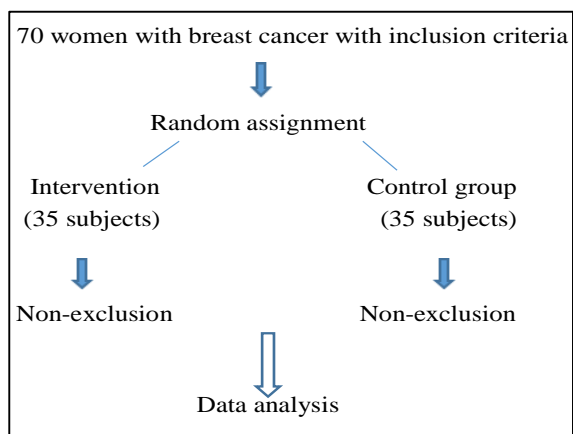


Figure 1. Study Diagram

After being informed about the goals of the research, women with breast cancer who had the inclusion criteria signed written informed consent for participation in the research. After determining the two groups based on the above method, members of the intervention group were informed of the time of the sessions by phone call. The intervention group underwent religious-spiritual psychotherapy. Each session was held in groups of 1-5. The training sessions for each intervention group consisted of six 90-minute sessions, held within week. Overall, six training sessions were held for each group. Nevertheless, the control group did not receive any other treatment until the end of the study, except for the usual protocol for treatment of malignancy. At the end of the two-month follow-up, similar sessions were held for the control group to observe ethical issues. The religious-spiritual psychotherapy package for cancer patients was based on some of the religious principles of Richards et al. with an emphasis on Islamic teachings (prayer, reading sacred books, going to religious places, forgiveness) (19).

The researcher designed this package based on the spiritual needs and priorities and consultation with religious clerics in the field of religion as well as health and psychology consultants. Religious and psychology books and articles were used for the preparation of this educational package. To confirm this educational package, it was provided to several prominent clerics

who were active in providing consolations, as well as three professors of psychology who approved this package. The first session began with the introduction of a therapist and getting familiar with each other, general information about the program, an explanation of the structure of the program, an explanation of the importance of quality of life, the importance of spirituality, the acceptance of the disease, and the determination of prayer for practice during the week. The second session included the effect of prayer on health, knowing the conditions before prayer, the importance of reciting the Quran, the influence of Quranic stories, and reciting prayers at the session. The third session included communion with God through the ways of thanksgiving blessings, the importance of thanksgiving, the impact of trust in God in enduring the disease, and reciting Quranic stories.

The fourth session included self-communion through self-esteem enhancement, the effect of patience on disease tolerance, and the importance of patience in Islam, association between recitation of prayer and increased patience, and reciting Quranic stories. The fifth session included communicating with others through considering the importance of proper communication with the child and the spouse, the principles of communication, the ways of effective communication with others, the importance of forgiving others, and reciting Quranic stories. The sixth session included discussing the communication with nature through the importance of looking at nature, the impact of communication with nature on health, and the importance of compassion towards animals and reciting Quranic stories.

Overall, the quality of life was evaluated before the intervention, at the end of the sixth session and two months after the sessions using the World Health Organization Quality of Life. This questionnaire is designed by the World Health Organization to assess quality of life. The concepts measured by this questionnaire are not associated with a specific age and disease group (20). The questionnaire consists of 26 items that assess quality of life in four areas related to health: physical health, social health, mental health, and environmental health. The physical health domain is the sum of the scores of questions 3, 4, 10, 15, 16, 17, 18 in the questionnaire. The mental health domain is the sum of the scores of questions 5, 6, 7, 11, 19, 26. The social health domain is the sum of the scores of questions 20, 21, 22. The environmental health domain is the sum of the scores of questions 8, 9, 12, 13, 14, 23, 24, 25 in the

questionnaire. Quality of life and general health is the sum of the scores of questions 1 and 2. After obtaining raw scores, each domain is convertible with a score of 0 to 100 (21). This questionnaire was first translated and validated by Nejat et al. In this study, the alpha coefficient of the questionnaire for the healthy subjects in the physical health domain was 0.70, in the mental domain was 0.73, in the social domain was 0.55, and in the environmental domain was 0.84. The reliability coefficient of the retest method was calculated to be 0.7 (22). To analyze the data, SPSS 21 software, repeated measures ANOVA, independent t-test, Mann-Whitney test, Fisher's exact test, and Chi-square test were used and $p < 0.05$ was considered significant.

Results

The mean age of women in the intervention and control groups were 44.74 ± 7.96 and 45.41 ± 9.53 , respectively, which were not statistically significant. The two groups did not differ significantly in terms of marital status and type of treatment and were mostly married.

After religious psychotherapy, the quality of life and all its dimensions (physical health, mental health, social health and environment) in the intervention group were more than the control group; in other words, changes in quality of life and its dimensions in the intervention group was significantly more than the control group ($p < 0.05$) (Table 1).

Table 1. Comparison of the mean scores of quality of life dimensions before intervention, after intervention and after two-month follow-up in the control and intervention groups in women with breast cancer

Dimensions of quality of life	Before intervention			After intervention			After two-month follow-up		
	Mean±SD			Mean±SD			Mean±SD		
	Control	Intervention	P-value	Control	Intervention	P-value	Control	Intervention	P-value
Health and quality of life	53.36±16.07	52.96±10.50	0.65	60±19.51	57.61±9.42	0.002	59±19.51	55.61±9.22	0.01
Physical dimension	46.73±20.33	49.59±25.66	0.1	61.35±13.36	46.22±19.53	0.016	58.35±13.36	46.22±19.53	<0.001
Mental dimension	60±21.48	53.21±17.90	0.14	67.55±13.24	57.85±24.16	0.005	65.55±13.24	55.85±24.16	0.02
Social dimension	54.52±24.53	51.42±25.92	0.58	62.79±18.35	54.28±24.45	0.001	60.79±18.35	51.28±24.45	0.001
Environmental dimension	59.46±26.05	63.57±27.34	0.39	67.33±33.43	62.05±38.55	0.048	66.33±33.43	58.05±38.55	0

Discussion

In this study, religious-spiritual psychotherapy and the use of religious teachings in women with cancer increased all dimensions of quality of life (physical, mental, social and environmental health), which continued throughout the two-month follow-up, and the results of this study are consistent with some studies. In their study, Taghadosi et al. showed that treatment with spiritual approach and the use of religious practices such as prayer, spiritual thought and meditation, forgiveness, companionship and serving, and focusing on mental and social development enhances the life quality of people who suffer from cancer (23).

Bolhari et al. also showed that spiritual support and paying attention to the spiritual needs of patients, especially those with cancer, are effective in improving quality of life and reducing stress and anxiety (18). Several studies have also shown that spirituality and spiritual interventions and the use of spiritual doctrines affect the quality of life and increase the quality of life of people with cancer (24, 25). Therefore, according to the studies, there is a positive and significant

relationship between spirituality and life expectancy. In addition, spirituality increases the quality of life and health, increases adaptation to cancer, and increases the ability of individuals to face the problems (26 – 28). Coleman stated that religion and spirituality increase social support, which in turn increases the quality of life (29). However, the results of this study are not consistent with some studies. Lotfie et al. in their quasi-experimental study with repeated measures entitled “The Effectiveness of Spiritual Intervention on Improving the Quality of Life of Mothers of Children with Cancer”, they held six sessions of psychotherapy based on spiritual interventions with an Islamic approach. It included six components of mental-spiritual self-awareness, prayer, trust and resort, patience, gratitude and asking for forgiveness every day for 90 minutes.

The results of this study indicated the ineffectiveness of spiritual care on the domains of physical health and environmental health (30). Colgrove et al. believed that spirituality does not affect

physical functioning (31). According to these results, it is suggested that due to the prominent presence of spiritual –religious culture in Iranian society and the topic of spirituality as an important issue, experts, and authorities pay more attention to this topic. Therefore, design and implementation of such programs at broader scales and based on the educational and supportive needs of patients is suggested.

Ethical considerations: The authors state that in this research all relevant ethical principles, including the confidentiality of the questionnaires, the informed

consent of the participants in the research, and the discretion of leaving the research have been observed.

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References

- 1.Siegel RL, Miller KD, Jemal A. Cancer statistics, 2016. CA: Cancer J Clin. 2016;66(1):7-30.
- 2.Ferlay J, Soerjomataram I, Dikshit R, Eser S, Mathers C, Rebelo M, et al. Cancer incidence and mortality worldwide: sources, methods and major patterns in GLOBOCAN 2012. *Int J Cancer*. 2015;136(5):E359-86.
- 3.Hagen KB, Aas T, Kvaløy JT, Eriksen HR, Sjøiland H, Lind R. Fatigue, anxiety and depression overrule the role of oncological treatment in predicting self-reported health complaints in women with breast cancer compared to healthy controls. *Breast*. 2016;28:100-6.
- 4.Rezaei Ardani A, Farid Hoseini F, Borhani Moghani M, Seyfi H. Cognitive behavioral stress management effects on quality of life and negative emotions in women with breast cancer. *Iranian J Obstet, Gynecol Infertil*. 2015;18(154):8-18.
- 5.Sahin ZA, Tan M. Quality of life and symptom experience of breast cancer patients undergoing chemotherapy. *Holist Nurs Pract*. 2016;30(4):193-200.
- 6.Smith AW, Reeve BB, Bellizzi KM, Harlan LC, Klabunde CN, Amsellem M, et al. Cancer, comorbidities, and health-related quality of life of older adults. *Health Care Financ Rev*. 2008;29(4):41-56.
- 7.Li Q, Lin Y, Qiu Y, Gao B, Xu Y. The assessment of health-related quality of life and related factors in Chinese elderly patients undergoing chemotherapy for advanced cancer: a cross-sectional study. *European journal of oncology nursing : the official journal of European Oncology Nursing Society*. 2014 Aug;18(4):425-35. PubMed PMID: 24721179. Epub 2014/04/12. eng.
- 8.Vahedi S, Badri Gargari R, Gholami S. Mediating role of cognitive emotion regulation strategies on the relationship between the attachment styles and emotional problems: a path analysis. *Iranian J Psych Behav Sci*. 2016;10(4): e4013.
- 9.Hojati H, Motlagh M, Nouri F, Sharifnia Sh, Mohammadnezhad E, Heydari B. Relationship between different dimensions of prayer and spiritual health in hemodialysis patients. *Iranian J Crit Care Nurs*. 2010;2(4):149-52. [In Persian]
- 10.Akbari ME, Asadi Lari M, Akbari A, Mousavi R, Mousavi M, editors. Spiritual care, neglected aspects of health in cancer management. *Palliative medicine in the 21st century Congress*; 2010.
- 11.Zargani A, Nasiri M, Hekmat K, Abbaspour Z, Vahabi S. A Survey on the relationship between religiosity and quality of life in patients with breast cancer: a study in iranian muslims. *Asia Pac J Oncol Nurs*. 2018;5(2):217-222.
- 12.Ahmadifaraz M, Reisi Dehkordi N, Mosavizadeh R, Ghaderi S. The effect of group spiritual intervention based on the quran and prayer on spiritual health of patients with cancer. *J Isfahan Med Sch*. 2015;32(320):2454-63.[In Persian]
- 13.Zeilani R, Seymour JE. Muslim women's experiences of suffering in Jordanian intensive care units: a narrative study. *Intens Crit Care Nurs*. 2010;26(3):175-84.
- 14.Newton AT, McIntosh DN. Specific religious beliefs in a cognitive appraisal model of stress and coping. *Int J Psychol Religion*. 2010;20(1):39-58.
- 15.Memaryan N, Jolfaei AG, Ghaempanah Z, Shirvani A, Vand HD, Ghahari S, et al. Spiritual care for cancer patients in iran. *Asian Pac J Cancer Prev*. 2016;17(9):4289-94.
- 16.Hosseini L, Kashani FL, Akbari S, Akbari ME, Sarafraz Mehr S. The Islamic perspective of spiritual intervention effectiveness on bio-psychological health displayed by gene expression in breast cancer patients. *Iranian J Cancer Prev*. 2016;9(2):e6360.
- 17.Kruizinga R, Hartog ID, Jacobs M, Daams JG, Scherer-Rath M, Schilderman JB, et al. The effect of spiritual interventions addressing existential themes using a narrative approach on quality of life of cancer patients: a systematic review and meta-analysis. *Psycho-Oncol*. 2016;25(3):253-65.
- 18.Richards P, Bergin AE. *Casebook for a spiritual strategy in counseling and psychotherapy*. Washington DC: Am Psychol Assoc; 2005.

19. Taghadosi M, Fahimifar A. Effect of life review therapy with spiritual approach on the life quality among cancer patients. *Feyz*. 2014; 18 (2) :135-44.
20. Bolhari J, Naziri G, Zamanian S. Effectiveness of spiritual group therapy in reducing depression, anxiety, and stress of women with breast cancer. *Sociol Women* . 2012;3(1):85-115.
21. Bovero A, Leombruni P, Miniotti M, Rocca G, Torta R. Spirituality, quality of life, psychological adjustment in terminal cancer patients in hospice. *Eur J Cancer Care*. 2016;25(6):961-9.
22. Paloutzian RF, Park CL. *Handbook of the psychology of religion and spirituality*: Guilford Publications; 2014.
23. Osorio IHS, Goncalves LM, Pozzobon PM, Gaspar Junior JJ, Miranda FM, Lucchetti ALG, et al. Effect of an educational intervention in "spirituality and health" on knowledge, attitudes, and skills of students in health-related areas: A controlled randomized trial. *Med Teach*. 2017;39(10):1057-64.
24. Mirjalili RA, Besharat MA, Koochi S. The moderating role of self-efficacy on the relationship between alexithymia and severity of pain in chronic pain patients. *Proced-Soc Behav Sci*. 2011;30:149-53.
25. Sherman AC, Merluzzi TV, Pustejovsky JE, Park CL, Fitchett G, Jim HS, et al. A meta-analytic review of religious or spiritual involvement and social health among cancer patients. *Cancer*. 2015;121(21):3779-88.
26. Weber SR, Pargament KI. The role of religion and spirituality in mental health. *Curr Opin Psychiatry*. 2014;27(5):358-63.
27. Coleman CL. Spirituality and sexual orientation: relationship to mental well-being and functional health status. *J Adv Nurs*. 2003;43(5):457-64.
28. Jim HS, Pustejovsky JE, Park CL, Danhauer SC, Sherman AC, Fitchett G, et al. Religion, spirituality, and physical health in cancer patients: A meta-analysis. *Cancer*. 2015;121(21):3760-8.
29. Colgrove LA1, Kim Y, Thompson N. The effect of spirituality and gender on the quality of life of spousal caregivers of cancer survivors. *Ann Behav Med*. 2007;33(1):90-8.