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DETERMINING THE EXTENT OF RELATION BETWEEN SPIRITUALITY AND LIFE EXPECTANCY WITH CANCER PATIENTS

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ABSTRACT

World Health Organization (WHO) considers quality of life as basicaspectsof life criteria such as physical, mental, social and environmental health. Based on this comprehensive definition, quality of life is closely related to physical, mental, social and doctrinalstance of the individual and environment.

Health related quality of life (HRQoL) is a multidimensional concept underling four essential dimensions,physical, psychology, social and well-being functioning. Moreover, HRQoL concerns disease and treatment as well as mental nature of life quality from viewpoint of thepatient. Considering the nature of study subject, i.e. determining the extent of relation of spirituality and life expectancy with cancer patients, the research method is correlation. Statistical population of this study includes all patients with cancer who go to Imam Hussein, Imam Khomeini and Mofid hospitals in 2014. In this study, 200 cancer patients who go to these three hospitals have been studied through convenience sampling method as statistical sample.

Results from these research show that there are significant positive relation between the degree of tendency toward spirituality and social support with life quality and life expectancy in cancer patients. From other side, comparing these results with theoretical background results in consistency of these results with foreign and domestic studies which implies the validity of obtained result in this study.

Keywords: Life quality, spirituality, life expectancy

INTRODUCTION

Counselors and psychologists by one way or another pay attention to spiritual life of their clients and emphasize the spirituality in their treatments too. Throughout history, different psychology and anthropology schools have attempted to find some solutions and pay attention to human and its needs.

Diseases such as cancer have destructive effects on the patient, its family and people around them. Cancer gives rise to a drastic imbalance in the patient and its family and brings about a set of new challenges for both of them, at least this changes their normal everyday life, because they attempt to adjust to the disease and respond to the demands of this threat.

Social support refers to caring, affection, respect, condolence and helping which other people or groups grant to the cancer patient. This support has different sources: spouse, family, relatives, friends and colleagues, physicians, social organizations and so on. People who receive the social support, feel that someone like them and pay attention to them, people consider them as respectable, valuable and beloved and they know themselves as a part of family or social organization that can be the source of material and spiritual help and mutual services when it is needed. Regarding the manner in which spirituality influences on quality of life and patients' social support, a lot of theories are suggested. Cancer is a chronic disease which in spite of all of advancements in the field of diagnosis and treatment, it keeps to remind pain, limitation, incongruence and death. According to statistics of WHO cancer is known as a global disease. The manner of communication of these patients with spouse, children, parents, siblings and other social network members varies from what was in the past. These people are dependent to others from small to great extent and they can hardly support other people, therefore their individual interaction with others is limited and it may make them isolated in the society and for this reason, these people call for more social support. Thus, current paper attempts to examine the extent of relation of spirituality and life expectancy in cancer patients.

Quality of life

History of rise of concept of quality of life dates back to Aristotle era in 385 B.C. at that time, Aristotle has considered the good life or doing things propertyas happiness, Therefore, simultaneously the difference between concept of happiness among different people is taken into account and he has mentioned that the health resulting in happiness of an ill patient is not identical with the wealth making a poor man happy

and specifically he notes that not only the happiness has different meanings for different persons, but also for the same individual, this notion is not constant over time. However at that time happiness or living happilyis referred to what today is known as quality of life, but the term "quality of life" is used only in the twentieth century (Fayers, 2000).

Researchers have divided quality of life into three categories: firstly, those who pay attention only to the subjective aspect of life quality. They don't consider the objective aspect of quality of life or underestimate it. Second group, unlike first group, examine the life quality objectively, however, number of these people are less than first group. However, the third group which their belief is becoming more popular increasingly are those who have more comprehensive view with respect to this notion and are of opinion that the qualityof life should be addressed both objectively and subjectively (Qaffari et al, 2012).

The WHO has considered the quality of life by obvious aspects relating to life criteria such as physical, mental, social and environmental health. Based on this comprehensive definition, life quality is closely related to physical, mental, social and doctrinal state of the individual and environment (Hadidchi, 2009, Heshmatifar et al, 2013).

Health related quality of life (HRQoL) is a multidimensional concept underling four essential dimensions, physical, psychology, social and well-being functioning. Moreover, HRQoL concerns disease and treatment as well as mental nature of life quality from viewpoint of the patient (Halkoaho et al, 2010).

Life expectancy and its spiritual influence on cancer patients

By definitions one can note that expectancy encompasses people images and attention to the future and by consideration that it is likely to give rise to positive results, it triggers patient's effort. Any kind of conceptualization of expectancy reflects multidimensionality, dynamism, foresight (McClement et al, 2008). Expectancy is an important adjustment mechanism in chronic diseases such as cancer and it is defined as a complicated multidimensional and potentially powerful factor in recovery and effective adjustment (Herth, 2000). According to Berg & Benzain, expectancy helps the patient physiologically and emotionally to be able to tolerate the disease crisis (Benzein et al, 2005).

Research results of McClein et al show that spiritual health has a strong influence on end of life despair in cancer patient. Study of Allahbakhshian et al shows that spiritual

health has a bearing on M.S. patients. For cancer patient in the final stages of the disease, the spiritually and religious tranquility may even be more important than physical and psychological health. Similarly, in the study of Ripentrup et al, more than 90 percent of patients have belief on a higher existence, also, in the study of Sturbridge et al people who attended more than once in a weak in religious centers have 24 % death probability less than control group (Halkoaho, 2010).

RESEARCH METHODOLOGY

Considering the nature of research subject which is determining the extent of relation of spirituality and life expectancy with the cancer patients, the methodology of the study is correlation. Statistical population of the research includes all patients suffering fromcancer going to Imam Hussein, Imam Khomeini and Mofid Hospital in Tehran in 2014. In this study, 200 patents suffering from cancer going to these three hospitals have been studied through convenience sampling as the statistical sample. Following tools have been used for collecting required information in this paper:

Personal information questionnaire: This questionnaire includes information such as age, gender, inhabitance city, type of disease, disease duration, marriage duration, number of children and record number.

Family Social Support Questionnaire in Chronic Illnesses: this questionnaire is devised and normalized by Khodapanahi et al (2009). At devising this tool, some questionnaire such as Social Support Questionnaire (SSQ) by Sarason et al (1983), Berlin Social Support Scales (BSSS) by Schwartzer (2000) and Persipierten Familiaten Untersch (PFUK) have been used. This tool has 79 items. In factor analysis, four dimensions have been identified based on its components. These four aspects measure emotional support, informational support, instrumental support and seeking support and in sum, all of items measure generally the social support.

This questionnaire uses for each article the 4-level Likert scale (disagree strongly, disagree somewhat, agree somewhat, agree strongly). For quantifying the answers the levels are scored from one to four and the scores of each factor is calculated separately.

Adult's Hope Scale: This questionnaire has 12 articles and for each article 4 Likert level is used (disagree strongly, disagree somewhat, agree somewhat, agree strongly).

This questionnaire includes two dimensions, factor and passageway. The calculated validity through Cronbach's

Alpha for each dimension is: factor 0.82 and passageway 0.84. In Iran, validity and reliability of this questionnaire is calculated on a sample with 100 participants. The total internal similarity coefficient of the questionnaire based on Cronbach's Alpha was 0.76. Similarly, the internal similarity coefficient was obtained for passageway dimensions 0.71 and for factor force 0.68. For examining the validity of question the simultaneous-force approach is used. Simultaneous validity of expectancy questionnaire with Beck despair scale has been obtained 0.81 (Shirinzadeh, 2006).

World Health Quality of Life Brief (WHOQOL-BREF): this scale has 26 questions with 4 subscales. This questionnaire studies the quality of life in four arenas relating to health namely a) physical health, b) mental health c) social relation d) environment. First question addresses the quality of life in general and second question addresses the health state in general. 14 subsequent questions deal with the evaluating quality of life in four mentioned arenas. Reliability coefficient of this test in the physical health arena (in patient and non-patient group) is 0.80, in psychological arena is 0.76, in social relation arena 0.61 and in life environment arena is 0.77 (Yusefi, 2009).

This questionnaire is an abstract form of WHO quality of life which is a scale with 100 questions (WHOQOL-100) and is standardized in 1952, by Yusefi et al in cardiovascular center of Isfahan medical science university and has 26 questions.

Spirituality intelligence questionnaire: this questionnaire has 29 questions which is developed and normalized by Abdollahzadeh *et al*.

It has five-level Likert scale. The range of scores is 29 to 145. Reliability of the questionnaire is obtained 0.89 based on administrating on 200 participants by Cronbach's Alpha formula. The convergence validity of the questionnaire with Amram & Dryer spiritual intelligence questionnaire (2007) is verified 0.71 by administrating on 190 students of Bandar-e Gaz University (Abdollahzadeh et al, 2008).

The descriptive statistic using average, standard deviation, minimum and maximum is used for analyzing data and Pearson correlation coefficient and stepwise regression analysis are used for inferential section.

In this stage, demographic features of statistical sample are studied. Firstly, the general information of respondents is addressed and in the following the opinions of respondents regarding each one of question are taken into account. Firstly the gender of participants has been examined. As it can be seen from table 1-4, 110

participantsnamely, 55% are women and 90 participants i.e. 45% of respondents are men.

In the following, marital status of sample group is studied that its results are reported in table 4-2. As it can be observed from the table, respondents are in two places in terms of marital status. 151 respondents namely, 75.5 % are married and 64 respondents, 24.5 % are single.

In the following, duration of suffering from the disease is studied in the sample group which its results are reported in table 3-4. Based on findings of table (4-3) it can be seen that majority of sample group, 64 % are between 2-5 years and 36 percent are suffering from cancer over 5-8 years.

Frequency of duration of suffering from disease in sample group

In the following, age of sample group is statistically described which its results are reported in table 4-4. Thus, sample group is divided into four age groups.

Based on findings of table 4-4, it can be seen that most of the respondents, i.e. 44 % are in the age group between 39 to 48 and the least with 7.5 % in age group between 18 to 28.

In the following the education degree of sample group is studied. Sample group is divided into five groups.

Based on findings of table (4-5), it can be seen that 36 respondents which constitute 48.4 % of sample group have M.S. degree and 10 respondents which are 14.4 % of group have M.S. degree.

In the following the sample group is studied in terms of cancer type which its results is reported in table 4-6.

Based on findings of table 4-6, it can be seen that 64 respondents who form 34 percent of sample have breast cancer and 8 respondents or 4% have colon cancer.

In the following the scores obtained from study questionnaire has been statistically examined and described which its results are reported in table 4-7.

In table 4-7, it can be seen that the average of raw scores obtained from quality of life questioner is obtained 52 with standard deviation 4.95. Minimum score which is observed in quality of life is 26 and the maximum score is 78.

Average of raw scores obtained from social support questionnaire was 158 with standard deviation of 7.05. The minimum score of social support is 79 and the maximum score is 237.

In table 4-7, it can be observed that the average of raw scores obtained from life expectancy questionnaire is 27/60 with standard deviation of 5.89. The minimum score of life expectancy is 12 and the maximum score is 48.

As it can be realized from table 4-7, the raw scores average of spirituality questionnaire

is 197.5 with standard deviation of 4.51. The minimum score in spiritualityis 29 and the maximum is 116.

Table 4-1, frequency distribution of respondents in terms of gender

Gender	Frequency	Percentage
Male	90	45
Female	110	55
total	200	100

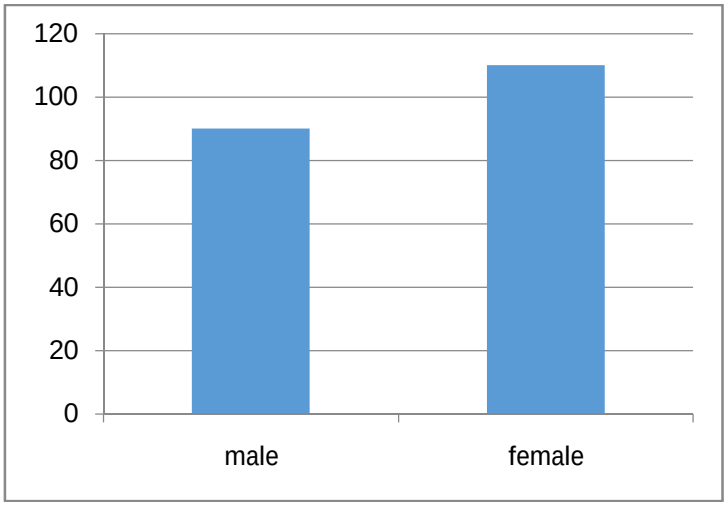

Figure 4-1: Sample group gender frequency

Table 4-2: Frequency distribution of sample group in terms of marital status

Marital status	Frequency	Percentage
Married	151	75.5
Single	64	24.5
Total	200	100

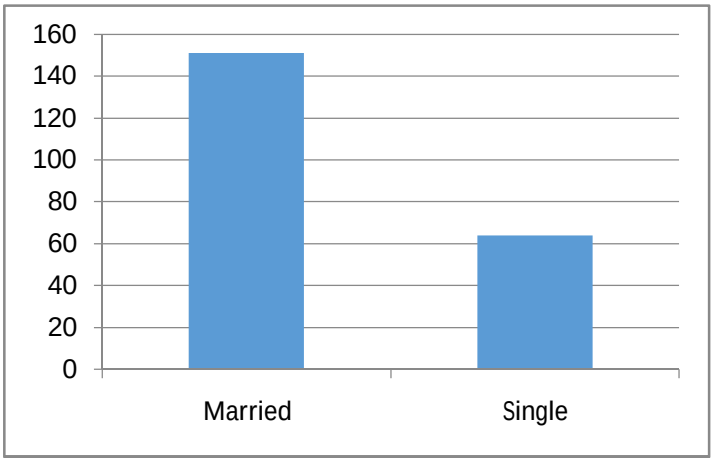

Figure 4-2, Frequency of marital status of sample group

Table 4-3, frequency distribution of respondents in terms of duration of suffering from the disease

Sufferance duration	Frequency	Percentage
2-5 years	128	64
5-8 years	72	36
Total	200	100

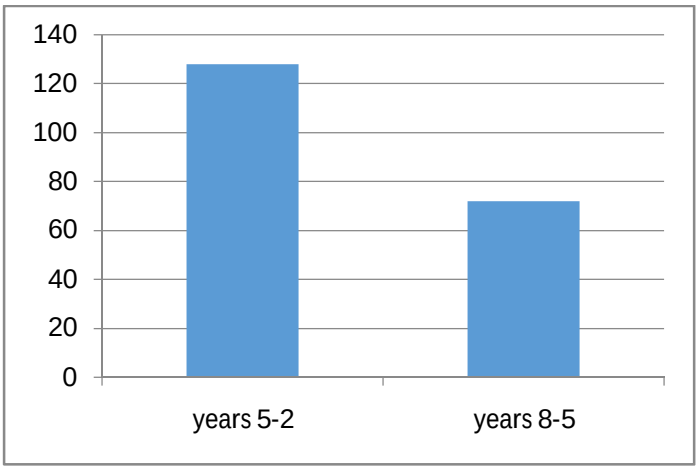

Table 4-4: Frequency distribution of respondents in terms of age

Age	Frequency	Percentage
18 to 28	15	7.5
29 to 38	71	35.5
39 to 48	88	44
older than 48	26	13
Total	200	100

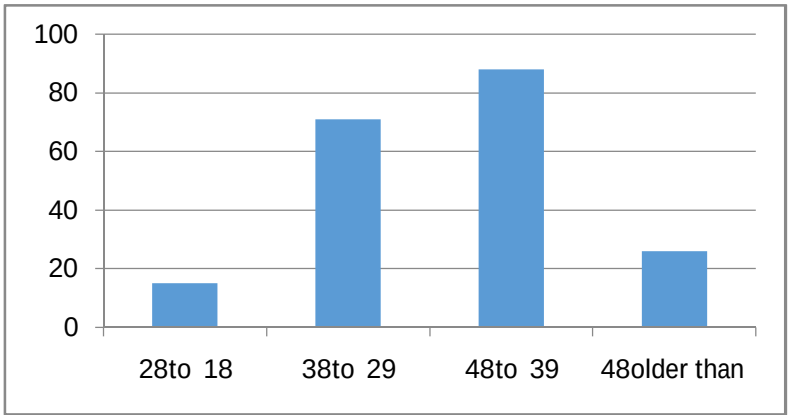

Figure 4.4: Respondents' frequency distribution in terms of age

Table 4-5: Education frequency of sample group

Education degree	Frequency	Percentage
Lower than diploma	38	19
Diploma	72	36
Associate degree	30	15
Bachelor	40	20
M.S.	20	10
Total	200	100

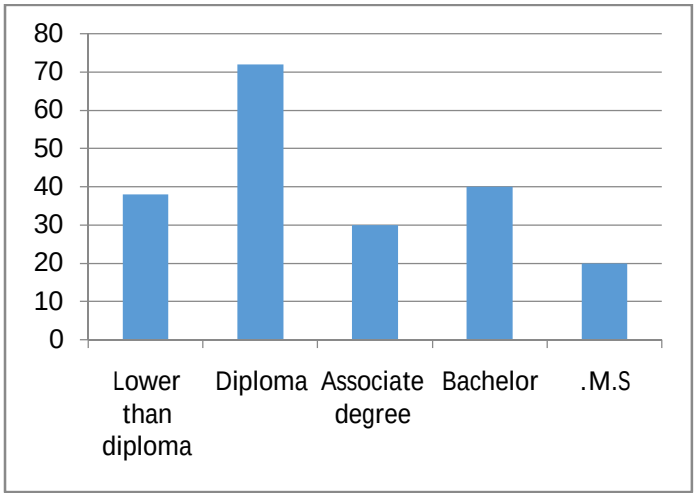

Figure 4-5. Frequency distribution of respondents in terms of education degree

Table 4-6. Respondents' frequency distribution in terms of cancer type

Cancer type	Frequency	Percentage
Breast cancer	68	34
Lung cancer	68	19
Stomach cancer	54	27
Blood cancer	32	16
Colon cancer	8	4
Total	200	100

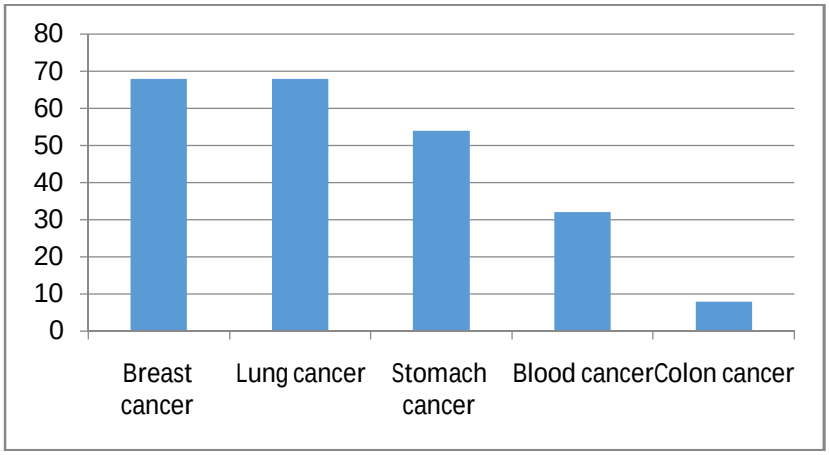

Figure 4-6. Respondents' frequency distribution in terms of cancer type

Table 4-7: scores distribution of spirituality variable

Indexes	Quality of Life	Social Support	Life expectancy	Spirituality
Average	52	158	27.60	197.5
Standard deviation	4.95	7.05	5.89	4.51
Minimum	26	79	12	29
Maximum	78	237	48	116
Group size	200	200	200	200

CONCLUSION

One of the criteria of measuring studies always is comparing with similar studied examples. As for comparing obtained results with other studies one should note that most of previous studies have results similar to Pahlavan & Avaula report. Sins & Camiki (2001) in their study have remarked that life threatening diseases such as cancer give rise to despair and aloneness

and change the life of patient and family. Perceived social support from family helps to get along with the disease. These researchers also have found the positive relation between despair and solitude and negative relation between solitude, despair and perceived social support from family.

In another research by Kedzi, Gimah, Ina and Izeh (2010), they found that the number of close friends, social support and extent of social involvement have direct and positive relation with self-evaluated health. Perceived social support has inverse relation with negative emotion and this mitigates the danger of depression-related cardiovascular disease and probably reduces the mortality risk. It has been assumed that a part of social support advantage is its potential ability for mediating the response to stress. Review of papers provides longitudinal and crossevidences for the important role of social support in mental health. Among different types of social support, emotional support plays an important role in recovery of functioning after stroke. Jackson, Weiss & Landquist (2003) have concluded that expectancy has direct relation with adaptive performance such as psychological adjustment, physical health and skill of problem solving. Taheri & Amiri in 2010 have concluded that there is inverse and significant relation between levels of depression, anxiety and stress with life quality of patients with breast cancer. Thud quality of life in patients with higher level of depression, anxiety and stress is significantly lower than that of patients with lower level of depression, anxiety and stress. However, this is the case not only regarding patients with particular diseases such as cancer but also so it is regarding other cases, thus, as the results of the study has shown, the relation between expectancy and life quality is mutual.

Results obtained from this study showed that there is a significant positive relation between tendency to spirituality and social support with quality of life and life expectancy in cancer patients, from other side, comparing these results with theoretical backgrounds results in consistency of results with foreign and domestic studies which suggest the validity of obtained results in this paper.

SUGGESTIONS

1. Administrating collecting counseling with families of patient with cancer regarding social support and tendency to spirituality.
2. Setting up meetings and training spirituality to patients and their families
3. Arranging meetings and the training social support from patients and their families

4. Planning and arranging seminars and conferences regarding the role of spirituality

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