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Psychological Well-Being of Elderly Women Who Early Survive Breast Cancer and its Associated Factors

Raefa Refaat Alam¹, Aziza Mahmoud Boughdady², Abdel-Hady El-Gilany³

^{1,2} Lecturer of Gerontological Nursing, Faculty of nursing, Mansoura University, Egypt

³ Professor of Public Health, Faculty of Medicine, Mansoura University, Egypt

E-Mail: dr.raefa.2015@gmail.com,

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Abstract: Background: Diagnosis and treatment of breast cancer (BC) adversely affect the psychological well-being (PWB) of elderly patients. **Aim of the study:** This study aims to describe the PWB of elderly women- survivors of (BC) and its associated factors. **Subjects:** A convenient sample of 163 old women undertaken treatment of BC was enclosed within the study. **Setting:** This study was carried out at Mansoura University hospital (oncology center) in the outpatient clinics. **Tools:** Data collected included: Socio demographic and clinical data structured interview schedule. Psychological well-being was measured by the Arabic version of Ryff's Psychological Well-Being (RPWB) Scale. Religious activities were measured by the brief Arab religious coping Scale (BARCS). **Results:** Older women with breast cancer showed highly low mean scores (ranging from 21.7 to 25.6) within the six subscales of PWB. The mean scores of environmental mastery, personal growth, positive relations and purpose in life vary significantly consistent with age groups of the participants, educational level. The mean scores of autonomy, positive relations and self-acceptance showed vital variation consistent with variety of work before retirement. The mean scores of autonomy, environmental mastery, personal growth, life purpose, and self-acceptance vary consistent with income level. On the other hand the mean scores of personal growth, positive relations, and self-acceptance subscales vary significantly consistent with presence or absence of co-morbidities. Religious-coping-activities have vital inverse, weak correlation with autonomy and vital positive, moderate correlations with environmental mastery, positive relations, and self-acceptance. **Conclusion:** This study concluded that the women with breast cancer have low PWB scores. Several factors are related to variation in PWB. Religious coping improves PWB of elderly women extant breast cancer in post-treatment phase. There is a space for improvement. **Recommendations:** Special attention should be paid to elderly women with impaired PWB during follow-up visits.

Key words: breast cancer – Psychological well-being – religiousness.

INTRODUCTION

Breast cancer is taking into consideration the foremost common cancer among women of developed and developing countries likewise as Egypt. It's additionally a basic clarification for cancer mortality in females^{1,2}. Breast cancer is every sex and age-related health problem. Aging together influences treatment and prognosis^{3,4}. Increasing lifespan among older Egyptians with breast cancer is expected to rise within the future². Older breast cancer have multiple number of disease⁵. Also, tumor size and nodal involvement increase with age as a result of delayed identification and aggressiveness^{6,2}.

One vital component of recent attention management is psychological well-being (PWB) of patients. PWB could be a basic conception in chronic diseases that ads which means and purpose to one's life, and is taken under a vital consider the promotion of public health and quality of life⁷. Not like the normal approaches, it provides a broad platform to identify the health of people living with chronic diseases, like breast cancer⁸.

PWB suggests that a long method of purposeful engagement in goal-based tasks or activities resulting in positive psychological status. These tasks replicate autonomy, life purpose, self-acceptance, personal growth, positive relations with others, and environmental mastery. Whereas a lot of women are surviving breast cancer, they face a large

number these days and long run physic-psychosocial challenges that result from being diagnosed and treated. Protecting health- effects associated with the experience of PWB will probably merge ill-being and benefit overall health of breast cancer survivors (BCS). Adequate preparation by health care teams to transmit them from primary treatment to early survivorship is crucial for the immediate and long-run PWB of BCS.^{9,8} It had been according that PWB can increase resilience (the capability to keep up or regain well-being) within the face of adversity¹⁰.

Research indicated that religiousness and spirituality appear to possess a positive impact on the health and well-being of older adults, as an example, it arises comforting emotions and feelings; offers strength, management, and control; reduces the emotional burden of the illness; offers social support and feeling of belonging; offers religious support through a personal religious relationship with God; facilitates which means and acceptance of the illness; preserves health; relieves the worry and uncertainty of death; and will increase self-acceptance and reduces self-blame^{11, 12}. Geriatric nurse plays a role in raising the patient's own resources by providing further emotional, informational and practical help, and suitably enhancing a sense of hope or optimism.¹³ Active spiritual participation is central to Muslim support. Spiritual engagement isn't examined in terms of its association with PWB in cancer patient.

In Egypt there is a lack of information about the psychological wellbeing and religion coping of elderly women survivors of breast cancer. **So this study aims at** describing the psychological wellbeing and its associated factors as well as its correlation to religious activities among elderly women surviving breast cancer.

Significance of the study:

Breast cancer is the most common among elderly women with incidence in Egyptian patients 38.4%. This percentage suggests that women with breast cancer experience effect on psychological wellbeing in early diagnosing and treatment of cancer. To the best of our knowledge, there is no published quantitative data on the psychological wellbeing of breast cancer patients.

Research question:

- What are the factors influencing the psychological wellbeing of older women with breast cancer?
- Relationship between psychological wellbeing and religious coping activities of older women with breast cancer?

Subjects and Methodology:

Study Design:

This cross-sectional, descriptive study with analytic elements was utilized.

Study Setting:

This study was carried out at Mansoura University Hospital (oncology center) in the Outpatient Clinics.

Subjects:

This study enclosed a convenient sample of 163 elderly women aged sixty years and more diagnosed with breast cancer and willing to share in the study. Women of a minimum of six months of finishing primary treatment were interviewed at the outpatient clinic throughout follow-up visits.

Sample size:

Sample size was calculated online (www.dssresearch.com). A pilot study on 10 patients revealed that the mean religious... score was 16.0 and SD =1.5, alpha error =5%, beta error=20% (i.e. study power=80%) and level of precision of 3%, the sample size =155 at least.

Tools of Data Collection:

To achieve the aim of this study, three tools were used for data collection.

Tool I: Socio demographic and clinical data structured interview schedule: It was developed by the researchers after reviewing literature and included the following items:

- Socio-demographic data (age, sex, legal status, education, occupation before retirement and living status).
- Medical history (diagnosis, stage of cancer, period of illness, type of treatment up to the time of interview, comorbidities and family history).

Tool II: Ryff's Psychological Well-Being (RPWB) Scale:

Psychological well-being was measured by Ryff's Psychological Well-Being (RPWB) Scale¹⁴. It includes a series of forty two statements reflective the six domains of

psychological well-being: autonomy, environmental mastery, personal growth, positive relations with others, and purpose in life, and self-acceptance. Respondents rate statements on a scale of one to six, with one indicating strong disagreement and six indicating strong agreement. Rearrange negative phrased items: # three, 5, 10, 13,14,15,16,17,18,19, 23, 26, 27, 30, 31, 32, 34, 36, 39, and 41. (i.e., if the scored is six in one in every of these things, the adjusted score is 1; if five, the adjusted score is two then on...). Higher scores indicate a better level of PWB.

Tool III: Brief Arab Religious Coping Scale (BARCS):

Religious activities were measured by the brief Arab religious cope Scale (BARCS), and developed by Amer¹⁵. It consists of 15-items and participants chosen however usually they engaged in such that behaviors after they skilled trying things or problems. Responses vary on a (4 Likert scale) and every question gets score from zero to three. Potential scores on this scale vary from zero to forty five (not used at all/ doesn't apply =0, used generally =1, used usually =2 and used continually =3).

Field work:

- Data were collected during the period from March to August 2016 through six months duration.
- The dimensions in tool II (RPWB) was translated into Arabic and tested for content validity by a jury from connected specialties. Suggestions of the jury members were followed and also the tools were changed consequently.
- The two scales for tool II (RPWB) and tool III (BARCS) were tested for its reliability throughout the pilot study on ten participants not enclosed within the complete study. These scales were repeated again for this participant after two weeks. The test-retest reliability of various items of the scales ranged from 0.7 to 0.9. The domains of the RPWB Scale and BARCS have Cronbach's alphas in a very vary of 0.86and0.91.
- In the previous selected study settings, oral consent was taken after explaining the purpose and procedures of the study. Data were collected from the previous setting on (Sunday, Monday, and Wednesday) every week in the outpatient clinics to fill the questionnaire sheet to collect data. The approximate time spent with each elderly woman during the interview was 20-30 minutes.

Pilot Study:

It was conducted on (10% of the whole sample) to evaluate the validity & practicability of tools used and to estimate the time required for filling the required forms and to evaluate whether or not items were understood by older women and then the necessary modifications were done, these older women were excluded from the study sample.

Ethical Considerations:

- The study proposal was approved by the analysis ethic committee of Faculty of Nursing, Mansoura University.
- Official approval of the Director of the medical specialty (oncology) Center was obtained.
- Women gave verbal consent to participate within the study.
- Anonymity, Privacy and confidentiality of information were maintained.

Statistical analysis:

Data were analyzed using SPSS version 20 (SPSS Inc., Chicago, IL, USA). Qualitative variables were presented as number and per cent while quantitative variables were presented as mean ± standard deviation. The different domains of RPWB Scale and the BARCS were found to be normally distributed as tested by Shapiro's test. The unpaired t-test was used for comparison between two categories. One way ANOVA test was used for more than two groups with Bonferroni's post hoc multiple comparisons. Pearson's correlation coefficient was used to calculate correlation between BARCS and the different domains of RPWB scale. P ≤ 0.05 was considered statistically significant.

RESULTS

Table one shows that the mean scores of autonomy, environmental mastery, personal growth, positive relations, life purpose and self-acceptance are 24.3, 21.7, 23.2, 25.03, 25.6 and 22.1; severally. The mean scores of environmental mastery, personal growth, positive relations and life purpose vary significantly in keeping with age group of the participants. The mean scores of autonomy, environmental mastery, personal growth, life purpose, and self-acceptance show vital variation in keeping with marital status. The mean scores of the six subscales vary significantly consistent with educational level. The

mean scores of autonomy, positive relations and self-acceptance showed vital variation in keeping with form of work before retirement. The mean scores of autonomy, environmental mastery, personal growth, life purpose, and self-acceptance vary in keeping with financial gain level. However, only the mean scores of autonomy, personal growth, and life purpose. The mean scores of autonomy, personal growth, positive relations, life purpose, and self-acceptance vary significantly in keeping with living condition.

Table two shows that the mean scores of the six subscales vary according to period of health problem, stage of disease, variety of treatment and side effects of medicines. On the opposite hand the mean scores of personal growth, positive relations, and self-acceptance subscales vary significantly in keeping with presence or absence of co-morbidities

Table three shows that there is a statistically vital inverse weak correlation between religious coping activities and autonomy (r= -0.3, P≤0.001). On the opposite hand religious coping activities show significant positive correlations with environmental mastery, positive relations and self-acceptance (r=0.38, 0.62 and 0.6; respectively). However, there is association degree inverse, non-significant, negligible correlation between religious coping activities and purpose of life.

Table (1): Relation between socio-demographic data and psychological wellbeing domains of elderly women with breast cancer

Variables	N=160 (%)	Autonomy Mean ± SD	Environmental mastery Mean ± SD	Personal Growth Mean ± SD	Positive Relations Mean ± SD	Purpose in life Mean ± SD	Self- acceptance Mean ± SD
Overall	Mean ± SD	24.3±1.32	21.7±2.4	23.2±2.5	25.03±3.29	25.6±4.06	22.1±2.5
Age (in years):	65.3±3.4						
60-	79(48.5)	24.3±1.5	22.4±2.03 ^{AC}	22.6±1.5 ^A	25.5±3.5	25.9±4.1 ^A	22.2±2.2
65-	51(31.3)	24.5±1.1	21.7±2.8 ^{BC}	24.2 ±3.9 ^A	24.1±2.7	26.5±3.5 ^B	22.5±1.9
≥70	33(20.2)	24.1±1.1	20.4±1.8 ^{AB}	23.0±0.9	25.3±3.4	23.4±4.2 ^{AB}	21.5±3.8
Significance		F=1.1,P= 0.33	F=8.5,P≤0.001	F=7.5,P≤0.001	F=3.0, P≤0.05	F=6.45,P=0.002	F=1.62, P=0.2
Marital status:							
Married	89(54.6)	24.7±1.4 ^{AB}	21.7±2.7 ^A	24.2±2.6 ^A	24.2±2.8	25.7±3.7 ^{AC}	21.6±2.6 ^A
Widowed	59(36.2)	23.9±1.03 ^A	20.58±2.2 ^{AB}	21.2±2.8 ^{AB}	25.7±2.5	21.7±2.9 ^{AB}	22.2±3.3
Divorced	15(9.2)	23.6±0.82 ^B	22.6±1.2 ^B	22.6±0.8 ^B	26.04±4.1	28.04±3.4 ^{BC}	23.3±1.3 ^A
Significance		F=8.7,P≤0.001	F=18.9,P≤0.001	F=13.5,P≤0.001	F=1.9,P =0.15	F=6.6,P =0.002	F=6.8,P=0.002
Education:							
Illiterate	86(52.8)	24.3±1.5 ^{AB}	21.7±2.7 ^A	24.2±2.6 ^A	24.2±2.8 ^A	25.7±3.7 ^{AC}	21.6±2.6 ^A
Read, write & basic	31(19.0)	23.2±0.77 ^{AC}	20.6±2.2	21.2±2.8 ^A	25.7±2.5	21.7±2.9 ^{AB}	22.2±3.3
Secondary and above	46(28.2)	25.08±0.5 ^{BC}	22.6±1.2 ^A	22.6±0.8	26.04±4.1 ^A	28.04±3.4 ^{BC}	23.2±1.3 ^A
Significance		F=25.8,P≤0.001	F=7.5,P≤0.001	F=22.0,P≤0.001	F=5.6,P=0.004	F=31.2,P≤0.001	F=31.2,P≤0.001
Work before retirement							
House wife	89(54.6)	23.9±1.4	21.7±2.7	23.2±2.8	24.3±2.7	25.3±3.3	21.2±2.5
Employee	74(45.4)	24.7±1.07	21.8±1.8	22.9±2.1	25.9±3.7	25.9±4.9	23.3±2.2
Significance		t=0.33, ≤0.001	t=0.5,P=0.59	t=1.2,P=0.24	t=3.4,P≤0.001	t=0.8,P =0.4	t=5.7, P≤0.001
Income :							
Enough	46 (28.2)	23.7±1.3	20.1±2.2	21.4±2.4	25.2±2.5	21.5±2.8	21.5±3.2
Not enough	117(71.8)	24.5±1.2	22.4±2.1	23.9±2.2	24.9±3.6	27.2±3.3	22.4±2.1
Significance		t=4.0, P≤0.001	t=6.0,P ≤0.001	t=6.3,P≤0.001	t=0.5,P =0.6	t=10.2,P≤0.001	t=1.9,P ≤0.05
Source of income							
Pension	85(52.1)	24.8±0.6	21.9±1.8	22.7±0.85	25.2±4.1	27.04±3.6	22.2±2.3
Son	78(47.9)	23.7±1.6	21.5±2.8	23.7±3.5	24.9±2.02	23.9±3.9	22.07±2.8
Significance		t=5.9,P≤0.001	t=1.1,P=0.29	t=2.4, P=0.016	t=0.7,P =0.51	t=26.9,P≤0.001	t=0.4,P= 0.67

Living condition:							
Alone	60(36.8)	24.4±1.00	21.5±2.2	21.90±1.8 ^{AB}	26.7±2.7 ^{AB}	25.5±4.8 ^A	22.6±2.8 ^A
With partner only	80(49.1)	24.05±1.6 ^A	21.8±2.8	22.7±1.60 ^{AC}	24.09±3.7 ^A	24.7±3.6 ^B	21.3±2.4 ^{AB}
With family	23(14.1)	24.9±0.4 ^A	22.2±0.39	28.0±0.000 ^{BC}	24.04±0.20 ^B	28.9±0.34 ^{AB}	24.00±0 ^B
Significance		F=4.2,P=0.017	F= 0.9,P=0.4	F=132.7,P≤0.001	F=13.7,P≤0.001	F=10.4,P≤0.001	F=13.4,P≤0.001

A,B,C&D significant differences between the corresponding groups by Bonferroni post hoc multiple comparison.

Table (2): Relation between medical history and psychological wellbeing domains of elderly women with breast cancer

Variables	N (%)	Autonomy Mean ± SD	Environmental mastery Mean ± SD	Personal Growth Mean ± SD	Positive Relations Mean ± SD	Purpose in life Mean ± SD	Self-acceptance Mean ± SD
Duration of Disease:							
<1 year	22(13.5)	21.9±1.4	23.6±3.3	24.04±0.95	27.1±2.2	20.9 ±3.2	23.7±3.6
1 year & above	141(86.5)	24.7±0.9	21.5±2.03	23.04±2.8	24.7±3.3	26.3±3.7	21.9±2.3
Significance		t=12.5,P≤0.001	t=4.2,P≤0.001	t=1.8,P= 0.08	t=3.3,P≤0.001	t=6.5 P≤0.001	t=3.1, P≤0.003
Stages of disease:							
Stage I	15(9.2)	25.5±0.83 ^{ABC}	20.40±1.2 ^A	23.0±0.00 ^A	20.20±1.4 ^{ABC}	24.6±1.7	20.9±0.35 ^{AE}
Stage II	68(41.7)	24.4±1.02 ^A	22.01±2.2 ^C	22.00±2.07 ^B	28.25±1.6 ^{ADE}	27.08±4.7 ^{AB}	24.02±1.8 ^{ABC}
Stage III	50(30.7)	24.1±1.8 ^B	22.5±2.80 ^{AB}	25.4±2.62 ^{A^{BC}}	23.3±1.9 ^{BD}	24.9±4.04 ^A	21.9±2.2 ^{BD}
Stage IV	30(18.4)	23.80±0.61 ^C	20.50±1.5 ^{BC}	22.1±1.00 ^C	23.03±1.4 ^{CE}	23.6±1.2 ^B	18.9±0.9 ^{CDE}
Significance		F=6.2,P≤0.001	F=7.3,P≤0.001	F=30.9,P≤0.001	F=158.0,P≤0.001	F=6.7,P≤0.001	F=62.1,P≤0.001
Type of treatment							
Chemotherapy	89(54.6)	24.9±0.64 ^{AB}	22.4±1.5 ^A	23.7±2.60 ^A	26.2±3.23 ^{AB}	27.7±3.8 ^{AB}	23.3±1.6 ^{AB}
Radiotherapy	32(19.6)	24.7±1.5 ^{AC}	22.2±3.9 ^B	21.06±2.8 ^{AB}	24.5±1.24 ^A	23.6±1.5 ^A	19.9±0.24 ^A
Surgery	42(25.8)	24.2±1.2 ^{BC}	20.09±1.3 ^{AB}	23.3±2.52 ^B	23.4±3.7B	22.5±3.06 ^B	21.5±3.6 ^B
Significance		F=55.2,P≤0.001	F=6.7,P≤0.001	F=17.4,P≤0.001	F=10.9,P≤0.001	F=42.3,P≤0.001	F=28.9,P≤0.001
Co morbidities#:							
1-3	103(63.2)	24.3±1.5	21.9±2.70	22.3±1.8	26.2±3.4	25.8±4.4	22.7±2.5
3+	60 (36.8)	24.2±0.7	21.5±1.6	24.6±2.8	22.9±1.8	25.2±3.4	21.3±2.50
Significance		t= 0.3,P=0.74	t= 1.1,P=0.28	t= 6.2,P≤0.001	t=7.0,P≤0.001	t=0.98,P=0.32	t=3.5,P≤0.001
Number of Medications used:							
1-3	75(46.0)	24.4±1.5	22.3±2.9	21.9±1.9	27.05±2.4	27.3±3.7	22.4±2.2
3+	88(54.0)	24.2±1.09	21.3±1.5	24.2±2.3	23.3±2.9	24.1±3.7	21.9±2.8
Significance		t=0.8,P=0.41	t=2.9,P≤0.003	t=6.5 P≤0.001	t=8.7,P≤0.001	t=5.4, P≤0.001	t=1.2,P= 0.23
Side effects of medication							
1-4	31 (19.0)	24.6±1.2 ^A	19.8±1.2 ^{AB}	22.9±0.35	21.2±1.4 ^{AB}	24.3±1.3 ^A	19.5±1.5 ^{AB}
5-10	48(29.4)	25.0±0 ^B	23.1±0.42 ^{AC}	22.3±0.80 ^A	28.6±1.08 ^{AC}	29.9±0.3 ^{AB}	24.00±0 ^{AC}
10+	84(51.5)	23.8±1.5 ^{AB}	21.7±2.8 ^{BC}	23.7±3.4 ^A	24.4±2.5 ^{BC}	23.6±4.02 ^B	22.1±2.7 ^{BC}
Significance		F=17.2,P≤0.001	F=24.4,P≤0.001	F=5.4,P=0.006	F=136,P≤0.001	F=73.3,P≤0.001	F=46.7,P≤0.001
Family history							
Yes	77(47.2)	24.3±1.2	21.2±2.2	23.9±3.4	25.2±3.1	24.8±4.8	23.09±2.5
No	86(52.8)	24.3±1.5	22.2±2.4	22.5±1.04	24.9±3.5	26.3±3.06	21.3±2.3
Significance		t=0.39,P=0.69	t=2.7,P=0.007	t=3.5,P≤0.001	t=0.53,P=0.59	t=2.3,P=0.02	t=4.6,P≤0.001

A,B,C,D,E & F significant differences between the corresponding groups by Bonferroni post hoc multiple comparison. #e.g. Hypertension, Diabetes,...etc.

Table (3): Correlation between religious coping activities and psychological wellbeing of elderly women with breast cancer

Psychological wellbeing domains	Religious coping activities	
	r	p
Autonomy	-0.3	≤ 0.001
Environmental mastery	0.38	≤ 0.001
Personal Growth	0.12	0.13
Positive Relations	0.63	≤ 0.001
Purpose in life	-0.02	0.78
Self-acceptance	0.6	≤ 0.001

DISCUSSION

The psychological well-being (PWB) of women with breast cancer is turning into progressively vital; in addition the health of this class of survivors is significantly vital because

the variety of breast cancer survivors is expected to rise over following decade. Co-morbidities additionally because the traditional method of aging can compound their post treatment challenges. Having a clear understanding of the component that can effect on their PWB will assist

clinicians and researchers to conduct interventions to either support or maintain well-being among these survivors⁸.

In this study, women with breast cancer showed very low mean scores (ranging from 21.7 to 25.6) of the six dimensions of PWB. Early survivorship is often an essential time. The PWB are often negatively affected as a result of trauma related to diagnosing and treatment¹⁶. A universal concern throughout this stage is that the worry that cancer can recur, doubt concerning the future, less social support and considerations with adequately resuming pre-treatment roles^{17,18,19}. The physical symptoms experienced were connected to PWB^{20,21}. The challenge is to re-engage in life²². The few months when diagnosing are usually most stressful and PWB step by step improves^{23,24}.

A much higher score were recorded by *Gochett (2015) and Chen et al, (2016)*^{8,25}. Just when diagnosing, patients are faced with newly and unknown treatments for cancer. They're unsure concerning their ability to tolerate the treatment, and if it'll be effective. The survivorship part is characterized because the time when cancer is inactive or once a patient is taken into account cured. The gradual recovery in well-being overtime would possibly characterize the adjustment method. Perceived social support and approach-oriented coping methods predict higher audaimonic well-being among women with stage I & II breast cancer²⁶. Additionally cancer survivors exhibit resilience in social well-being, spirituality and personal growth¹⁷.

It is necessary not only to know the PWB of BCS, however additionally to gain insight into factors that may have an effect on their PWB throughout an essential time that may have lasting effects on the balance of their lives.

This study illustrated that the socio-demographic factors exerted a significant impact on the foremost of the PWB subscales. *Perkins et al (2007)*²⁷ commented that older women who survive breast cancer might differ significantly in their well-being. They found that higher age wasn't related to life satisfaction or general health perception. However they need increased psychological resilience to breast cancer diagnosing because of their life stage²⁸. However, advanced age is related to co-morbid diseases and functional impairment. *Ustundag & Zencircle (2015)*^{29,30} reported that cancer who are single and the housewives had worse psychological, social and general well-being.

This study presented that the cancer connected factors exerted a major impact on the most of the PWB subscales. However, a previous study discovered that cancer related variables as well as period of survival and type of cancer treatment weren't considerably related to survivors' well-being²⁷.

The variations in sickness severity don't justify well why some patient's expertise psychological issues while others don't³¹. It absolutely was advised that an optimistic personality appear to play a far more necessary role.^{32,33} Furthermore, *Howell, et al, (2007)* in their meta-analysis showed that, both short and long-term well-being are related to the capacity of controlling symptoms of diseases.

The low score of autonomy or independency reflects the lack of looking for a way of private independence and authority. Patients weren't concerned in medical higher cognitive process with the assumptions that doctors were best suited to function decision-makers for the welfare of their patients. Respecting patient autonomy in decision-making will be difficult. Patients face varied choices associated with their treatment³⁴. Patient autonomy is conceptualized because the patient's right to create informed selections regarding their own care while not undue influence or manipulation from others. *Van Kleffens et al (2004)*^{35,36} in their qualitative study revealed that patient autonomy was a comprehensive thought with elaborations on making decisions and defining life choices as sub-concepts of patient autonomy. In contrast to what's usually believed, decisions of patients relating to refusing a medicine treatment don't so much rely on the medical information about disease and treatment options, but are rather inspired by patients' own experiences or those of close others. The medical information and the role of the physician do, however, influence patients' experience of being free and/or of having a choice. The extent of pressure physicians will exert to persuade the patient to be treated as recommended depends on the medical distinction between a curative and a non-curative treatment goal.

Environmental mastery is attempting to form one's living environment so as to fulfill one's desires and needs⁹. The low score of environmental mastery means patient has issue managing everyday affairs; feels unable to change or improve surrounding context; is unaware of surrounding opportunities; and lacks sense of control over external world¹⁰. This low environmental mastery may be attributed to the low socioeconomic status of study population. Purpose of life is that the ability to search out which means in one's difficulties or problems in life⁹. Patients lack a way of which means in life; has few goals or aims, lacks sense of direction; doesn't see purpose in past life; has no outlooks or beliefs that offer desiring to life.¹⁰

Personal growth means that making personal skills and abilities⁹. Cancer survivors have reported an enhanced sense of personal growth³⁷. Patients have a way of personal stagnation; lack sense of improvement or expansion over time; feel bored and uninterested with life; and feel unable to develop new attitudes or behaviors.¹⁰ Positive relationship with others, that is, having affirming relations with others⁹ It looks that patients who have few close, trusting relationships with others, find it difficult to be warm, open, concerned about others and they are isolated and annoyed in interpersonal relationships, and moreover they're not willing to create compromises to sustain necessary ties with others.¹⁰

Self-esteem or self-acceptance is that the ability to feel sensible regarding oneself whereas being conscious of one's limitations⁹. Patient, with low self-esteem, feels dissatisfied with self; unsuccessful with what has occurred in past life; and troubled regarding certain personal qualities, additionally she desires to differ from what she is¹⁰. Self-acceptance is a very important issue affecting psychological state³⁸. It means a personal accepts all of her positive and negative sides as well as her real self with regards

to feeling and attitude. *Cong & Gao, (1999)* it was demonstrated that adults who graduated from university were additional inclined to be self-critical³⁹. University life and level of education play vital roles within the development of self-acceptance of individuals^{40, 41}. *Chen et al, (2016)*²⁵ revealed that self-acceptance was positively associated with the diagnosing time, and house income; whereas TNM stage was negatively related to self-acceptance. Retired patients had the highest levels of self-acceptance. They reported that disease stage, surgery type, TNM stage, co morbidities, breast cancer family history and repeat or metastasis, could also be associated with the extent of self-acceptance.

The role of religion has been considered necessary in life threatening conditions such as cancer. Various religious coping methods that people adopt and how they modify throughout the health problem course have implications for illness adjustment⁴². The majority US women with breast cancer expressed that religion helped them cope with their health problem⁴³. There is evidence for the positive association between religion, well-being and adjustment life satisfaction (*Lin et al, 2003; Thune-Boyle et al, 2005; Moore, 2012*).^{44, 45, 46}

There is an inverse correlation between religious coping activities and autonomy.⁴⁷ *Schreiber (2011)* found a non-significant correlation between PWB and spiritual conservation subscales. However, a moderate negative correlation was found between autonomy and religious struggle subscales.

Religious coping activities showed significant positive correlations with environmental mastery, positive relations and self-acceptance. However, *Schreiber (2011)*⁴⁸ found moderately strong negative correlations between PWB and spiritual struggle subscales. Religion usually helps older to buffer the stresses inherent in having physical health problem. Religion and spirituality provide emotional support, social support and Meaning. (*Feher & Maly, 1999*)⁴⁸ it was concluded that the belief in God is significantly related to the increased PWB, the decreased psychological distress and the decreased concern about cancer recurrence.⁴

CONCLUSION

Women with breast cancer have low PWB scores. Several factors are related to variation in PWB. Religious coping improves PWB of elderly women extant breast cancer in post-treatment phase. There is a space for improvement.

Recommendations:

Based on the findings of this study, the following recommendations are suggested:

- Special attention should be paid to elderly women with impaired psychological well-being during follow-up visits. There is a need for long-term study to link psychological well-being to key events rather than merely time since diagnosis. It is important to assess the PWB and religiosity of breast cancer elderly women patients.

- Aging women should receive care that addresses to their physical and psychological needs.
- Culturally competent gerontological nurses should recognize the religious coping being used by women undergoing breast cancer treatment and the factors that improve the psychological well-being. These should be incorporated in patient's care.
- Promotion and supporting the religious activities could be important items of comprehensive cancer treatment. It may be important to encourage patients to seek religious support and/or reconnect with their religious community.

Study Limitations:

This is a single center, small-scale study with cross-sectional design that lacks generalizability. The cross-section design does not allow monitoring changes of PWB at (post intervention diagnosis) diagnosis following intervention, and at follow-up.

Conflicts of Interests: None

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