

Effect of Spiritual Care on Pain of Breast Cancer Patients: A Clinical Trial

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ABSTRACT

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Background: One of the most important symptoms and complications of breast cancer is pain with an extensive impact on life dimensions, management of which requires comprehensive nursing care and interventions. Given that spiritual care is an essential and unique part of care and spirituality is an indispensable part of man's life, we aimed to determine the effect of spiritual care in breast cancer patients from a multidimensional viewpoint

Methods: This clinical trial was conducted on breast cancer patients who presented to two medical centers at Isfahan, Iran, during 2014. Fifty patients were randomly selected and assigned to intervention and control groups. For the intervention group, the spiritual care program was implemented in groups of five in ten 60-minute long sessions. Both groups completed the Multidimensional Pain Inventory (MPI), which is a self-report questionnaire, immediately before and six weeks after the intervention. To analyze the data, descriptive statistics, analysis of covariance, and Chi-squared test were performed in SPSS, version 18.

Results: After administering the spiritual care program in the intervention group, the mean scores of pain severity dimensions ($P=0.004$), disrupted daily activity ($P<0.001$), emotional disturbance ($P<0.001$), and negative reaction ($P<0.001$) decreased significantly. Analysis of covariance indicated significant differences between the intervention and control groups in terms of pain severity ($P<0.012$), disrupted daily activity ($P<0.001$), life control ($P=0.021$), emotional distress ($P<0.001$), and negative reaction ($P=0.004$).

Conclusion: Spiritual care is effective on the reduction of pain severity and its adverse effects on the lives of breast cancer patients. Therefore, it is suggested to be used as a non-pharmaceutical complementary treatment for pain relief.

1. Introduction

Despite the growing advancements in medical sciences, cancer continues to be one of the most important health challenges worldwide. Breast cancer is the most commonly diagnosed type of cancer among women, such that it constitutes 26% of gynecologic cancers and it is the leading cause of cancer death in women aged between 20 and 59 years.¹ Pain is one of the chief complaints of breast cancer patients, this pain is experienced due to medical procedures and treatment rather than the disease itself.²⁻⁴ Feeling and perception of pain is the most common, distressing, and costly symptom of

cancer, which can negatively affect the quality of life in these patients.⁵ Most patients with advanced cancer (60-85%) report pain, which in many cases (14-26%), leads to hospitalization.⁶ However, about 43% of patients do not receive proper treatment for pain relief,³ which can be attributed to the consideration of the objective signs of pain as a measure for evaluation and the lack of trust in patients' self-reports as a scientific standard for pain monitoring.²

In other words, a comprehensive assessment of pain involves assessment of the role of psychosocial factors affecting the pain experience with considering its social context.⁷ Since most patients

have physical and spiritual or existential considerations with respect to their pain, it is essential to adopt a comprehensive approach to detecting and assessing pain.⁸

For many people, religion and spirituality are important aspects of day-to-day life. The results of a survey showed that 59% of people around the globe described themselves as religious, despite their lack of regular attendance at religious ceremonies.¹ Religion and spirituality are very essential for cancer patients, such that 69% of American cancer patients pray for their health, while praying is prevalent in 45% of the general American population.⁵

Spirituality can help cancer patients understand the meaning of their illness² and stay composed in the face of their fears.³ The results of several studies have shown the positive effects of spirituality on physical and mental health of cancer patients.⁹⁻¹⁴ Barlow *et al.* (2008) reported the key role of spirituality in cancer treatment, alleviating its side effects, facilitating patient cooperation, and reducing psychological problems such as depression, anxiety, feeling of guilt, reclusion, diminishing the physiological complications, and increasing the sense of strength and relaxation.¹⁵ Jafari *et al.* (2013) showed that spiritual psychotherapy could promote the quality of life in women with breast cancer.¹⁶ All these findings indicate the need for spiritual care, as a complementary therapy, based on the cultural and religious sensitivities of individuals at all stages of cancer since diagnosis until the end-of-life care.¹⁷ Therefore, because of the high prevalence of pain, its poor detection, and its effect on various aspects of life, the present study was carried out to ascertain the effect of spiritual care on pain severity of breast cancer patients from a multidimensional viewpoint.

2. Methods

2.1. Design

This clinical trial was conducted among women with breast cancer who visited two medical centers in Isfahan, Iran, during 2015.

2.2. Participants and settings

The standard sample size was estimated at 25 individuals according to a pilot study and the sample size formula for each group: $n = ((z_1 + z_2)(2s))/2a$

Fifty participants were selected using the convenience sampling method and were allocated to intervention and control groups using random number table. The inclusion criteria consisted being aged 30 to 55 years and having a history of chronic pain, definitive diagnosis of cancer, modified radical

adjustment of mastectomy, at least one chemotherapy course, ability to communicate, literacy, and religious beliefs. The exclusion criteria included absence for more than three sessions and the occurrence of acute physical and psychological problems such as acute depression, psychosis, and physical disability.

2.3. Instruments

In this study, a demographic characteristics form and the Multidimensional Pain Inventory (MPI) were used. The demographic characteristics form included items on marital status, age, and disease duration. The MPI (originally WHYMPI) was designed by Robert Corncce *et al.* (1985); it is a self-report scale for the assessment of cancer pain¹⁸. This tool includes 34 questions and 8 subscales (disrupted daily activity, severity of pain, social support, control of life, emotional distress, negative response, compassion, and distraction). The items in this questionnaire are rated based on a 7-point Likert-type scale ranging from 0 (never) to 6 (mostly).¹⁹ In this questionnaire, higher scores indicate increased pain-related problems. Validity, reliability, and normalization of the instrument were established by Abedi *et al.* (2008). The Cronbach's alpha coefficients of the subscales ranged between 0.77 and 0.92, and the mean correlation coefficients between the items of each subscale varied from 0.25 to 0.40; thus, all the subscales of this tool had a sufficient level of validity.⁷

2.4. Data Collection

We chose the patients who met the inclusion criteria by using the convenience sampling method. After explaining the study objectives and completing the informed consent forms by the patients, the demographic characteristics form and the Multidimensional Pain Inventory (MPI) questionnaire for pain were distributed among them. Then, the samples were allocated to two groups of intervention and control by using random number table. After the pre-test, for the intervention group, the spiritual care program was implemented in ten 60-minute sessions in groups of five during five weeks. The course was held by the researcher at a classroom in the research setting.

The spiritual care program is a psychological intervention devised by Taghizadeh and Miralaei in Isfahan, its contents were compiled by using Islamic sources and according to the sociocultural context in cognitive, behavioral, emotional, and spiritual dimensions (2013).²⁰ Therefore, in this study, the program was implemented in ten sessions (Table 1). Patients in the control group received the routine

care, and they attended two group discussion sessions about the disease. Six weeks after the

pretest, the intervention and control groups were asked to fill out the MPI again.

Table 1. Contents of the spiritual care sessions

Session	Contents
First	Introducing the participants and the spiritual care approach, the preliminary definition of pain and tolerance, preliminary introduction to the basic principles of cognitive-behavioral approaches, and overview of the spiritual care steps
Second	Explanation and definition of self-knowledge, self-knowledge as an introduction to theology, delineating some of the individual characteristics and explaining the importance of practice in .cognitive-behavioral approaches
Third	Explaining the concept of divinity and explaining the spiritual dimension of spiritual care approach with .an emphasis on the concept of God's presence and monotheistic attitude
Fourth and fifth	Defining and determining the destiny, sins, and atrocities we have committed to ourselves and to the God and others, explaining the proper reaction to negative evaluations of others, explaining the roles .and masks and their position in cognitive monotheism
Sixth	Committing all actions to God and spiritual learning and belief, explaining the self-worth criterion from the Islamic spirituality viewpoint, deciding for the spiritual growth, and teaching two key techniques of "questioning" and "coping whispers", and substituting negative thoughts with positive alternatives.
Seventh and eighth	Spiritual targeting and decision making for the development of spirituality and being spiritual with modeling, intellectual flexibility and venting emotions and feelings, and teaching cognitive-emotional ."key techniques, "decisive questioning" and "decisive coping whispers
Ninth	The necessity of avoiding the destructive feeling of humiliation and extreme and unhealthy feeling of sin and guilt, explaining the feeling of healthy sorrow and its distinction from destructive feeling of guilt and empowerment to resolve own problems of self and others
Tenth	Developing spiritual experiences and peak of pleasure and expression of spirituality and spiritual experience, and constant evaluation of spirituality under a spiritual person's supervision and explaining the concept of return to ineffective intellectual system and how to deal with it

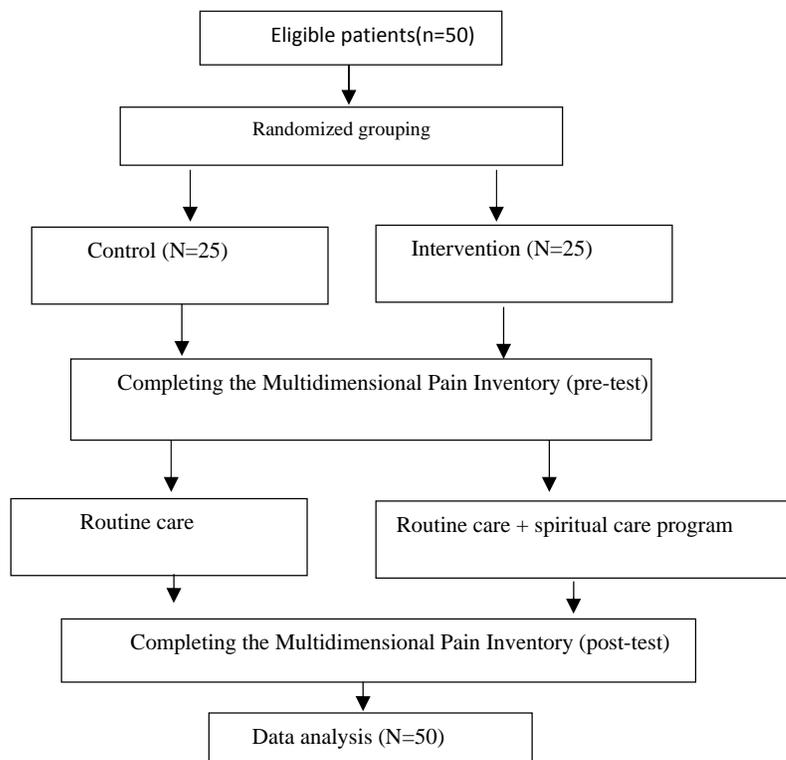


Diagram 1. Research procedure

2.5. Ethical considerations

At the beginning of the study, the researcher outlined the purpose of study for the participants and informed consent forms were received from them. The participants were assured of the confidentiality of the data and they were informed that they could withdraw from the study at any time. At the end of the study, two group discussion sessions were held for the control group about the disease and their experiences, and an educational pamphlet on spiritual care was given to them.

2.6. Statistical analysis

The data were entered into SPSS, version 18, and analyzed by using descriptive and inferential statistics. In addition to descriptive indices, Chi-squared test (to examine the difference in demographic characteristics between the intervention and control groups), t-test (for comparing the mean scores of multidimensional pain score before and after the intervention), and analysis of covariance (for comparison of mean scores of MPI between the two groups) were used.

3. Results

Patients' demographic characteristics are presented in Table 2. Based on this table, there was no significant difference between the intervention and control groups. According to Table 3, after the implementation of the spiritual care program, pain intensity dimensions ($P=0.004$), disrupted daily activity ($P<0.001$), emotional distress ($P<0.001$), and negative reaction ($P<0.05$) decreased significantly in the intervention group. Table 4 illustrates that spiritual care had a significant impact on at least one of the eight subscales of pain in women with cancer ($P<0.05$). The effect size is strong in terms of squared ITA (56%). Also, the test has a very high power. Of the eight MPI subscales, there were significant differences between the intervention and control groups in terms of dimensions of pain intensity ($F=6.93$), disrupted daily activity ($F=16.29$), life control ($F=5.79$), emotional distress ($F=41.13$), and negative reaction ($F=9.14$)

Table 2. Demographic and clinical characteristics of the control and intervention groups

Variable	Groups	Intervention	Control	P-value*
		N.(%)	N(%)	
Marital status	single	1(4)	6(24)	0.37
	married	13(52)	15(60)	
	Widow/divorced	11(44)	4(16)	
Duration of illness	1-9 months	3(12)	5(20)	0.20
	10-18 months	8(32)	6(24)	
	19-27 months	6(24)	4(16)	
	28-36 months	4(16)	7(28)	
	More than 36 months	4(16)	3(12)	
Age	30-34 years	2(8)	5(20)	0.36
	35-39 years	8(32)	2(8)	
	40-44 years	8(32)	6(24)	
	45-49 years	4(16)	7(28)	
	50-55 years	3(12)	5(20)	

*Chi-squared test

Table 3. The mean of scores of pain and its dimensions in the intervention and control groups

Variable	Group	Time	Pre-intervention	Post-intervention	P*
			Mean±SD	Mean±SD	
Disrupted daily activity	Intervention		4.14±1.22	3.26±1.08	0.001
	Control		1.24±3.93	4.1±1.12	0.071
Pain intensity	Intervention		4.58±0.819	3.78±1.17	0.004
	Control		4.37±1.03	4.64±1.02	0.4
Social support	Intervention		3.97±1.41	3.88±1.2	0.800
	Control		3.97±1.11	3.81±0.98	0.392
Life control	Intervention		3.52±1.13	3.16±0.85	0.175
	Control		3.72±1.13	3.94±1.18	0.352
Emotional distress	Intervention		4.1±1.12	3.39±0.92	0.001
	Control		4.06±1.32	4.25±1.11	0.535
Negative reaction	Intervention		3.68±1.03	2.71±0.86	0.001
	Control		4.46±1.29	3.36±1.05	0.735
Compassion	Intervention		4.05±1.05	4.41±0.97	0.083
	Control		4.16±1.31	4.26±1.23	0.105
Distracted attention	Intervention		4.59±0.97	4.49±1.17	0.676
	Control		4.27±1.27	4.4±1.48	0.638
Total score	Intervention		32.64±2.92	29.8±2.93	0.293
	Control		31.94±3.62	32.76±3.42	0.001

*Paired t-test

Table 4. Results of analysis of covariance on scores of the pain subscales of women with breast cancer

Subscales	Source	Total sum of squares	Degree of freedom	Mean squares	F	Significance level
Pain severity	Post-test	8.73	1	8.73	6.93	0.012
	Error	50.37	40	1.25		
Disrupted daily activity	Post-test	11.80	1	11.80	16.29	0.001
	Error	28.99	40	0.725		
Social support	Post-test	0.274	1	0.274	0.286	0.595
	Error	38.321	40	0.958		
Life control	Post-test	5.95	1	5.951	5.79	0.021
	Error	41.103	40	1.028		
Emotional distress	Post-test	11.78	1	11.78	13.41	0.001
	Error	35.150	40	0.879		
Negative reaction	Post-test	7.38	1	7.38	9.143	0.004
	Error	32.29	40	0.807		
Compassion	Post-test	0.550	1	0.55	1.23	0.273
	Error	17.80	40	0.445		
Distracted attention	Post-test	0.178	1	0.178	0.12	0.728
	Error	58.14	40	1.45		

4. Discussion

The results of this study signified that providing group spiritual care can decrease pain intensity and have positive effects on some aspects of self-management such as disrupted daily activity, emotional distress, and negative reactions in women with breast cancer.

In alignment with the present study, Bush et al. (1999) showed that religious and spiritual strategies can diminish the perception of pain,²¹ which reflects the fact that the use of spiritual strategies increases positive changes in individuals that not only gives meaning to life, but also boosts their coping mechanisms, and in turn, pain tolerance. Koolk et al. (2006) also showed that psychological strategies,

such as praying, could have an impact on pain relief.²² Wachwatz *et al.* (2007) in their research showed that religious and spiritual practices resulted in lessened perception of pain.²³ Glour, Marini, and Beck (2007) also demonstrated that spirituality lowers the perception of pain in patients with chronic pain.²⁴ Alcorne *et al.* (2010) expressed that religion and spirituality can enhance the positive coping strategies against cancer. Büssing *et al.* (2013) also showed that since spirituality satisfies the need for inner peace and dependence on an Omnipotent, it could lead to composure and reduced perceived pain.²⁵

Results of the above-mentioned studies are in line with our findings. Perhaps one of the reasons for reduced feeling and perception of pain in patients receiving spiritual care is that perception is influenced by complex and multidimensional factors such as biological, psychological, social, and spiritual factors, and considering each of these can impact an individual's perception of pain. On the other hand, improvement of coping mechanisms, social support, and beliefs can influence the individual's opposition to the disease. Individuals' beliefs are also influenced by increased hope and spiritual power and decreased self-deprecation.

Other studies, in congruence with the results of this study, pinpointed the relationship of religion and spirituality with the advancement of various aspects of an individual's life. For example, Balboni *et al.* (2013) showed that strengthening the patient's spiritual beliefs facilitates obtaining optimum results from any situation,²⁶ even in convoluted conditions. Mazzotti *et al.* (2011) also reported that attention to spirituality and spiritual care is one of those management techniques that can affect various dimensions of the quality of life in cancer patients.²⁷ Vallurupalli *et al.* (2012) highlighted the impact of spirituality and religion on promotion of physical, social, and existential dimensions of patients under radiotherapy.²⁸

The results of Rustoen *et al.* (2010) also showed that religious and spiritual powers were associated with health and well-being.²⁹ Finally, it can be stated that this unconditional acceptance, away from judgment, as well as the feeling of efficacy may be because of connection to a divine power, the God, which influences the cognitive assessments of individuals during the coping process, thus, spirituality can help evaluate the negative events in a different way. On the other hand, spirituality creates a strong sense of control in humans, which can help with mental adaptation.

However, the findings of Rippentrop *et al.* (2005) showed that religious and spiritual practices have a negative relationship with physical health.³⁰

This difference can be due to the fact that people participate in spiritual activity to see a miracle when they experience the deterioration of physical condition and pain, while the aforementioned studies and the present one have used spiritual and religious practices as an approach to adapt individuals to their physical condition. Of limitations of the present research were focusing solely on women with breast cancer and limited sample size due to lack of access to patients meeting the inclusion criteria. Further, complete control of the conditions was not feasible and the results should be interpreted and generalized carefully.

5. Conclusion

The results of this study indicate that the implementation of collective spiritual care programs can assuage the severity of pain and its adverse effects on breast cancer patients' lives. Therefore, it is recommended to use it as a complementary therapy for pain relief. Other care and treatment approaches should also be conducted on the perception and experience of pain in cancer patients, and outcomes should be compared with the present results. Spiritual care and treatment is a new therapeutic approach in nursing and psychology domains that requires extensive research. In addition, to investigate the strengths and weaknesses, as well as assess the long-term impact of the intervention, further follow-up tests are recommended in reasonable intervals.

Conflicts of interest

The authors declare no conflicts of interest.

Authors' contributions

Mohammad Reza Jahanizade: conducted the study and contributed to data collection, Mohsen Shahriari: supervised the project and designed the project, Nasrollah Alimohammadi: drafted and submitted the manuscript, Abdolrahim Hazini: provided consultation in the research project.

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