

RESEARCH ARTICLE

Content of Spiritual Counselling for Cancer Patients Undergoing Chemotherapy in Iran: A Qualitative Content Analysis

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Abstract

Background: Cancer is one of the leading causes of human death. Besides clinical treatment, cancer patients may need emotional and spiritual counselling to overcome their mental and morale problems. Such counselling sessions have been reported influential by many patients. We aimed to explore the structure of spiritual counselling sessions and their content as one of services provided to patients who experience chemotherapy in Iranian hospitals. **Methods:** Through a qualitative content analysis study, we recorded the discussions between a counsellor, who was a cleric as well, and cancer cases who were undergoing chemotherapy in a hospital in Tehran. The sessions were only recorded if the patient consented to attend at the study. All consideration were taken to avoid release of patients' identity. The recorded discussions were transcribed verbatim and analyzed thematically after each session, until no new theme was emerged. **Result:** Twenty two sessions were held. The patients aged 53 years old on average. The content of discussions were analyzed along which 165 codes emerged. Four general themes or phases were recognized through counseling as (i) history-Taking (including demographic, disease-related and spiritual history and characteristics), (ii) general advice, (iii) spiritual-religious advice, and (iv) dealing with patients' spiritual or religious ambiguities and paradoxes. **Conclusion:** Counselling of cancer patients needs special and in depth knowledge on spiritual and religious issues. The counsellor should be able to motivate patients, among whom many are disappointed, to follow the curative instructions well and stay hopeful about their treatment and life. Exploring and understanding what happens during a spiritual counselling session can counselling to the conformity and standardization of such interventions.

Keywords: Spiritual counselling- cancer- chemotherapy- religion- Islam- Iran- qualitative study- thematic analysis

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Introduction

Cancer is the second leading cause of death after cardiovascular diseases in developed countries and the fourth in developing countries (Moghimian and Salmani, 2012). More than 50 thousand new cases of cancer are diagnosed in Iran every year (Esmaeili, 2012). Based on the type of cancer, patients may suffer from different problems including fatigue, eating problems, sleep disorders, pain, bleeding and emotional problems (Charalambous and Beadsmoore 2008). Chemotherapy, as one of the most used therapies for cancer, can cause different complications and side-effects such as vomiting, hair loss, mouth sores, fatigue, diarrhea and constipation, sexual dysfunction and memory loss (Sun et al., 2005)

Awareness of having a life-threatening disease such as cancer, changes people's perception of life (Yeganeh, 2013). Hence apart from medicine therapy, patients and even caregivers should receive mental and emotional care

for their spiritual needs (Hatamipour et al., 2015; Markani et al., 2013). Patients with cancer experience severe mental stress (Mohammadian akerdi, 2016) and occasionally develop complex negative emotions toward God that can exacerbate their stress (Rashid et al., 2012). Moreover, awareness about the diagnosis of cancer dramatically increases patients' spiritual needs (Agha Hosseini, 2011) and puts their religious beliefs and self-esteem severely at risk (Ghahramanian et al., 2016). Therefore spiritual and spiritual/religious interventions which are increasingly used (Musarezaie et al., 2014; Salajegheh and Raghbi, 2014) even as a coping strategy in non-patient groups (Sarani, 2016) need to be provided by experienced counsellors (Sankhe et al., 2017).

"Spirituality", internationally, is defined and classified rather different form religion (Edwards et al., 2010). Indeed spirituality considers the personal perceptions of meaning and aim of life, which can be related or unrelated to the religion (Tanyi, 2002). However, based on a local

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definition in Iran, spirituality refers to “the noble dimension of human existence which all humans have been endowed to follow the path of transcendence that is proximity to God” (Memaryan et al., 2016b). All people and patients can therefore benefit from spiritual interventions. The best reason for addressing the spiritual and religious aspects of patients in Iran is that, in addition to being a general need of any human-being, many patients in this country have religious beliefs and spiritual/religious needs (Karimollahi et al., 2009), and attention to this aspect can affect their acceptance of medical interventions and even their compliance and adherence to the interventions. Then summoning all the inner strength of a patient, including spiritual dimension, is necessary for providing complete care and support (Rahnama et al., 2012).

Spiritual counselling is a type of spiritual interventions (Azarnik et al., 2015) in which the counsellor takes steps to resolve the patient’s problems by relying on his faith and spiritual powers (Aghajani et al., 2013). A major part of spiritual counseling is to encourage the patient to speak about his/her religious or spiritual problems and concerns according to his/her own demand and needs (Memaryan et al., 2016a).

In Iranian hospital with oncology departments some services are provided for cancer cases such as exemption from or discount in their cost (Aryankhesal et al., 2016) and provision of spiritual counselling on their demand. Regarding that counselling sessions are held for several years in one of Iranian hospitals, we assumed the sessions as successful and helpful for the patients.

Given the dire need for practical models and guidelines for providing spiritual care like spiritual counselling in Iran (Jafari et al., 2014), the present study was conducted to explain spiritual counselling services as one of these models. This study seeks to explore and determine the means of identifying the spiritual needs of patients and to examine the content of the conversations taking place in counselling sessions. As an explorative approach is needed, qualitative method was used. Such methods can develop deep understanding of meanings, anecdotes and human behavior (Tong et al., 2007).

Materials and Methods

This study was a qualitative descriptive thematic analysis (Vaismoradi et al., 2013). The method tries to extract meaning units from anecdotes and interviews and condense them until a code can be labeled to the meanings (Graneheim and Lundman, 2004). Such approach will let the researchers to classify concepts into themes. To ensure the quality of the study method, relevant items of the 32-item Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007) was considered.

Participants

The spiritual counsellor was a cleric with level-2 seminary education and a master degree in counselling, who had a few years of work experience in providing spiritual counselling to cancer patients. He was informed about the study and agreed to have the sessions recorded

if the patients consented.

The patients who chose to get spiritual counselling consisted of 22 cancer cases that were receiving chemotherapy in the Hematology and Oncology Department of Rasoul-e-Akram Hospital in Tehran (see Table 1). Their age ranged from 18 to 85 years old. The study inclusion criteria were a definitive diagnosis of either gastrointestinal, breast or blood cancer, having begun chemotherapy at least for two weeks and being capable of communicating with others. The patients were referred to the spiritual counsellor by their oncologist on their consent. Patients’ whom their physician was not happy with the counselling session were excluded for medical considerations.

Data Collection

The counselling sessions were held face-to-face at the patients’ bedside in hospital where just the patient, counsellor and one member of study team (NM) were present. The patients’ relatives were allowed to be present in the interview sessions on patient’s consent. At the onset of all counselling sessions, the study objectives and its voluntary and confidential nature were introduced to the patient and then the discussions were recorded by sound recorder if the patient agreed. All participants signed a consent forms before beginning the interview. The present researcher also took note of some of the points discussed in the interviews. The mean duration of interviews was 22±7 minutes and the interviews continued until data saturation occurred and no new information emerged. The 22 counselling sessions were held from 15.11.2015

Table 1. Participants' Demographic Details

Patient Code	Type of Cancer	Gender	Age (years)
1	Breast	Female	51
2	Gastrointestinal	Male	40
3	Gastrointestinal	Female	84
4	Blood	Male	69
5	Gastrointestinal	Male	69
6	Breast	Female	59
7	Blood	Male	23
8	Breast	Female	59
9	Gastrointestinal	Female	71
10	Breast	Female	58
11	Gastrointestinal	Male	57
12	Blood	Female	40
13	Gastrointestinal	Female	65
14	Breast	Female	33
15	Breast	Female	65
16	Gastrointestinal	Female	42
17	Breast	Female	41
18	Breast	Female	46
19	Breast	Female	54
20	Blood	Female	21
21	Gastrointestinal	Male	67
22	Gastrointestinal	Female	56

to 19.4.2016.

Data Analysis

The recorded sessions were transcribed verbatim immediately after each session. We analyzed data according to the model proposed by Graneheim and Lundman (Graneheim and Lundman, 2004) which involved the following steps:

The transcribed interviews were regarded as units of analysis. Meaning units were extracted from the interview texts after several reviews and achieving a good understanding of the statements. Then the meaning units were shortened into condensed meaning units. A number of codes, also referred to as the 'labels' of the condensed meaning units, were then formed. The codes were then assessed in terms of similarities in their content and sub-categories and categories were developed respectively. Two themes then emerged as the foundation of the categories and their content (Memaryan et al., 2015). No software was used for this purpose, and the meaning units and codes were extracted and were then classified and extracted into themes. The participants did not review the transcribed interviews; however, the counsellor added some comments. To clarify the extracted codes, categories and themes, direct quotations are provided from the interviews in the results section.

Data Rigor and Trustworthiness

While meeting 31 out of the 32 items of the COREQ checklist, the credibility, transferability, and consistency of the data were ensured based on Lincoln and Guba's evaluative criteria as an integral part of any qualitative study (Tabatabaee et al., 2013). These were considered through prolonged engagement with and immersion in the subjects, peer check, external check, presenting details on the participants as well as the study setting, providing a background on the subject and discussing any relevant literature, explaining the process of recording the raw data and providing a lengthy explanation of the processes of coding and analysis.

Ethical Considerations

This study was approved by the Research Council of Iran University of Medical Sciences under the code 25978-185-02-94. Written consent for participation in the study was obtained from all the participants prior to beginning the interviews. The research team adhered to the ethical principles of research and respected participants' rights throughout the interviews.

The leading author (NM), who had experience of working on psychology and spiritual care, and AA, who had experience of doing qualitative data analysis, reached an agreement on data coding after discussion on five first sessions' content and the emerging codes. Then the leading author coded the rest of interviews. All authors studied and worked on the study protocol and all worked on the first and final draft of the manuscript.

Results

Four general themes of history-taking, general advice,

spiritual-religious advice, and further explanations on spiritual or religious ambiguities and paradoxes were recognized through the analysis (Table 2).

1. History taking: This was the first theme extracted from the data and consisted of 'demographic information', 'disease history' and 'spiritual history' categories.

a. Demographic Information: Including data on age, place of residence, level of education and details about the patient's spouse and children and even grandchildren.

b. Disease History: Including questions on the type, progress and duration of the disease, medical history and physical symptoms such as physical status and pain.

c. Spiritual History: Including questions on religious-spiritual behaviors first and cognitive behaviors next. The behavioral domain of this category is concerned with the patient's connection with God and the Infallible Imams and religious practices during illness and at the hospital; the cognitive domain is concerned with the patient's beliefs, his trust in God and religious figures and his appeal to them, and the sources of serenity for him.

An example of the questions posed to patient No. 4 by the spiritual counsellor in the 'spiritual history' category was:

"I'd like to ask, who or what you normally appeal to in times of hardship? How important is this source of support for you? Given that connection with God and spiritual source indicates a spiritual person, do you consider yourself a spiritual person? How do you establish a connection with that?"

2. General Advice: General advice are provided by the spiritual counsellor as solutions to the patient's problems and concerns in different areas (not just religious-spiritual). These included hope for a cure, appreciation of other blessings, strengthening self-esteem and the need for self-care, which sometimes contained psychological care.

"When you are not well, you may think about what you have lost, your beauty, your youth, and your power. However these may disturb you of having a blessing life. You should think about what you have now. You should appreciate them and keep the medical instructions", (counsellor said to patient No. 20)

3. Spiritual-religious Advice: Such advises included the recitation of several disease-related verses and anecdotes. The counsellor also discussed about causes of the disease and afflictions from the perspective of religion, the desirability of illness, spiritual enhancement following illness, belief in an eternal life. He also advised patients to trust in God and the holy figures and encouraged them to appeal to God and the holy figures. Discussions about certain religious rules and practices and resolving religious problems concerned with the means of worshipping in the hospital setting were among other advice.

A sample of the spiritual advice given to patient No. 1 was:

"I have read near 20 different narratives from the Infallible Imams that say, 'for every sigh uttered by the sick and for every sleepless night he experiences, his sins are completely removed, as if he has just been born; so that he has no sin. Hence, patient's spiritual standing with God will increase. That is why they say that being

Table 2. Themes, Categories and Codes Recognized in Across the Interviews with Patients' Counselling Sessions

Demographic	History taking		General advice		Spiritual-religious advice	Further Explanations on spiritual or religious ambiguities and paradoxes
	Disease-related	Spiritual				
		Behavioral	Cognitive			
*Name	*Physical status	*Connection with God and the Infallible Imams	*Source of belief and faith	*Hoping in the effect of the treatment	*Hoping in the effect of the treatment	*The counselling method
*Age	*Type of disease	*Praying, reciting Holy verses	*Sources of support and peace	*The need to focus on the treatment	*The need to focus on the treatment	*Spiritual counselling
*Place of residence	*Duration of the disease	*Hospital worship facilities	*Patient's spiritual sources	*The desire for life	*The desire for life	*Spirituality
*Occupation	*Type of treatment	*Performing religious practices in the hospital	*Signs of spirituality in life	*Resolving the threat of death	*Resolving the threat of death	*Spiritual history
*Level of education	*Disease progress and diagnosis	*Religious practices associated with the sense of healing	*The relationship between health and spirituality	*Accepting death	*Accepting death	*Spiritual needs
*Children's characteristics	*Duration of hospitalization	*Asking about comforting religious practices	*Patient's religious beliefs	*Lack of despair and disheartenment	*Lack of despair and disheartenment	*Characteristics of a spiritual person
*Marital status and spouse's characteristics	*Pain	*The effect of disease on performing religious practices	*Meaning of life	*Positive views on others' feelings	*Positive views on others' feelings	*Spiritual experiences
*Grandchildren's details	*Satisfaction with the treatment procedure	*The appeal to God and the Infallible Imams	*Interesting spiritual issues	*Emphasizing realistic thinking	*Emphasizing realistic thinking	*Spiritual thoughts
	*Medical history	*Pilgrimage	*Spiritual self-assessment	*Positive attitude toward one's possessions	*Positive attitude toward one's possessions	*The philosophy of praying
		*The effect of disease on performing religious practices	*Asking about the effects of religious thought	*Personal anecdotes of being realistic about the disease	*Personal anecdotes of being realistic about the disease	*Other religions
		*Asking about the non-performance of religious practices in the hospital	*The fundamental reason for spiritual tendencies	*Anecdotes about unforeseen events in life	*Anecdotes about unforeseen events in life	*Patient's challenges with God
			*Patient's source of trust	*Resolving the patient's challenges about the reason for his illness	*Resolving the patient's challenges about the reason for his illness	*The purpose of asking about whether the patient has said his prayers
			*The effect of trust on the patient	*Reinforcing the patient's self-esteem	*Reinforcing the patient's self-esteem	*Validating the source of the anecdotes
			*Hope	*Remaining hopeful and trusting	*Remaining hopeful and trusting	*The validity of the anecdotes
			*The source of appeal during hardships	*Encouraging resilience against illness	*Encouraging resilience against illness	*Ambiguities and the issues discussed
			*Asking about the reason for appealing	*Discussing the worse conditions of some other patients	*Discussing the worse conditions of some other patients	
			*Asking about patient's expectations of appealing	*Anecdotes about difficult diseases	*Anecdotes about difficult diseases	
			*Attitude on the non-performance of rituals	*Not expecting the worst in life	*Not expecting the worst in life	
			*The reason for the desire to talk to a spiritual counsellor	*Anecdotes about recovery in other patients	*Anecdotes about recovery in other patients	
			*Observing belief-related principles in the treatment program	*Avoiding hasty judgments	*Avoiding hasty judgments	
				*The need for self-care	*The need for self-care	
				*Encouraging optimism regarding the disease	*Encouraging optimism regarding the disease	
				*Encouraging emotional release	*Encouraging emotional release	
				*Accepting the trials and tribulations of life	*Accepting the trials and tribulations of life	

ill is desirable. As you said, God gives us pain. In the words of Imam Sadeq, Prophet Muhammad once said that God sends two angels on earth every day and they

visit patients' bedsides and are ordered by God to write their deeds and return and report them to Him. Then the angels return and say that the person has done nothing

but sleep, and then God tells the angels that the person is ill, so go back down and write all the deeds that he would do if he was healthy”.

4. Further Explanations on spiritual or religious ambiguities and paradoxes: Sometimes patients encounter paradoxical situations, especially when their own beliefs just did not match counsellor's explanations. Sometimes situations may have been ambiguous for the patient, including spirituality, spiritual experiences, the philosophy of praying, the characteristics of a spiritual person, the patient's challenges regarding God and even the validity of the narrations told and their narrators.

“Sometimes you may think why I am not getting better, although I prayed to get well. God says in Surah Baqarah, verses 155-7 that he test people with something of fear, hunger, loss of wealth, lives etc., but gives glad tidings to As-Sabirin (tolerant and patient ones); whom, when afflicted with calamity, say: “Truly! To Allah we belong and truly, to Him we shall return. They are those on whom are the Salawat (i.e. blessings, etc.) from their Lord, and (they are those who) receive His Mercy, and it is they who are the guided-ones.” (Said the counsellor to patient No. 16).

Discussion

The present study addressed the content and processes of the spiritual counseling sessions provided by a cleric with an expertise in counseling. Although this study is a case study, but the present qualitative research is efficient in exploring, identifying and explaining what happens in these sessions, since qualitative studies are the proper choice for exploring and understanding human relationships, such as care relationships (Abedi et al., 2006).

Given the increasing number of studies on spiritual interventions, especially cancer patients (Hatamipour et al., 2015; Zeighamy and Sadeghi, 2016), and the numerous scientific evidence on the efficacy of these interventions in improving patient outcomes (Puchalski, 2013), the type of intervention used and the methods of providing it are both highly important. Nevertheless, any mistake in counselling may result in an increased disease burden (Fitchett et al., 2004). By discovering four main themes, namely history taking, general advice, religious-spiritual advice, and further explanations of religious or spiritual ambiguities and paradoxes we tried to make a better understanding of complex processes of spiritual counselling sessions held for cancer patients undergoing chemotherapy.

In the ‘history-taking’ theme, just as is the case in any other history taking, the counsellor first asks about the patient's demographic information and takes a history of his current disease. Then he proceeds to taking his spiritual history. For the spiritual history, the counsellor asks about the patient's spiritual behaviors and then gets into the realm of his beliefs and spiritual perceptions. The process of spiritual history taking in this study is similar to the SACBT model developed by D'Souza (2004) includes a combination of the well-known Cognitive Behavioral Therapy (CBT) model and a spiritual approach.

Through other stages, the counsellor advised about

general topics, religious-spiritual issues and clarifying patients about their doubts and paradoxes appeared through the previous sections especially religious-spiritual ones. Speaking about self-care, physical and psychological, are found helpful in other studies (Galway et al., 2012). The spiritual and religious advice provided were based on Islamic teachings and supported in valid sources such as the Quran and anecdotes from the Infallible Imams. Responses to the religious questions and doubts posed by the patient and discussing the rules of Sharia were also based on religious treaties. The codes extracted in this section may be said to constitute a novelty of this study, because although previous studies have examined the specialist conversations between clergymen or chaplains and patients (Post et al., 2000; Puchalski et al., 2006; Puchalski, 2010), the content of their conversations have not been reported.

The themes provided in the present study contain delicate points that can be considered in these types of counselling in order to establish a better communication with the patients. The codes and themes also provide spiritual counsellors and caregivers with a more effective counselling content that is consistent with the principles and strategies of counselling, including mainly a respectful attitude toward the patient, empathy, flexibility, noticing nonverbal behaviors and actively listening (Pour Asghar, 2011). Moreover, due to the particular nature of spiritual counselling and the use of a counsellor who is a cleric, other techniques were also used. These included preparation for getting into spiritual debate and providing relevant verses and narratives, approving the patients' spiritual-religious coping strategies and the performance of good deeds emphasized in Islam upon meeting and talking to the patients and clarifying about patients' ambiguities, as well as praying and reciting Hamd Surah to request healing.

Although the patients' spiritual needs and the subsequent interventions provided to them have many common aspects (Karimollahi et al., 2007), the best intervention is one which is compatible with the specific needs of the given disease and is even in line with the different needs identified for the different stages of that disease and which provides solutions according to these needs (Rassouli et al., 2015). Since the present study's population consisted of a specific group of patients (i.e. Muslim cancer patients hospitalized in a teaching hospital), the transferability of the results should be pursued with caution. Moreover, we did not examine the effect of the counselling session, because it was out of our study's scope. The researchers therefore recommend that similar studies be conducted in other groups of patients in term of their religions and illness. Effectiveness and impact of spiritual-religious counselling sessions also are among topics that need further research.

In conclusion, exploring and understanding what happens during a spiritual intervention such as spiritual counselling contributes significantly to the conformity and standardization of such interventions, which are among the urgent needs of the Iranian health system. Thematic analysis as used in the present study provides a mean of accomplishing this understanding.

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