

RESEARCH ARTICLE

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A Qualitative Study of Strength, Hope, and Meaning: Multi-Stakeholder Perspectives on Spiritual Care for Breast Cancer

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Abstract

Objective: To explore the multi-stakeholder experiences of spiritual care for breast cancer patients from the perspectives of patients, families, medical personnel, and religious leaders. **Methods:** This qualitative descriptive study employed Braun and Clarke's reflexive thematic analysis. A purposive sample of 20 participants (five patients, five family members, five medical personnel, and five religious leaders) was recruited in Semarang, Indonesia. Data were collected through semi-structured interviews and field notes between January and April 2025, and analyzed using NVivo 12. Credibility was ensured through source triangulation, member checking, peer debriefing, and audit trail procedures. **Results:** Four themes emerged. First, spirituality was identified as a source of strength and hope, reflected in practices such as repeated prayer recitations that helped patients cope with treatment-related fear. Second, the family served as a pillar of spiritual support, illustrated by joint family prayers that reduced chemotherapy-related distress and motivated treatment adherence. Third, spiritual care was integrated by medical personnel, including simple practices such as offering space for prayer or initiating brief spiritual discussions despite time constraints. Fourth, religious leaders played a role in reinforcing meaning, shown through personalized guidance that helped patients reinterpret illness as a meaningful life test. **Conclusion:** Effective spiritual care requires the coordinated engagement from families, medical personnel, and religious leaders. Practical implications include the need for training in spiritual care for healthcare providers and the structured collaboration among families and religious leaders. This study is limited by its single-region setting and relatively homogeneous religious background. Future studies should evaluate structured spiritual care interventions longitudinally.

Keywords: Breast cancer- experience- spiritual care

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Introduction

Breast cancer is a major global health problem with a growing burden each year. According to 2022 Global Cancer Observatory (GLOBOCAN) data, it is the most commonly diagnosed cancer in women worldwide, with an estimated 2.3 million new cases and approximately 685,000 deaths annually [1]. In Indonesia, breast cancer is also the most prevalent cancer in women, with an incidence rate of over 42 cases per 100,000 people and a substantial mortality burden [2]. Beyond its physical manifestations, breast cancer exerts a multidimensional impact on patients' lives, affecting psychological well-being, social relationships, and the spiritual dimension related to meaning, purpose, and hope [3].

Spirituality in the context of health is increasingly recognized as a core dimension of human well-being. The

World Health Organization (WHO) describes spirituality as an aspect of human life related to the search for meaning and purpose, and to connections with oneself, others, nature, and transcendent entities [4]. In contemporary psycho-oncology and palliative care literature, spirituality is often distinguished from religiosity, although the two may overlap [5]. Religiosity generally refers to formal beliefs and practices within a particular religious tradition, whereas spirituality is broader and may include personal beliefs, values, and experiences that are not necessarily tied to institutional religion [6]. For people living with cancer, including those with breast cancer, spirituality and religiosity can both function as important coping resources, supporting hope, meaning-making, and emotional resilience throughout the illness trajectory [7, 8]. Adequate spiritual support has been associated with better quality of life and reduced psychological symptoms

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such as anxiety and depression [9].

Patients with breast cancer often face complex emotional and existential challenges. The diagnosis and treatment process can evoke fear of death, concerns about recurrence, and a sense of loss related to bodily changes, such as mastectomy or altered physical appearance, which may affect self-image and self-confidence [10]. These experiences create a profound need to find or reconstruct meaning in life, accept the illness, and achieve inner peace. Meeting such spiritual needs is inseparable from the patient's cultural, religious, and personal value systems. In Indonesia's religiously plural context, where Islam, Christianity and other faith traditions coexist, spiritual care must be adapted to different belief systems and practices. Within this context, families, medical personnel, and religious communities play crucial roles in facilitating spiritual support [11]. Families provide daily emotional and moral support, medical personnel have opportunities to integrate spiritual aspects into clinical care, and religious communities offer shared spaces for worship, reflection, and strengthening faith [12].

Families are often the closest and most consistent source of emotional and spiritual support for breast cancer patients. Spiritual support from families may take the form of praying together, offering verbal encouragement, accompanying patients in religious practices according to their beliefs, and conveying hopeful narratives that foster inner strength [13]. Prior research has shown that such family-based spiritual support can enhance psychological well-being and help patients navigate treatment with greater optimism [14]. At the same time, families may struggle with their own emotional burdens, limited spiritual knowledge, and uncertainty about how to operationalize spiritual care in everyday interactions, which can hinder their ability to provide consistent and targeted support [15]. Despite this, little is known about how families concretely translate spiritual beliefs into daily practices during active cancer treatment, particularly in Indonesian settings.

The concept of spiritual care refers to planned and integrated efforts to address patients' spiritual needs as part of holistic care. These efforts can include supporting patients' search for meaning in life, strengthening faith and hope, and facilitating religious or personal reflective activities that are relevant to the patient's situation [16]. To provide spiritual care effectively, healthcare workers require spiritual competencies that encompass conceptual understanding, skills in identifying and responding to spiritual needs, and an empathic attitude that respects religious and cultural diversity [17]. Integration of spiritual care into clinical practice can be achieved through routine assessment of spiritual needs, sensitive therapeutic communication, and collaboration with religious leaders or chaplains. However, the implementation of spiritual care is frequently constrained by time pressures, heavy workloads, biomedical priorities, and limited formal training in spiritual care within health professional curricula [17-19]. How clinicians in Indonesian oncology settings negotiate these constraints and coordinate with clergy or religious leaders to support patients' spiritual needs remains under-explored.

In Indonesia, research on spiritual care for breast cancer patients is still limited, particularly qualitative studies that explore spiritual experiences in depth. Existing work has tended to focus on patients or family caregivers as single stakeholder groups, with fewer studies incorporating the perspectives of multiple actors who jointly shape spiritual care, such as patients, families, medical personnel, and religious leaders [20-22]. This leaves important questions insufficiently addressed, including how families operationalize spiritual practices in the context of ongoing treatment and side effects, how clinicians recognize and respond to spiritual concerns in busy oncology services, and how formal or informal coordination with religious leaders is enacted in practice. At the same time, spiritual care in many healthcare facilities is not systematically integrated into cancer services, and is often delivered in an ad hoc manner.

These gaps highlight the urgency of research that is sensitive to Indonesia's cultural and religious context and that captures the interrelated roles of different stakeholders involved in spiritual care. Therefore, this study aims to thematically analyze how breast cancer patients, family members, medical personnel, and religious leaders experience and interpret spiritual care in the context of breast cancer treatment in Indonesia, and how their perspectives can inform contextually appropriate, multi-stakeholder models for integrating spiritual care into routine oncology practice.

Materials and Methods

Research Design

This study adopted a qualitative descriptive design using reflexive thematic analysis as described by Braun and Clarke [23]. This design was selected because it allows a rich, low-inference description of participants' perspectives and accommodates variation across stakeholder groups without the idiographic commitment required in phenomenological traditions. The focus of the study was to explore how patients, family members, medical personnel, and religious leaders experience and interpret spiritual care within the context of breast cancer.

Research Setting

The study took place in Sorong, Papua Barat Daya, Indonesia, across three primary settings: a cancer referral hospital, an oncology outpatient clinic, and a community-based cancer support organization. These settings were purposively selected to ensure access to diverse participants actively engaged in spiritual support or breast cancer care.

Participants and Recruitment

Participants were recruited through purposive sampling based on their direct involvement in the provision, experience, or support of spiritual care for breast cancer. The inclusion criteria for participants (four stakeholder groups) there are:

Patient

women diagnosed with stage I-IV breast cancer, aged

18 years or older, currently undergoing treatment or in the post-treatment phase, physically fit to participate, and willing to share their spiritual experiences. This group was selected because they are the primary subjects who directly experience spiritual needs and services.

Family

A core family member (spouse, child, or sibling) who is actively involved in accompanying the patient throughout the treatment process and providing support, including spiritual support. The family perspective is important for understanding the role of emotional, moral, and religious support provided in the patient's immediate environment.

Medical personnel

Doctors, nurses, or other healthcare professionals with at least two years of experience caring for breast cancer patients. This group plays a crucial role in providing spiritual care as part of a holistic care approach and can provide insight into the challenges of integrating spiritual care into clinical practice.

Religious leader

Religious leaders or clergy who have been directly involved in providing spiritual support to breast cancer patients. This group's participation is necessary to explore the role of moral guidance, faith strengthening, and religious perspectives in influencing patients' acceptance of the disease and life expectancy.

Recruitment was conducted through several channels. Patients were approached by oncology nurses who were not part of the research team to minimize potential coercion. Family members were contacted through participating patients upon receiving their consent. Healthcare providers were invited through departmental coordinators, and religious leaders were identified through hospital chaplaincy networks and community-based religious organizations. Participation was voluntary, and all individuals provided written informed consent, including permission for anonymized verbatim quotations.

Exclusion criteria included severe cognitive impairment, diminished consciousness, inability to communicate verbally, or emotional distress that made participation inappropriate. A total of twenty participants were included, with five individuals representing each stakeholder group. Sample size was informed by the concept of information power, and saturation was assessed within each group. Across the data set, no new codes emerged after the eighteenth interview, and thematic stability within groups, for example, among clinicians was observed from the fourth interview onward.

Data Collection

Data collection was conducted through face-to-face, semi-structured, in-depth interviews supported by an interview guide developed from the literature and reviewed by experts in oncology nursing and spiritual care. Interviews explored participants' spiritual experiences during illness, the forms of support received from various parties, barriers encountered in accessing

spiritual care, and expectations for future improvements. Interviews lasted between 45 and 90 minutes and were conducted in private locations based on participants' preferences, such as consultation rooms, participants' homes, or community meeting spaces.

All interviews were conducted in Bahasa Indonesia, audio-recorded with consent, and transcribed verbatim. Field notes captured contextual information, nonverbal cues, and researcher reflections. Translated excerpts presented in the manuscript were cross-checked by bilingual researchers to ensure fidelity to participants' intended meanings. Data were collected within January until April 2025.

Data Analysis

Data were analyzed using reflexive thematic analysis following Braun and Clarke's six phases [23]: familiarization with the data; generation of initial inductive codes; construction and review of candidate themes; refinement and naming of themes; and synthesis into a coherent narrative. Coding was conducted with attention to both semantic and latent meanings, emphasizing researcher reflexivity rather than consensus-driven processes. NVivo 12 software was used to support the management and organization of data. The analysis was iterative, with ongoing reflection and discussion within the research team to examine evolving interpretations and positionalities.

Researcher Reflexivity

The research team comprised individuals with backgrounds in oncology, nursing, and spiritual health. Reflexive practices included maintaining analytic memos, examining personal assumptions related to religiosity and spiritual care, and holding team discussions to reflect on how professional roles and cultural perspectives might shape data interpretation. These practices helped enhance transparency and minimize interpretive bias during analysis.

Trustworthiness

Credibility was strengthened through triangulation across stakeholder groups, member checking through returning interpretive summaries to participants, peer debriefing with experts in qualitative methodology and spiritual care, and maintaining a detailed audit trail documenting methodological decisions throughout the study.

Ethical Considerations

This study received ethical approval from the Diponegoro University Research Ethics Committee (No. 565/EC/KEPK/FK-UNDIP/X/2024). All participants provided written informed consent. Confidentiality was protected through pseudonyms, de-identification of transcripts, and secure digital storage accessible only to the principal investigator. Participants were informed of their right to withdraw at any time without any consequences to their access to health services.

Results

Demographic Characteristics of Participants

Twenty participants contributed to this study, comprising five breast cancer patients (P), five family members (F), five healthcare personnel (HP), and five religious leaders (RL). Patients were women aged 34 to 62 years, with an average age of 48.2 years, spanning stages I to IV. Four identified as Christian and one as Muslim. Family participants were husbands, adult children, or siblings aged 25 to 58 years, with four identifying as Christian and one as Muslim. Healthcare personnel included oncologists, oncology nurses, and clinical psychologists aged 29 to 52 years, with an average age of 39.4 years; two identified as Muslim and three as Christian. Religious leaders were Protestant (two), Catholic (two), and Muslim (one), aged 33 to 57 years, all with active roles in providing worship support and spiritual counseling (Table 1). The relationships among themes are summarized in Figure 1.

Key Findings of the Reflexive Thematic Analysis

Four overarching themes emerged from the analysis. These themes describe how spirituality was understood, practiced, and supported across participant groups. While the themes largely complemented each other, differences in expectations, capacities, and theological interpretations became evident across stakeholders.

Theme 1: Spirituality as a Source of Strength and Hope

All participant groups described spirituality as the main coping mechanism grounding patients emotionally throughout diagnosis and treatment. Patients viewed spirituality as giving meaning and stability, while families and healthcare personnel observed its influence on treatment adherence and resilience. Nevertheless, spiritual interpretations sometimes clashed with medical uncertainties, revealing moments of tension.

Subtheme 1.1: Belief in the Divine Plan

Reported by patients, healthcare personnel, and religious leaders.

Patients often framed cancer as part of a divine purpose that required acceptance. One patient explained, “I believe this illness is a test from God. As long as I pray, my heart feels calm even when the pain comes” (P3). Healthcare personnel observed similar patterns, as one stated, “Patients who see their illness as part of God’s plan tend to be more cooperative during treatment” (HP2). Religious leaders reinforced this belief, though with differences across traditions, with Protestant and Catholic leaders emphasizing endurance and trust while Muslim leaders highlighted purification and spiritual growth.

Subtheme 1.2: Spirituality as a Coping Resource

Reported by all groups

Spiritual practices provided emotional relief. A

Table 1. Demographic Characteristics of Participants

Category	Number (n)	Average Age (years)	Age Range	Religious Affiliation	Additional Information
Patient	5	48.2	34–62	Christianity (5)	Stages I–IV, all female
Family	5	42.6	25–58	Christianity (5)	Husbands, adult children, siblings
Medical personnel	5	39.4	29–52	Islam (2), Christianity (3)	Oncologist, oncology nurse, psychologist; ≥2 years oncology experience
Religious leaders	5	45.8	33–57	Protestant (2), Catholic (3)	Provided direct spiritual counseling and worship support

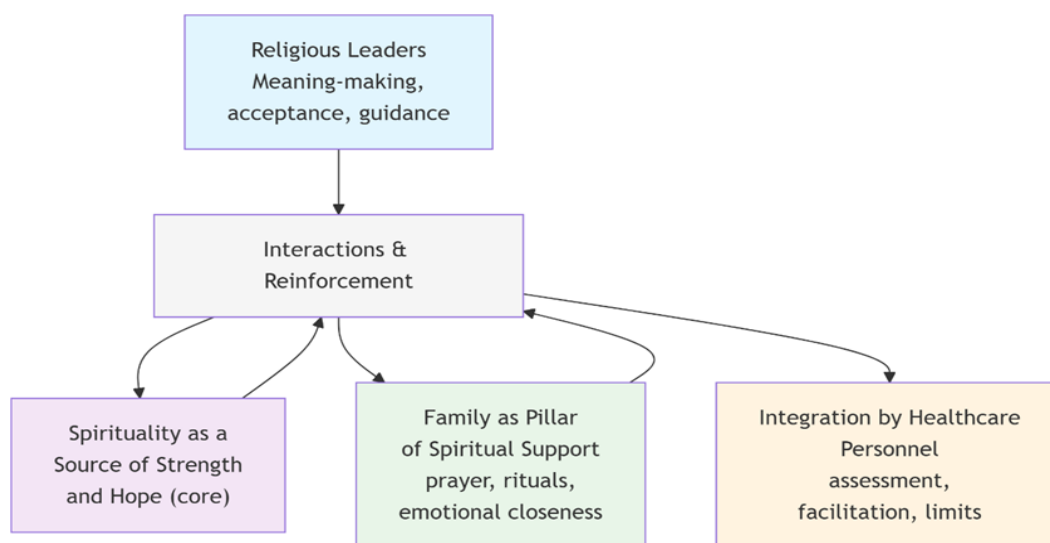


Figure 1. Summarizes the Relational Structure among the Four Themes

patient noted, “When fear comes, I pray and feel strength returning” (P4). A family member echoed, “We pray together so she does not feel alone” (F3). Healthcare personnel recognized that patients with strong spiritual grounding often persisted through treatment fatigue or distress.

Spirituality acted as a stabilizing anchor for patients, giving emotional coherence to the cancer experience. Although theological interpretations differed, spirituality consistently supported hope and resilience.

Theme 2: The Family as a Pillar of Spiritual Support

Families shaped patients’ spiritual well-being through shared rituals, accompaniment, and verbal encouragement. This role provided comfort yet also exposed the vulnerability of family members who navigated their own emotional struggles.

Subtheme 2.1: Shared Worship and Ritual Practices Reported by patients, families, and religious leaders

Family presence in worship was a meaningful source of comfort. A husband shared, “I always accompany my wife when she prays and reads Scripture so she does not feel alone” (F1). A Christian daughter expressed a similar sentiment, “If my mother wants to go to church, I take her because worship strengthens her” (F5). Religious leaders also noted that families often facilitated spiritual continuity for patients.

Subtheme 2.2: Emotional Burdens and Limitations Reported by families and healthcare personnel

Family members often endured emotional strain. One sibling explained, “I want to be positive, but seeing her pain breaks my heart” (F4). Healthcare personnel recognized this hidden distress and observed that emotional fatigue sometimes limited families’ ability to consistently provide spiritual reassurance.

Family members were essential spiritual companions but also carried emotional burdens that shaped the quality and continuity of their support.

Theme 3: Integration of Spiritual Care by Healthcare Personnel

Healthcare personnel acknowledged the importance of spirituality and attempted to integrate spiritual considerations into care. Their strategies included facilitating worship, asking about spiritual needs, and contacting religious leaders. Despite this, systemic constraints limited their capacity to do so consistently.

Subtheme 3.1: Efforts to Incorporate Spiritual Needs Reported by healthcare personnel and patients

Clinicians described making efforts to align care with patients’ spiritual beliefs. One oncologist stated, “We ask about their beliefs so we can support their worship routines” (HP4). Patients valued small gestures such as privacy for worship or acknowledgment of their spiritual needs.

Subtheme 3.2: Challenges in Implementation Reported by healthcare personnel

Clinicians cited time limitations, heavy caseloads, and lack of training as barriers. One explained, “With so many patients and little time, it is difficult to address spiritual needs consistently” (HP4). Another added, “Not all healthcare personnel have specific training in spiritual care” (HP5). These practical constraints sometimes diverged from family expectations.

Healthcare personnel attempted to operationalize spiritual care but were constrained structurally, revealing the need for clearer institutional support and training.

Theme 4: Religious Leaders as Strengtheners of Meaning and Acceptance

Religious leaders helped patients interpret illness and cultivate acceptance through counseling, prayer, and theological framing. Their involvement complemented clinical care and often deepened patients’ sense of meaning.

Subtheme 4.1: Spiritual Counseling and Meaning-Making Reported by religious leaders and patients

Religious leaders provided individualized guidance. A Protestant pastor shared, “I tell patients that suffering is not punishment but a way God strengthens them” (RL2). A Muslim ustadz emphasized patience and spiritual purification, while the Catholic priest focused on compassion and divine presence. Patients described these encounters as clarifying and emotionally grounding.

Subtheme 4.2: Collaboration with Healthcare Personnel Reported by religious leaders and healthcare personnel

Cross-role collaboration was described positively. A Catholic priest explained, “We coordinate with doctors to understand the patient’s condition before offering spiritual support” (RL1). Healthcare personnel confirmed this collaborative pattern and often initiated referrals to religious leaders at patients’ requests.

Religious leaders contributed meaning-making frameworks that supported acceptance and helped patients navigate existential concerns. Collaboration with healthcare personnel strengthened these efforts.

Discussion

This study explored how patients, family members, healthcare personnel, and religious leaders experience and interpret spiritual care in the context of breast cancer. Four main themes were identified. Spirituality functioned as a source of strength and hope for patients. Families acted as a pillar of spiritual support. Healthcare personnel attempted to integrate spiritual aspects into clinical care despite systemic constraints. Religious leaders played a central role in reinforcing meaning and acceptance. Taken together, these themes describe a multi stakeholder ecosystem of spiritual care that is shaped by cultural, religious, and organizational contexts.

Theme 1: Spirituality as a Source of Strength and Hope

The finding that spirituality constitutes a primary

copied resource for patients aligns with theoretical models of meaning making and Sense of Coherence. Spiritual beliefs help patients situate cancer within a broader life narrative, support comprehensibility and manageability, and offer a framework for viewing illness as meaningful rather than purely random or punitive [24]. Participants described prayer, surrender to God's plan, and trust in divine presence as ways to regain emotional balance in the face of uncertainty. These experiences are consistent with previous studies that have reported associations between religiosity, spiritual well being, and better psychological adjustment among women with breast cancer [25].

At the same time, the present study nuances existing literature by showing that spirituality is not only an internal resource but also relational and context dependent. Patients' narratives of divine testing and spiritual growth were reinforced by families, clinicians, and religious leaders [26]. This collective reinforcement resonates with spiritual history tools such as FICA and HOPE, which emphasize beliefs, community, and ways of addressing spiritual needs in care [27]. In this study, however, spiritual conversations were often informal rather than structured [28, 29]. The themes suggest that integrating simple spiritual history questions into routine clinical assessment could provide a more systematic way to recognize and respond to these coping processes.

Our findings also highlight cultural particularities. While some Western studies describe spirituality as a broad search for personal meaning that may be independent from formal religion, participants in this study primarily expressed spirituality through explicitly Christian and Muslim beliefs and rituals. Worship, prayer, and scriptural references formed the core of spiritual experiences [30]. This reflects the strong religious culture in Indonesia, where belief in a transcendent power and regular worship are integral to daily life [31]. In such settings, spirituality and religiosity are deeply intertwined [32]. For practice, this implies that spiritual assessment and support need to be sensitive to explicit religious expressions and not assume a secular or non institutional understanding of spirituality.

Participants perceived that strong spiritual conviction supported emotional resilience and, in some cases, treatment adherence. However, given the cross sectional design of this study, these patterns should be interpreted as perceived or associated rather than causal [33]. Future longitudinal or mixed methods research is needed to test hypotheses such as "greater alignment between spiritual beliefs and care plans is associated with reduced anxiety during chemotherapy and more consistent clinic attendance."

Theme 2: The Role of the Family as a Pillar of Spiritual Support

Families in this study acted as primary spiritual companions by praying with patients, facilitating worship, and offering verbal encouragement. These practices strengthened patients' sense of not being alone and contributed to feelings of security and hope. The findings are consistent with evidence from collectivist cultures, including other Asian settings, where family involvement

in spiritual and emotional care is more normative than in individualistic contexts. Families often function as a bridge between patients and religious communities, linking clinic based care with community based spiritual resources [34].

At the same time, the study shows that family support has both strengths and vulnerabilities. Family members carried substantial emotional burdens as they witnessed the patient's suffering and navigated their own fear and grief [35]. Some reported feeling unsure how to provide spiritual encouragement when they themselves were overwhelmed. This echoes research that describes the double role of families as both caregivers and "co sufferers." In practice, it suggests that interventions should not assume limitless family capacity [36]. Instead, family focused spiritual care might include basic psycho education about spiritual needs, communication strategies for offering support, and spaces where family members can express their own distress [37].

These findings have several operational implications. Co prayer and shared worship can be viewed as lay level spiritual interventions whose potential pathways include reduced treatment related anxiety, increased perceived support, and better engagement with care [38]. Future research could test hypotheses such as "family co prayer before chemotherapy is associated with lower self reported anxiety scores and improved clinic attendance." Clinically, healthcare personnel can play a facilitative role by asking simple questions about how families currently provide spiritual support and by validating these practices when they are helpful [39].

Theme 3: Integration of Spiritual Care by Medical Personnel

Healthcare personnel in this study recognized the importance of spiritual aspects in cancer care and described concrete actions such as asking about beliefs, facilitating prayer spaces, and contacting religious leaders at the patient's request. These practices align with international guidance, including the European Association for Palliative Care consensus on spiritual care, which recommends basic spiritual screening for all patients and referral to specialized spiritual support when needed [29, 40].

However, the study also reveals a consistent gap between awareness and implementation. Clinicians reported limited time, high caseloads, and insufficient training as reasons why spiritual care was not routinely integrated. Many expressed uncertainty about appropriate language, boundaries, and referral pathways [41]. This reflects findings from other contexts where healthcare professionals are generally supportive of spiritual care but feel underprepared to deliver it in a structured and ethically sensitive way [17].

These findings point to the need for specific competencies rather than generic encouragement. Core competencies might include the ability to conduct brief spiritual screening using simple tools such as FICA or HOPE, to use respectful and non coercive language when exploring beliefs, to recognize signs of spiritual distress, to understand professional boundaries, and to know

when and how to refer patients to chaplains or religious leaders [42, 43]. Existing curricula and toolkits in spiritual care could be adapted to the Indonesian context, with attention to Christian and Muslim beliefs and to the multi stakeholder nature of care [44].

From an operational perspective, spiritual care training could be embedded in continuing professional development programs. Hospitals could also develop simple protocols that define roles, for example that all patients are offered a brief spiritual screen, that nurses can initiate referrals to religious leaders, and that spiritual needs are documented alongside physical and psychological assessments [45]. These system level supports would help ensure that spiritual care does not depend solely on individual initiative.

Theme 4: The Role of Religious Leaders as Strengtheners of the Meaning of Life

Religious leaders in this study played a crucial role in helping patients reinterpret illness and find meaning. Through sermons, individual counseling, and prayer, they helped patients view cancer as a test, an opportunity for spiritual growth, or a context in which God remains present [46]. This meaning making function is consistent with previous research in palliative and oncology settings, where spiritual leaders are central to addressing existential concerns, easing fear of death, and reinforcing hope [47].

The study adds nuance by showing how religious leaders work in relation to healthcare personnel. In many cases, religious leaders coordinated with clinicians to understand the patient's health status before offering spiritual counsel [48]. This allowed them to tailor messages and avoid contradicting medical guidance. At the same time, differences in theological emphasis occasionally shaped expectations about healing and prognosis. These dynamics underscore the importance of respectful dialogue between medical and religious professionals [49].

In practice, formalizing collaboration mechanisms between healthcare facilities and religious communities could strengthen spiritual support. This might include clear referral pathways, agreed communication channels, and mutual orientation sessions where clinicians and religious leaders learn about each other's roles and constraints [50]. Early involvement of religious leaders, especially when requested by patients or families, may facilitate acceptance, reduce existential anxiety, and improve trust in healthcare services. These potential pathways again require empirical testing in future studies.

Limitations and Transferability

Several limitations should be considered when interpreting these findings. The study was conducted in a single urban region and involved a relatively small number of participants. Although the sample included Christian and Muslim participants from different roles, other religious traditions were not represented. Transferability to other regions, rural areas, or settings with different religious compositions may therefore be limited. Participants were recruited through clinical and religious networks, which may have introduced selection

bias toward individuals who are more engaged with healthcare or religious communities.

As with many qualitative studies, social desirability may have influenced participants' accounts, especially in discussions about faith, family, and professional roles. Power dynamics between patients and clinicians may also have shaped what patients felt comfortable expressing. Although efforts were made to create a safe interview environment and member checking was conducted, these factors cannot be fully excluded. These limitations underline the need for cautious interpretation and for further research in more diverse settings.

Implications and Future Directions

Despite these limitations, the study offers several important implications. First, the multi stakeholder approach highlights that spiritual care in breast cancer is not the responsibility of one actor alone but is co constructed by patients, families, healthcare personnel, and religious leaders. This perspective extends existing models that focus primarily on patient clinician or patient chaplain dyads by showing how spiritual support flows across home, clinic, and religious spaces.

Second, the themes can be translated into concrete mechanisms that future research can test. Examples include family co prayer as a strategy to reduce chemotherapy related anxiety, brief spiritual screening by clinicians as a way to identify unmet spiritual needs, and structured collaboration with religious leaders as a means to support meaning making and acceptance. These mechanisms lend themselves to feasibility studies, intervention development, and eventually randomized or mixed methods trials.

Third, hospitals and health systems can use these findings to guide the development of structured spiritual care policies. Potential steps include integrating brief spiritual screening into admission or assessment forms, providing training modules on spiritual care competencies for healthcare personnel, establishing clear referral pathways to religious leaders or chaplains, and involving families in spiritual care planning when appropriate. In the Indonesian context, where religiosity is high and spiritual concerns are interwoven with daily life, such structured approaches have the potential to make spiritual care more accessible, consistent, and culturally congruent.

Conclusions

This qualitative study shows that spiritual care is a central component of support for women living with breast cancer. The findings indicate that spirituality as a source of strength and hope, the role of families, the efforts of healthcare personnel, and the involvement of religious leaders are interconnected elements within a shared spiritual care ecosystem. Together, they illustrate that holistic support emerges when patients, families, healthcare professionals, and religious leaders work in a coordinated way that is sensitive to cultural and religious context. As a qualitative study from a single region, these conclusions should be understood as context specific insights that inform practice rather than definitive system level prescriptions. Implementation efforts will require

further adaptation, testing, and evaluation in diverse settings.

For practice, the results suggest that hospitals and oncology services in Indonesia can use these insights as a basis for developing more structured approaches to spiritual care. This may include basic training in spiritual assessment and communication for healthcare personnel, educational support for families to strengthen their role as spiritual companions, and formal mechanisms for collaboration with religious leaders that respect patients' preferences and plural religious backgrounds. Future research should focus on co designing a culturally adapted and structured spiritual care pathway with input from all stakeholder groups, followed by feasibility or pilot trials that evaluate its impact on psychological distress, quality of life, perceived spiritual support, and treatment adherence. Longitudinal qualitative studies are also needed to explore how spiritual needs and multi stakeholder roles evolve over time across the illness trajectory.

Author Contribution Statement

Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data: HMS, SI, AP; Involved in drafting the manuscript or revising it critically for important intellectual content: HMS, SI, AP; Given final approval of the version to be published. Each authors should have participated sufficiently in the work to take public responsibility for appropriate portions of the content: HMS, SI, AP; Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved: HMS, SI, AP.

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Ethical Declaration

This study has received ethical approval from the Diponegoro University Research Ethics Committee with approval letter number (No. 565/EC/KEPK/FK-UNDIP/X/2024)

Conflict of Interest

The authors declare no competing interests.

References

1. Globocan. Breast cancer, estimated incidence, mortality and prevalence worldwide in 2020. [internet]. 2020. Available from: <https://geo.iarc.fr/today/data/factsheets/populations/792-turkey-fact-sheets.Pdf>.
2. Ministry of health of the republic of indonesia. Chronic disease situation in indonesia; 2018.
3. Snaman J, Morris SE, Rosenberg AR, Holder R, Baker J, Wolfe J. Reconsidering early parental grief following the death of a child from cancer: A new framework for future research and bereavement support. *Support Care Cancer*. 2020;28(9):4131-9. <https://doi.org/10.1007/s00520-019-05249-3>.
4. Ghahramanian A, Markani AK, Davoodi A, Bahrami A. Spiritual needs of patients with cancer referred to alinasab and shahid ghazi tabatabaie hospitals of tabriz, iran. *Asian Pac J Cancer Prev*. 2016;17(7):3105-9.
5. Park S, Sato Y, Takita Y, Tamura N, Ninomiya A, Kosugi T, et al. Mindfulness-based cognitive therapy for psychological distress, fear of cancer recurrence, fatigue, spiritual well-being, and quality of life in patients with breast cancer-a randomized controlled trial. *J Pain Symptom Manage*. 2020;60(2):381-9. <https://doi.org/10.1016/j.jpainsymman.2020.02.017>.
6. Borges ML, Caldeira S, Loyola-Caetano EA, Magalhães PAPd, Areco FS, Panobianco MS. Spiritual/religious coping of women with breast cancer. *Religions*. 2017;8(11):254.
7. Purba CIH, Johnston B, Kotronoulas G. An exploration of family caregivers' health care needs when caring for patients with cancer in the resource-challenged context of west java, indonesia. *Semin Oncol Nurs*. 2023;39(3):151369. <https://doi.org/10.1016/j.soncn.2022.151369>.
8. Shergill Y, Rice DB, Khoo EL, Jarvis V, Zhang T, Taljaard M, et al. Mindfulness-based stress reduction in breast cancer survivors with chronic neuropathic pain: A randomized controlled trial. *Pain Res Manag*. 2022;2022:4020550. <https://doi.org/10.1155/2022/4020550>.
9. Türkbek Polat H, Kiyak S. Spiritual well-being and care burden in caregivers of patients with breast cancer in turkey. *J Relig Health*. 2023;62(3):1950-63. <https://doi.org/10.1007/s10943-022-01695-2>.
10. Akkol-Solakoglu S, Hevey D, Richards D. A randomised controlled trial comparing internet-delivered cognitive behavioural therapy (icbt) with and without main carer access versus treatment-as-usual for depression and anxiety among breast cancer survivors: Study protocol. *Internet Interv*. 2021;24:100367. <https://doi.org/10.1016/j.invent.2021.100367>.
11. Arndt V, Stegmaier C, Ziegler H, Brenner H. A population-based study of the impact of specific symptoms on quality of life in women with breast cancer 1 year after diagnosis. *Cancer*. 2006;107(10):2496-503. <https://doi.org/10.1002/cncr.22274>.
12. Fabi A, Falcicchio C, Giannarelli D, Maggi G, Cognetti F, Pugliese P. The course of cancer related fatigue up to ten years in early breast cancer patients: What impact in clinical practice? *Breast*. 2017;34:44-52. <https://doi.org/10.1016/j.breast.2017.04.012>.
13. Lu Q, Dong L, Wu IHC, You J, Huang J, Hu Y. The impact of an expressive writing intervention on quality of life among chinese breast cancer patients undergoing chemotherapy. *Support Care Cancer*. 2019;27(1):165-73. <https://doi.org/10.1007/s00520-018-4308-9>.
14. Ottenbacher A, Sloane R, Snyder DC, Kraus W, Sprod L, Demark-Wahnefried W. Cancer-specific concerns and physical activity among recently diagnosed breast and prostate cancer survivors. *Integr Cancer Ther*. 2013;12(3):206-12. <https://doi.org/10.1177/1534735412449734>.
15. Omidi Z, Kheirkhah M, Abolghasemi J, Haghghat S. Effect of lymphedema self-management group-based education compared with social network-based education on quality of life and fear of cancer recurrence in women with breast cancer: A randomized controlled clinical trial. *Qual Life Res*. 2020;29(7):1789-800. <https://doi.org/10.1007/s11136-020-02455-z>.
16. Yosep I, Hikmat R, Lindayani L, Mardhiyah A, Hernawaty T. Spiritual needs in cancer patients: A narrative review. *Malaysian J Med Heal Sci*. 2022;18(s17):385-90.
17. Yosep I, Hikmat R, Lindayani L, Mardhiyah A. Spiritual

- intervention to improve psychological well-being on cancer patient: A scoping review. *J Nurs Care*. 2022;5.
18. Miller M, Greenwalt K, Lehto R, Wu H-S, Moser J, Wyatt G. Pain and spirituality among women with advanced breast cancer: Insights from a phenomenological study. *Cancer Care Research Online*. 2021;1(1):e001. <https://doi.org/10.1097/cr9.0000000000000001>.
 19. Soriano GP, Calong Calong KA. Spiritual well-being, self-transcendence, and spiritual practices among filipino women with breast cancer. *Palliat Support Care*. 2021;19(6):723-6. <https://doi.org/10.1017/s1478951521000079>.
 20. Muzdalifah F, Ariyani M, Gazadinda R, Tsalitsaturrajbiyah. Spiritual well-being as a predictor of quality of life among breast cancer patients in indonesia. In: *Proceedings of the 3rd borobudur international symposium on humanities and social science 2021*. Atlantis press; 2022. P. 258–68. https://doi.org/10.2991/978-2-494069-49-7_44.
 21. Dewi IP, Gartika N, Sanusi S, Suryatiningsih D. Determinants of spiritual well-being that impact breast cancer patients' quality of life. *J Holist Nurs*. 2024;42(2_suppl):S40-s6. <https://doi.org/10.1177/08980101231181272>.
 22. Nuraini T, Andrijono A, Irawaty D, Umar J, Gayatri D. Spirituality-focused palliative care to improve Indonesian breast cancer patient comfort. *Indian J Palliat Care*. 2018;24(2):196-201. https://doi.org/10.4103/ijpc.Ijpc_5_18.
 23. Braun V, Clarke V, Hayfield N, Terry G. Thematic analysis 48. *Handbook of research methods in health social sciences*. 2019:843-60.
 24. Komariah M, Hatthakit U, Boonyoung N. Impact of islam-based caring intervention on spiritual well-being in muslim women with breast cancer undergoing chemotherapy. *Religions*. 2020;11(7):361.
 25. Keten Edis E, Kurtgöz A. The role of spirituality for coping with cancer and the spiritual care needs of women with breast cancer and their family caregivers in turkey: A qualitative study. *J Relig Health*. 2024;63(2):1475-89. <https://doi.org/10.1007/s10943-023-01984-4>.
 26. Dydjow-Bendek D, Zagodzdon P. Breast cancer and spirituality among women in poland: A case-control study. *J Relig Health*. 2022;61(6):4288-301. <https://doi.org/10.1007/s10943-022-01584-8>.
 27. Anandarajah G, Hight E. Spirituality and medical practice: Using the hope questions as a practical tool for spiritual assessment. *Am Fam Physician*. 2001;63(1):81-9.
 28. Borneman T, Ferrell B, Puchalski CM. Evaluation of the fica tool for spiritual assessment. *J Pain Symptom Manage*. 2010;40(2):163-73. <https://doi.org/10.1016/j.jpainsymman.2009.12.019>.
 29. Puchalski C. Spiritual care in health care: Guideline, models, spiritual assessment and the use of the fica spiritual history tool. In: Büssing A, editor. *Spiritual needs in research and practice: The spiritual needs questionnaire as a global resource for health and social care*. Cham: Springer International Publishing; 2021. p. 27-45.
 30. Srinivasan A, Gottlieb P, Sleeth G, Mennillo M, Anandarajah G. An evaluation of the uses of the hope spiritual assessment tool: Preliminary project findings. *J Pain Symptom Manage*. 2024;67(5):e605. <https://doi.org/10.1016/j.jpainsymman.2024.02.025>.
 31. Schreiber JA, Brockopp DY. Twenty-five years later--what do we know about religion/spirituality and psychological well-being among breast cancer survivors? A systematic review. *J Cancer Surviv*. 2012;6(1):82-94. <https://doi.org/10.1007/s11764-011-0193-7>.
 32. Phenwan T, Peerawong T, Tulathamkij K. The meaning of spirituality and spiritual well-being among thai breast cancer patients: A qualitative study. *Indian J Palliat Care*. 2019;25(1):119-23. https://doi.org/10.4103/ijpc.Ijpc_101_18.
 33. Nasution LA, Afyanti Y, Kurniawati W. The effectiveness of spiritual intervention in overcoming anxiety and depression problems in gynecological cancer patients. *J keperawatan Indones*. 2021;24(2):99-109.
 34. Liu X, Peng W, Yang H, Tong F, Tang H, Jiang L. Exploration of clinical spiritual care in conventional cancer treatment. *Chin cancer*. 2016;25.
 35. Petersen CL. Spiritual care of the child with cancer at the end of life: A concept analysis. *J Adv Nurs*. 2014;70(6):1243-53. <https://doi.org/10.1111/jan.12257>.
 36. Helton G, Beight L, Morris SE, Wolfe J, Snaman JM. One size doesn't fit all in early pediatric oncology bereavement support. *J Pain Symptom Manage*. 2022;63(3):366-73. <https://doi.org/10.1016/j.jpainsymman.2021.10.016>.
 37. Farrington N, Richardson A, Bridges J. Interventions for older people having cancer treatment: A scoping review. *J Geriatr Oncol*. 2020;11(5):769-83. <https://doi.org/10.1016/j.jgo.2019.09.015>.
 38. Nasution LA, Afyanti Y, Kurniawati W. Effectiveness of spiritual intervention toward coping and spiritual well-being on patients with gynecological cancer. *Asia Pac J Oncol Nurs*. 2020;7(3):273-9. https://doi.org/10.4103/apjon.apjon_4_20.
 39. Azizi M, Elyasi F, Naghizadeh S, Mohammadi A, Kamali M, Shirzad M. Effect of psycho-socio-spiritual strategies on hope level of patients with cancer: A narrative review. *Iran J Psychiatry Behav Sci*. 2021;15(2):1–11. <http://10.0.22.180/ijpbs.107640>.
 40. Puchalski CM. The fica spiritual history tool #274. *J Palliat Med*. 2014;17(1):105-6. <https://doi.org/10.1089/jpm.2013.9458>.
 41. Lucette A, Brédart A, Vivat B, Young T. Pilot-testing the french version of a provisional european organisation for research and treatment of cancer (eortc) measure of spiritual well-being for people receiving palliative care for cancer. *Eur J Cancer Care (Engl)*. 2014;23(2):221-7. <https://doi.org/10.1111/ecc.12107>.
 42. Oner Cengiz H, Bayir B, Sayar S, Demirtas M. Effect of mindfulness-based therapy on spiritual well-being in breast cancer patients: A randomized controlled study. *Support Care Cancer*. 2023;31(7):438. <https://doi.org/10.1007/s00520-023-07904-2>.
 43. Whitehead IO, Jagger C, Hanratty B. Discussing spiritual health in primary care and the hope tool-a mixed methods survey of gp views. *PLoS One*. 2022;17(11):e0276281. <https://doi.org/10.1371/journal.pone.0276281>.
 44. Ahn SH, An YL, Yoo YS, Ando M, Yoon SJ. Effects of a short-term life review on spiritual well-being, depression, and anxiety in terminally ill cancer patients. *J Korean Acad Nurs*. 2012;42(1):28-35. <https://doi.org/10.4040/jkan.2012.42.1.28>.
 45. Effendy C, Uligraff DK, Sari SH, Angraini F, Chandra L. Experiences of family caregivers of children with cancer while receiving home-based pediatric palliative care in indonesia: A qualitative study. *BMC Palliat Care*. 2022;21(1):104. <https://doi.org/10.1186/s12904-022-00986-5>.
 46. Ellington L, Billitteri J, Reblin M, Clayton MF. Spiritual care communication in cancer patients. *Semin Oncol Nurs*. 2017;33(5):517-25. <https://doi.org/10.1016/j.soncn.2017.09.002>.
 47. Mansurifard f, ghaljaei f, navidian a. The effect of spiritual care on the spiritual health of adolescents with cancer: A pre-experimental study. *Med - surg nurs j [internet]*. 2020;8. Available from: <https://doi.org/10.5812/msnj.100567>.

48. Martinez-Calderon J, García-Muñoz C, Cano-García FJ, Heredia-Rizo AM. Psychological and spiritual interventions to enhance meaning in adults diagnosed with cancer: A systematic review with meta-analysis and meta-regression. *Support Care Cancer*. 2023;31(9):523. <https://doi.org/10.1007/s00520-023-07986-y>.
49. Gaston-Johansson F, Haisfield-Wolfe ME, Reddick B, Goldstein N, Lawal TA. The relationships among coping strategies, religious coping, and spirituality in african american women with breast cancer receiving chemotherapy. *Oncol Nurs Forum*. 2013;40(2):120-31. <https://doi.org/10.1188/13.Onf.120-131>.
50. Ahmadi A, Noormohammadi MR. The effect of spiritual interventions on the quality of life among patients with common cancers in southwest iran. *Biomed Pharmacol J*. 2017;10(1):231–6. .



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