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Comparing the Effectiveness of Spiritual Therapy and Religious Coping Strategies Training on Anxiety and Depression in Women with Breast Cancer

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ABSTRACT

Introduction:
Cancer disease and issues related to its treatment have been introduced as the most important stressors in breast cancer patients, which can cause psychological disorders in these patients. The purpose of this research was to compare the effectiveness of spiritual therapy and teaching religious coping strategies to reduce symptoms of anxiety and depression in women with breast cancer.

Materials and Methods:
The current research was semi-experimental based on pre-test-post-test and follow-up (3 months later) design with control group. The statistical population comprised women diagnosed with breast cancer who attended Khatam Al-Anbia Cancer Hospital in Tehran from July to October 2023. A total of 45 patients were selected from this population using purposive sampling. The participants in the spiritual therapy experimental group participated in eight sessions of one 60-minute session per week, and the participants in the religious confrontation training group participated in ten sessions of one 60-90-minute session per week. Research tools included Beck Depression Inventory (BDI-II) and Zang Anxiety Inventory (SAS). The obtained data were statistically analyzed using covariance analysis with repeated measurements in SPSS version 27 software.

Results:
The results of this study indicated that there was no significant difference in depression scores between the spiritual therapy and religious coping groups ($p = 1.000$). However, both the spiritual therapy and religious coping groups showed significant improvements in depression compared to the control group ($p < 0.01$). Additionally, there was a significant difference in anxiety scores between the religious coping and spiritual therapy groups during the follow-up phase, as well as between these groups and the control group at follow-up ($p < 0.001$). Conversely, no significant difference was observed in anxiety levels between the spiritual therapy and religious coping groups ($p > 0.05$).

Conclusion:
The results of this study indicated the effectiveness of spiritual therapy and religious coping strategies in reducing anxiety and depression symptoms in women with breast cancer. By improving effective coping mechanisms in people, spirituality-based interventions can help patients to face and deal with anxiety and depression caused by the disease and its consequences in a positive and effective way.

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Introduction

Globally, breast cancer is the second leading cause of cancer death, affecting roughly 1.67 million people (1). In Iran, the annual incidence rate is 20 new cases per 100,000 women, with the average age of diagnosis being more than a decade younger than in developed countries (2). Breast cancer and its associated physical changes and side effects frequently induce chronic psychological stress in patients, which can lead to a higher prevalence of mental health disorders such as depression and anxiety compared to the general population (3).

Depression in women with breast cancer is frequently exacerbated by factors such as the disease onset, pain, fatigue, altered appearance, impaired intimacy, insufficient support, fear, and the challenges of adapting to new life circumstances (4). Studies indicate that depression is 2 to 3 times more prevalent in cancer patients than in the general population (5). Research highlights the significant impact of depression and anxiety on breast cancer recurrence and survival (3). A diagnosis of breast cancer is a highly stressful and distressing event that often triggers feelings of anger and anxiety. As a result, the rates of depression, stress, and anxiety are elevated among cancer patients, with anxiety being particularly prominent and widely observed (6,7).

Studies confirm that depressive disorders, anxiety, and perceived stress are common psychiatric conditions among breast cancer patients (8). Pain is also a frequent symptom, and pain-related anxiety encompasses the cognitive, psychological, and behavioral responses to pain or pain-related stimuli (9).

Given the interconnectedness of physical and mental health, interventions to alleviate anxiety and depression in cancer patients are crucial (10). Patients frequently use religion to find meaning in their illness and manage stress, highlighting religion's influence on coping mechanisms. Spirituality, central to religion, also offers support during challenging times like illness. Further research is needed to understand how both religion and spirituality can improve patients' symptoms (11). Religious coping, in particular, is a fundamental factor in cancer patients' adaptation and effective coping (12). Religious coping, the utilization of religious resources like prayer and faith in God to manage life's challenges (13), is categorized as either positive or negative. Positive religious coping involves a secure relationship with God, a sense of meaning, and spiritual connection with others, whereas negative religious coping reflects a less secure relationship with God and a pessimistic worldview (14). Research indicates that both adaptive and maladaptive religious coping strategies can significantly influence the experience of cancer symptoms and overall coping effectiveness (12). Furthermore, studies suggest a strong link between religious and spiritual factors and the experiences of cancer patients. Specifically, aspects such as positive and negative religious coping, spiritual intelligence, and spiritual well-being have been found to correlate with perceived stress levels and patients' attitudes toward their cancer diagnosis (15).

Negative religious coping may hinder adjustment in the first year after breast cancer diagnosis (16), while strengthening religious coping skills in routine care can improve cancer patients' quality of life (17). Positive religious coping strategies appear to promote post-traumatic growth (18). Given the prevalence of depression, anxiety, and stress and their impact on performance, spiritual interventions may offer a more effective approach than non-spiritual treatments in reducing depression (19).

Spiritual therapy integrates clients' cultural-religious beliefs and their transcendent connection to the divine into the therapeutic process (20). It's a psychotherapy that employs spiritual-religious principles to facilitate a transmaterial understanding of self, the world, and events, promoting well-being through connection with this realm (21). For example, research indicates that spiritual therapy can significantly reduce the fear of disease recurrence in women with breast cancer (7). Several studies suggest that spiritual therapy offers notable benefits for breast cancer patients. For instance, research by Fardi et al. (2023) (22), Sajjadian et al. (2021) (24), and Jamshidifar et al. (2020) (25) demonstrate its effectiveness in improving quality of life, reducing existential anxiety and stress, and promoting psychological adaptation. Additionally,

spiritual therapy may help decrease fear of recurrence and improve patients' perception of their illness, with these positive effects lasting over time (26). Breast cancer is the most common malignancy among Iranian women, presenting significant physical and psychological challenges. Addressing depression and anxiety in these women is crucial. While research exists, no prior study has simultaneously investigated the effects of spiritual therapy and coping strategies. This study aims to fill this gap by comparing the effectiveness of spiritual therapy and religious coping strategies training in reducing anxiety and depression symptoms in women with breast cancer. Thus, this research explores whether these interventions can alleviate these psychological symptoms.

Materials and Methods

This study was a quasi-experimental study based on a pre-test-post-test design and follow-up (three months later) with a control group. Between July and October 2023, 45 breast cancer patients were selected via purposive sampling from women with medical records referred to Khatam Al-Anbia Specialized Cancer Hospital in Tehran. Sample size adequacy was determined using G*Power software, considering α= 0.05 and effect size= 0.55 power test= 0.90. Based on the covariance method, the researcher calculated 45 people for the sample size.

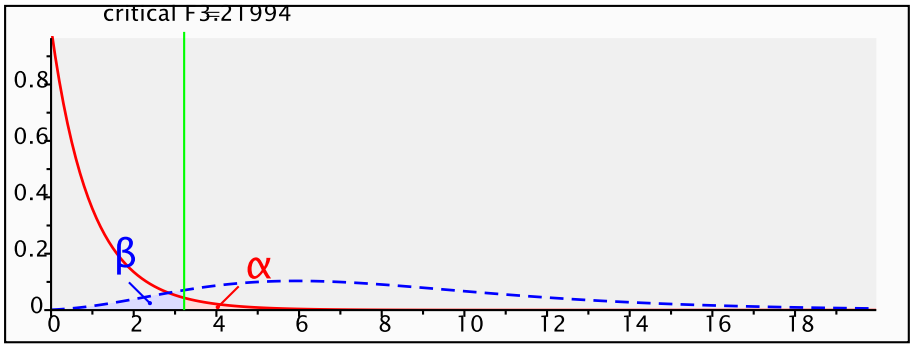

Figure 1. Sample size calculation with G*Power software

Inclusion criteria: high school diploma or higher, married, age over 20, hospital medical record, and no prior training in spiritual therapy or religious coping. Exclusion criteria: missing more than two sessions, being late for four sessions, use of antidepressants or anxiety medications, concurrent participation in similar interventions, and withdrawal from the sessions. Following ethical approvals and permission from the university education department, researchers visited Khatam Al-Anbia Specialized Cancer Hospital in Tehran, explained the study's significance to officials, and secured permission to proceed. Participants were then purposefully selected from patients meeting the inclusion criteria and possessing medical records at the hospital. Participants completed a pre-test and were then randomly assigned to one of three groups (n = 15 per group): spiritual therapy, religious coping training, or control. Randomization was achieved using a random number table (Figure 2).

The first experimental group participated in eight weekly sessions of spiritual therapy, each lasting 60 minutes (27). The session content was adapted from existing research on the impact of spiritual therapy on the quality of life in women with breast cancer. While previous studies typically used twelve sessions, this study focused on delivering the core content within eight sessions. The second experimental group conducted ten weekly sessions, each lasting between 60 and 90 minutes, centered on religious coping training (28).

The intervention, based on research into

Islamic teachings on happiness and life satisfaction for parents of children with learning disabilities, involved 10 and 8-session group training programs focused on coping strategies. A control group remained on a waiting list.

A hospital clinical psychologist conducted the weekly sessions in a hospital setting. Session topics and content are summarized in Tables 1 and 2.

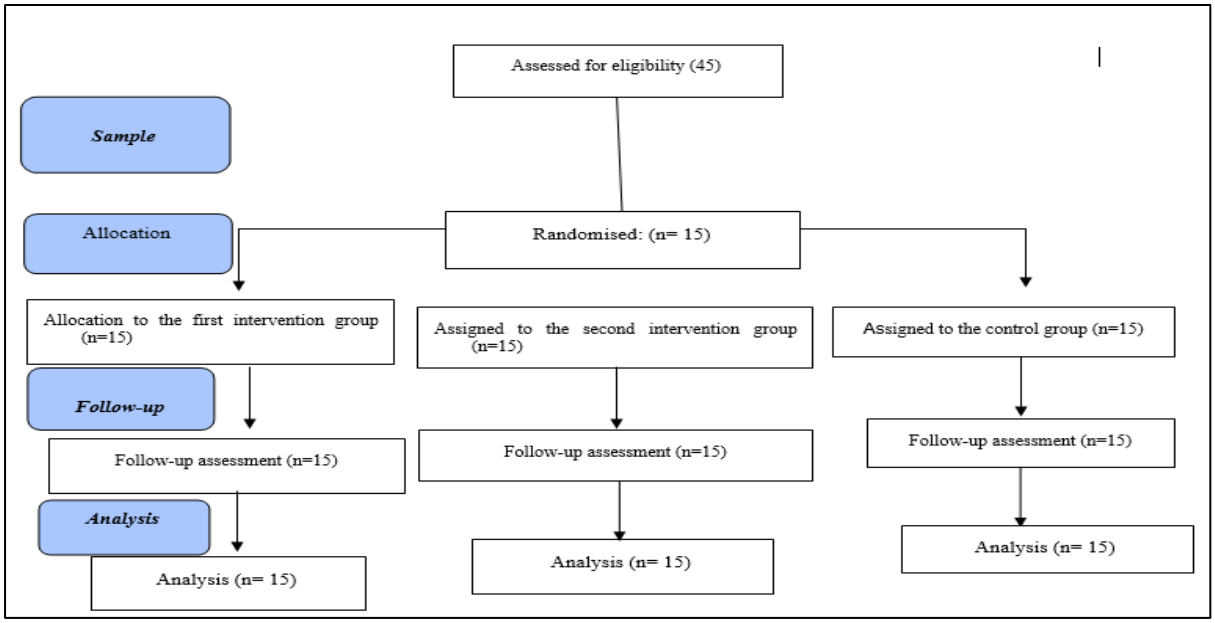

Figure 1: The figures show the CONSORT flow diagram.

Beck Depression Inventory - Second Edition (BDI-II): The Beck Depression Inventory (BDI) (Beck, 1996) is a widely used 21-item questionnaire designed to assess the severity of depression and depressive symptoms in individuals (29). Each item is scored on a scale from 0 to 3, resulting in a total score that can range from 0 to 63. Based on the total score, depression severity is categorized as follows: minimal (0-13), mild (14-19), moderate (20-28), or severe (29-63). Beck et al. reported that the BDI has a concurrent validity coefficient of 0.79 and a test-retest validity coefficient of 0.67. An earlier study conducted in Iran reported a high internal consistency with a Cronbach's alpha of 0.92 (30), while the current study found a Cronbach's alpha of 0.81, indicating good reliability for the questionnaire in this sample. Zang Anxiety Questionnaire (SAS): Zang's 1971 questionnaire measures anxiety using 20 items, each scored from 1 (never) to 4 (almost always), yielding a total score range of 20-80 (31). Zang reported a reliability of 0.84 for the instrument. Studies in Iran reported a Cronbach's alpha of 0.87 (32), while the present study found a Cronbach's alpha of 0.85.

Table 1. Summary of Spirituality Therapy Sessions

Session 1: Introduction to treatment and spiritual therapy, including confidentiality limits, informed consent, introductions, and a discussion of spirituality and religion's impact on the individual.
Session 2: Focused on self-awareness and communication, listening to the inner voice, and strengthening self-concept through faith-based practices (e.g., prayer and connection with a higher power).
Session 3: Explored communication with the divine, including exercises and a review of the previous session.
Session 4: Reviewed coping skills, established the session agenda, and focused on identifying and recording spontaneous thoughts; homework assigned.
Session 5: Addressed altruism in a group setting, resentment, unforgiveness, guilt, and self-forgiveness, including exercises and session review. Examined the concepts of death, fear of death, and suffering, including exercises and session review.
Session 6: Explored the concepts of faith and trust in God, including exercises and session review.
Session 7: Focused on gratitude and appreciation techniques, including exercises and session review.
Session 8: The final session reviewed prior sessions, summarized key content, and administered a post-test.

Table 2. Summary of Religious Coping Strategies Training Sessions

First Session: The content of this session included introducing and presenting the general plan of education, preparing patients to participate in the sessions, explaining the concept of religious encounter and its effects, focusing on religious rituals, reading the Quran and praying to promote purification and helping patients to build, maintain and change their perceptual orientation, and teaching them to seek help from God in difficulties and illnesses, to be patient in the face of calamities, and to provide homework.
Second session: The content of this session included presenting content on the subject of testing the divine nature of unpleasant events and illnesses, religious help and active religious surrender, as well as reviewing the previous session and reviewing assignments, teaching spiritual peace, imagining a supporting God, praying and spiritual communication with God, hoping in a supporting God, reviewing one's attitude towards God and religious surrender, and presenting homework.
Third session: The content of this session included expressing gratitude for God's blessings, reevaluating religious benevolence, reviewing the previous session and reviewing assignments, teaching based on the occurrence of events and their relationship with benevolence, wisdom, prudence, patience, and God's strengthening of man, and presenting homework.
Fourth Session: The content of this session included teaching the belief in the effectiveness of reading the Quran and supplications during illness, spiritual connection and religious orientation, and reviewing and reviewing homework from the previous session, examining the effects of connecting with a higher power, feeling spiritual, examples of practical behaviors based on life memories, and presenting homework at home.
Fifth Session: The content of this session included teaching about considering God's pleasure when making difficult decisions, support from fellow believers, religious focus, and reviewing homework assignments from the previous session, spiritual support from others, caring for like-minded people, requesting prayers from fellow believers, and receiving spiritual support from religious people, performing spiritual activities, focusing and thinking about God, loyalty, mystery, and need, thinking about forgiveness as a driver of faith, worshipping in the mosque, and submitting homework at home.
Sixth Session: The content of this session included teaching the life of the Imams in times of hardship and illness, reviewing and reviewing homework from the previous session, examining the belief in God as a punisher, the lack of evidence for God's punishments, committing sins and punishments from God, disbelief in God and God's punishment of oneself and one's family, examples of practical behavior based on life experiences, and presenting homework.
Seventh Session: The content of this session included teaching about avoiding sin in the face of problems and illnesses, reviewing and reviewing homework assignments from the previous session, examining belief in the existence of Satan, Satan's responsibility for life events, life events and belief in Satan, examining examples of practical behavior based on life memories, and presenting homework.
Eighth Session: The content of this session included teaching the benefits of visiting the shrines of the Infallibles to reduce mental and physical stress, reviewing and reviewing homework from the previous session, examining the belief that prayers are not answered, not being dissatisfied with God, being forgotten by God, not being protected by God, believing in God's inability, examples of practical behaviors based on life memories, and presenting homework.
Session 9: The content of this session included teaching how to turn to the Infallibles in times of hardship, reviewing and reviewing the homework assignments from the previous session, examining beliefs about not trying and surrendering oneself to God, waiting on God without trying, the existence of negative life events and surrendering to God to solve problems, examples of practical behaviors based on life memories, and presenting homework.
Tenth Session: The content of this session included teaching how to help those in need to seek God's support, reviewing and reviewing homework assignments from the previous session, examining beliefs of dissatisfaction with like-minded people, seeking release from like-minded people during negative events, examining examples of practical behaviors based on life memories, and reviewing and concluding all sessions and administering a post-test.

Data analysis

The data in this study were analyzed using Kruskal-Wallis tests and repeated measures analysis of covariance (ANCOVA) conducted with SPSS (version 27) and JASP (version 0.18.1.0), with a significance level set at 0.05. To ensure the appropriateness of these tests, the normality of the data distribution was assessed using the Kolmogorov-Smirnov test, which indicated that the research variables were normally distributed, as the test was not significant ($P > 0.05$). Outlier scores were also examined using Z scores, and no significant outliers were detected. Homogeneity of variances across groups was verified with Levene's test, which confirmed equal variances ($P > 0.05$). Additionally, the assumption of homogeneity of covariance matrices was tested with Box's M test, yielding a significance level higher than 0.001, thus confirming this assumption. For the sphericity assumption required in repeated measures analysis, Mauchly's sphericity test was conducted, and it was significant ($P < 0.001$). Consequently, the Greenhouse-Geisser correction was applied during

interpretation to adjust for violations of sphericity.

Results

In this study, information about the participants was collected in three stages: pre-test, post-test, and follow-up in the spirituality therapy, religious coping training, and control groups. The researcher first examined and described the research variables. The participants were divided into three groups based on average age: 20-30 years, 31-40 years, and 41 years and older. The participants were divided into four groups based on education: diploma and bachelor's degree, and master's degree and doctorate. The results of the Kruskal-Wallis test also showed that there was no significant difference between the participants in terms of demographic variables (P >0.05), and as a result, the groups were homogeneous.

Table 3. Demographic characteristics in the experimental and control groups

Variables	Groups	Spirituality therapy group	%	Religious coping group	%	Control	%
Age	20 to 30 years	2	28.6%	2	28.6%	3	42.9%
	31 to 41 years	6	37.5%	5	31.3%	5	31.3%
	41 and above	7	31.8%	8	36.4%	7	31.8%
Education	Diploma	1	33.3%	0	0.0%	1	66.7%
	Bachelor's degree	7	35.0%	8	40.0%	5	25.0%
	Master's degree	6	31.6%	6	31.6%	7	36.8%
	PhD	1	33.3%	1	33.3%	1	33.3%

Table 4. Descriptive indices of research variables

variable		Spirituality therapy group		Religious coping group		Control	
		M	SD	M	SD	M	SD
Depression	Pretest	54.46	4.85	53.06	6.06	52.26	3.84
	Posttest	51.80	4.85	50.66	5.85	53.93	4.63
	Follow-up	48.80	4.76	47.46	5.66	51.46	4.89
Anxiety	Therapeutic spirituality	69.46	5.76	71.0	5.22	68.66	5.19
	Religious coping	66.66	5.02	68.60	4.64	69.46	5.76
	Control	64.06	5.23	66.20	4.52	70.73	5.0

Based on the results of this study, Table 4 showed that in the spirituality therapy and religious coping groups and the control group at the pre-test, the average anxiety and depression scores of the participants did not differ significantly. In contrast, there was a difference in the average anxiety and depression scores in the two post-test and follow-up assessment stages in the spirituality therapy and religious coping groups and the control group. The average scores of individuals in the anxiety variable in the spirituality therapy and religious coping groups at the post-test and follow-up stages were lower than the average of the control group among the participants, and this value has decreased. Similarly, the average scores of individuals in the depression variable in the spirituality therapy and religious coping groups at the post-test and follow-up stages were lower than the average of the control group among the participants, and this value has decreased.

Table 5. Analysis of Covariance Test

variable	Source	SS	MS	F	Significance	Effect size
Depression	Time	0.108	0.108	0.011	0.917	2.699×10^{-4}
	Time∗ Pre-test	0.836	0.836	0.086	0.771	0.002
	Time∗ Group	1.874	0.937	0.096	0.908	0.005
	Group	336.768	168.384	10.882	< .001	0.347
Anxiety	Time	136.723	136.723	11.470	0.002	0.219
	Time∗ Pre-test	127.323	127.323	10.681	0.002	0.207
	Time∗ Group	99.053	49.526	4.155	0.023	0.169
	Group	431.350	215.675	10.668	< .001	0.342

Similarly, based on the results of the analysis of covariance test in Table 5, the within-group significance value was significant for both variables ($p < 0.001$), and as a result, by keeping the effects of the pre-test stage constant, a significant difference was observed in the research groups. At the same time, the significance level for the anxiety variable in the interactive effects between time and groups was significant ($p = 0.023$).

Table 6. Bonferroni test for depression variable

variable	Time	(I) Group	(J) Group	Difference in Means	Standard Error	Significance Level
Depression	post-test	Spirituality therapy group	Religious coping group	0.056	1.269	1.000
			Control	-3.826*	1.282	0.014
		Religious coping group	Control	-3.882*	1.263	0.011
	follow-up	Spirituality therapy group	Religious coping group	0.312	1.340	1.000
			Control	-4.271*	1.353	0.009
		Religious coping group	Control	-4.584*	1.334	.0040

Based on Table 6, it can be shown that there was no significant difference between the scores of the depression variable between the spiritual therapy and religious coping groups ($p=1.000$). Accordingly, it can be concluded that the two spiritual therapy and religious coping groups did not have a significant difference in the participants' depression ($p>0.05$).

However, it can be observed that there was a significant difference between the spiritual therapy and religious coping groups and the control group in the depression variable ($p<0.01$).

Accordingly, it can be concluded that there is a difference in the scores of individuals in depression between the experimental and control groups.

Table 7. Pairwise comparison of time-group interactive effects on anxiety variable

(I) Group	(J) Group	Difference in Means	Standard Error	t	Significance Level
Spirituality Therapy Group - Post-Test	Religious coping group - post-test	-1.466	1.474	-0.994	1.000
	Control - post-test	-3.044	1.467	-2.076	0.619
	Spirituality therapy group - follow-up	2.489	1.261	1.973	0.829
	Religious coping group - follow-up	1.522	1.472	1.034	1.000
	Control - follow-up	-4.787	1.468	-3.260	0.025
Religious Coping Group - Post-Test	Control - post-test	-1.578	1.488	-1.061	1.000
	Spirituality therapy group - follow-up	3.954	1.472	2.686	0.133
	Religious coping group - follow-up	2.988	1.273	2.346	0.358
	Control - follow-up	-3.321	1.479	-2.245	0.414
Control - Post-Test	Spirituality therapy group - follow-up	5.533	1.468	3.768	0.005
	Religious coping group - follow-up	4.566	1.479	3.087	0.042
	Control - follow-up	-1.743	1.269	-1.373	1.000
Spiritual Therapy Group - Follow-Up	Religious coping group - follow-up	-0.967	1.474	-0.656	1.000
	Control - follow-up	-7.275	1.467	-4.961	< .001
Religious Coping Group - Follow-Up	Control - follow-up	-6.309	1.488	-4.240	< .001

Based on the data presented in Table 7, it can be observed that there were significant differences in anxiety scores between the experimental groups and the control group at various follow-up stages. Specifically, the anxiety scores in the religious coping group at the follow-up stage were significantly lower compared to the control group at the same stage ($p < 0.001$). Additionally, the anxiety scores in the religious coping group at follow-up differed significantly from those in the control group at the post-test stage ($p = 0.042$). Similarly, the spirituality therapy group showed significant reductions in anxiety scores at follow-up compared to the control group at the same stage ($p < 0.001$), and there was a significant difference between the spirituality therapy

group at follow-up and the control group at the post-test stage ($p = 0.005$). These findings suggest that the interventions implemented in this study primarily impacted anxiety levels during the follow-up period, indicating a decrease in anxiety in participants during the three months following the interventions. Furthermore, the results show that there was no significant difference in anxiety levels between the spirituality therapy and religious coping groups ($p > 0.05$), implying similar effectiveness of both interventions in reducing anxiety. Discussion This study compared the effectiveness of spirituality therapy and religious coping training in reducing anxiety and depression among women with breast cancer. The results indicated that both interventions were effective in alleviating these psychological symptoms. Importantly, there was no significant difference in the efficacy of the two approaches, suggesting that both can be valuable strategies for supporting mental health in this population. This study's finding that spirituality therapy reduces anxiety and depression aligns with research by Ahmadi et al. (34), Fardi et al. (22), Moein et al. (23), and Sajjadian et al. (24). Similarly, Barki et al. (2021) found spirituality therapy effective in reducing anxiety in elderly women, suggesting its potential for promoting mental health in this population (23). Furthermore, Waziri et al. (2020) demonstrated that spiritual intervention improves biological, psychological, and social well-being in breast cancer patients (35). Religion offers mental and cognitive strategies for achieving inner peace, including fostering knowledge, faith, patience, prayer, and a connection to the divine, enabling individuals to reframe negative experiences. This spiritual connection strengthens resilience and promotes psychological well-being. Spiritual therapy utilizes existential capacities, divine motivation, and moral virtues to improve health. Consequently, spirituality-based interventions enhance positive affect and self-esteem while diminishing negative affect, leading to reduced anxiety, depression, and psychological distress (20). Spirituality therapy has been shown to enhance the mental health of breast cancer patients by reducing stress, depression, anxiety, and fear of recurrence or death. At the same time, it can increase self-compassion and hope through fostering a connection with a higher power (25). Our findings that religious coping strategies help decrease anxiety and depression are consistent with previous research by Moharrar et al. (36), Hajizad et al. (37), Sharifi et al. (38), and Haj Babaei et al. (39), which also support the beneficial role of religious coping in improving psychological well-being among cancer patients.

Furthermore, research indicates that religious coping, spiritual intelligence, and spiritual well-being influence perceived stress and attitude toward cancer (15). Pour Mohseni et al. (2020) also suggest that both adaptive and maladaptive religious coping strategies affect cancer symptoms and coping effectiveness (12).The study's findings suggest that incorporating coping skills and strengthening religious coping mechanisms in routine care can enhance the quality of life for cancer patients (27). This improvement likely stems from religion's ability to help individuals adapt to stress by providing a framework for understanding negative events and fostering hope. Religious commitment buffers against stress and mitigates the adverse health effects of caregiving stress (14). Ultimately, religious coping strategies facilitate long-term adaptation to cancer by bolstering self-esteem, instilling purpose, cultivating hope, and alleviating anxiety (12).

Strengthening spirituality may enhance motivation and hope, leading to a greater emphasis on health. This study suggests that spiritual therapy and religious coping effectively reduce anxiety and depression in women with breast cancer. Spirituality-based interventions can improve coping mechanisms, helping patients manage the psychological distress associated with the disease and its consequences. Given the prevalence of anxiety and depression in cancer patients, developing programs to alleviate these issues is recommended. Future research should compare the effectiveness of different treatment methods and employ single-subject designs for in-depth analysis.

Research Limitations

Like all research, this study has certain limitations. Primarily, the sample consisted exclusively of women with breast cancer treated at Khatam Al-Anbia Specialized Cancer Hospital in Tehran, which restricts the ability to generalize the findings to broader populations, including men and patients from different regions. Future studies should aim to include larger and more diverse samples to enhance generalizability.

Additionally, completing the questionnaires was challenging for some participants due to their physical conditions related to cancer, though efforts were made to mitigate this by providing sufficient time and accommodating individual needs. Other limitations involved participant relocation, changes in willingness to participate, and reluctance to fully disclose thoughts and feelings, all of which may have influenced the results. Future research should consider larger sample sizes to better address these issues.

Moreover, because mental health is influenced by numerous factors, this study was unable to examine all relevant variables. Future investigations should explore other influential elements such as socioeconomic status, personal fulfillment, income, education, social interactions, life events, personality traits, and overall health to achieve a more comprehensive understanding of the factors affecting mental well-being.

Conclusion

Given the demonstrated efficacy of treatment methods, spiritual therapy intervention, and religious coping strategies training in reducing anxiety and depression symptoms in women with breast cancer, further research should examine the long-term effects of these treatments.

The training on Spiritual Therapy and Religious Coping Strategies demonstrates promising potential as a complementary approach to manage anxiety and depression in women with breast cancer. By integrating spiritual and religious practices into conventional cancer care, patients may benefit from improved emotional well-being, increased resilience, and a deeper sense of peace. These approaches can provide vital psychological and spiritual support, helping women cope more effectively throughout their treatment journey.

However, to maximize their potential, further rigorous research is needed to develop standardized protocols, assess long-term outcomes, and tailor interventions to individual needs. Overall, incorporating spiritual and religious strategies can serve as a valuable component of holistic cancer care, fostering comprehensive support for patients both psychologically and spiritually.

Ethical considerations

Following ethical approval (IR. ACECR. ROYAN.REC.1401.154), the study was implemented. To ensure research ethics, the control group received an intensive session. After participant selection, the researcher explained the research objectives and ethical principles during an initial in-person interview, answering questions about intervention implementation and screening participants. Simultaneously, participants received necessary information regarding the intervention sessions in person and provided written informed consent.

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Author Contributions

First author: Writing the introduction and necessary coordination for implementing the intervention, second author: Implementing the questionnaires in two testing stages and writing the research method and instruments, Research stages: Third and fourth authors: Analyzing and editing the writing stages, Responsible author: Writing the discussion and implementing the research plan and supervising all stages of the research.

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