INTEGRATING PRAYER AND FAITH IN COMPLEMENTARY ALTERNATIVE MEDICINE INTO TREATING BREAST CANCER: LIVED EXPERIENCES

by

Barbara M. Orticelli

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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ABSTRACT

The purpose of this transcended phenomenological study was to describe the lived experiences of women who have survived breast cancer and how complementary alternative medicine (CAM), such as prayer and spirituality, were incorporated into their treatments. The research questions used to frame this study include: *1) How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment? 2) How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?* The theory guiding this study is based on two key frameworks: the CAM decision-making process and CAM modality integrated decision-making model, as they explain the general decision-making elements of a patient under severe stress, such as in cancer (Chowdhuri & Kundu, 2020). Therefore, such trends raise both concerns and interest about the effectiveness and other ramifications of these approaches, where more detailed studies are required (Buckner et al., 2018). Data were collected from six women survivors of breast cancer using semi-structured interviews and cognitive representations. Two significant themes that emerged from the study and interviews included the lived experiences of the women and the importance of CAM, such as prayer, spirituality, and faith played a role in their healing journey. The implications of the results apply to the women survivors of breast cancer, their family members and friends, as well as the medical, mental health, and providers who serve them.

Keywords: *complementary alternative medicine, breast cancer, women survivors, lived experiences, prayer, spirituality*

Copyright Page

Dedication

First, I would love to dedicate this research to my Lord and Savior, Jesus Christ, or as I know Him, Jehovah Rapha, the God who has healed me; as He honored me with the purpose to seek out those who were healed from breast cancer, as He gave me the grace to journey on until all the stories were told. Second, I dedicate this research to my daughter, as she continues to be a godly inspiration to me and for me. Third, but not least, I dedicate this research to all the women I interviewed who gracefully shared their journeys through breast cancer.

Acknowledgments

My first and only acknowledgment is Dr. Volk, as his tough love and godly wisdom has allowed me to see more of God's greatness in me and his encouragement through this tough journey. Thank you, Dr. Volk, for your mentorship!

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List of Abbreviations

Complementary Alternative Medicine (CAM)

American Joint Committee of Cancer (AJCC)

The International Union for Cancer (UICC)

Dutual Carci Noma *in site* (DCIS)

Estrogen Receptor (ER)

Chinese Herbal Medicine (CHS)

Transcendental Phenomenology (TPh)

Institutional Review Board (IRB)

American Counseling Association (ACA)

CHAPTER ONE: INTRODUCTION

Overview

Breast cancer is one of the major healthcare issues which affects women all around the globe. The current advances in the treatment and screening indicate the presence of a prominent and profound improvement within these processes. Traditional approaches play a central role in ensuring that breast cancer does not lead to fatal outcomes by increasing survival rates. However, it is critically important not to overlook the undeniable relevance of complementary alternative medicine (CAM) and its role during a patient's struggles with a given health problem.

One should not ignore that CAM practice revolves around various religious and cultural practices, which are deeply ingrained within the diagnosis, treatment, and post-survival phases. Although several cultures use CAM differently, the monotheistic Abrahamic religions primarily adhere to prayer and faith (Ahmadi et al., 2019). The corresponding structure of the given chapter will primarily focus on outlining the purpose and significance of the study and its problem statement with an emphasis on the background of the issue. Therefore, it is necessary to increase the overall understanding of the role of CAM among breast cancer patients alongside identifying the key motivating factors, where the prime manifestations of the phenomenon are faith and prayer. Thus, the research questions are:

1) How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?

2) How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?

Background

The high incidence of cancer is a global risk in modern times. The impact of powerful stress factors of the disease and often extremely difficult treatment leads to a decrease in the performance and quality of life of patients with oncological diagnoses. At the same time, it is generally accepted that the result of treatment largely depends on the patient's position in life and on the choice of a strategy for overcoming a stressful situation. Today, in combination with other methods of treating oncological diseases, radiation therapy is often used, which requires mandatory preparation, several sessions, immobilization of the patient during a session, and the possibility of radiation complications.

Breast cancer occurs when breast cells, due to mutations, begin to divide uncontrollably and spread to surrounding tissues. These cells form a tumor, which can be detected by palpating the breast or mammography. Cancer can form in various parts of the breast. Most breast tumors develop from the epithelium of the ducts that carry milk to the nipple (ductal cancer), but others develop from glandular cells (lobular cancer). There are also fewer common forms, including non-specific cancers, sarcomas, and breast lymphoma.

The tumor can grow locally, spread through the lymphatic system to the lymph nodes (regional metastasis), and spread throughout the body (distant metastasis). Regional lymph nodes include axillary, intrathoracic, supra- and subclavian lymph nodes—on the same side as the tumor in the mammary gland. The stage, prognosis, and extent of breast cancer treatment depend on the size of the tumor, involvement of regional lymph nodes, and absence or presence of distant metastases.

Signs and symptoms of breast cancer include the presence of a solid tumor in the breast, which does not decrease at divergent phases of the menstrual cycle but increases over time. In

addition, the symptoms may be nipple retraction, nipple discharge, breast or nipple pain, and skin infiltration in the breast area. Skin ulceration in the breast area, swelling of all or part of the breast, unexplained weight loss, weakness, and redness, peeling, or thickening of the nipple or breast skin may also occur.

Historical Context

Historically, breast cancer has always been a major health issue and is one of the most aggressive and dangerous types of oncological disturbances among the female population. The main topic of this research is focused on breast cancer and cancers in general, particularly those primarily handled and treated through traditional medicine (TM). Despite its high degree of usefulness and effectiveness, some cases of the disease also require powerful coping mechanisms due to the uncertainty of the outcomes.

This explains why there is a substantial prevalence and presence of CAM, which can be useful in conjunction with the main treatment. If the topic is viewed within its historical context, it becomes clear that religion and cultural practices play a central role in determining the form of CAM exhibited by a particular group of people. For instance, a study from Malaysia showcased how Islamic belief plays a vital role in coping mechanisms among local cancer patients (Ahmadi et al., 2019). These coping mechanisms are primarily centered around faith and prayer, which differ in the style of performance but possess the same function of connecting with God. Islam, being one of the dominant monotheistic Abrahamic religions of the world, can be a representative element of other religions, such as Christianity and Judaism.

Social Context

Social context plays a vital role in the prevalence of CAM use among cancer patients, including breast cancer. One should be aware that not all cases among oncology patients can

result in the desired outcome, where a person has a chance for survival. In some instances, the treatment might not be useful if the identified stage is late. In other words, such people must rely on coping mechanisms, which can be derived through a wide range of measures. In addition, coping with the given challenge is still relevant among patients who have a chance for survival. The mere process of undergoing the treatment can be stressful and depressing for many individuals, making CAM prevalent. For instance, evidence from Indigenous Australians demonstrates the significance of CAM as traditional medicine (Adams et al., 2015). Therefore, it proves that using CAM is not limited to religious practices because various cultures that developed independently also possess alternative approaches to cancer.

Although the main subject is centered around the role of prayer and faith, CAM can be manifested in several forms. For example, Caribbean communities employ CAM in the form of spiritual therapies and medicinal herbs, without the knowledge of health care providers (Bahall, 2017). In other words, herbs alongside certain rituals may form part of CAM, which can support or even interfere with the traditional measures. Thus, in the social context, CAM is of paramount importance because it is present in all cultural and religious elements, and serves the purpose of building a strong and effective coping mechanism.

Theoretical Context

It is important to state that there is a solid theoretical context, based on the various advantages and disadvantages of CAM-based practices in breast cancer and cancer in general. Therefore, such trends raise concerns and interest regarding the effectiveness and ramifications of these approaches, requiring more detailed studies (Buckner et al., 2018). In other words, it is evident that some practices, such as herbs, might counteract or even suppress the effect of traditional cancer treatment procedures. For example, a person undergoing chemotherapy is

generally in a weakened state, and the use of toxic or harmful herbs might result in undesired complications.

However, the topic is primarily focused on faith and prayer, which are not harmful. One should be aware that religion and its specific elements can be useful for improving the overall situation with cancer. For example, faith-based health promotion programs can be incredibly useful in the educational process among people of color and minorities (Brown & Cowart, 2018). Therefore, there is a certain appeal and authority, which emanates from such approaches, and is helpful to illuminate key causes and risk factors of breast cancer. There are no in-depth studies on the importance of religion among cancer patients, which makes the analysis of CAM even more relevant.

This research provides invaluable evidence and data on the role of faith and prayer among breast cancer patients. The benefit encompasses a wide range of cultures that practice Abrahamic religions and primarily communicate with God through the specified means. Although the existing studies mainly revealed that CAM is prevalent among all cultures and can be useful in conjunction with certain approaches, such as education, there is no solid data on the direct impact of most common practices—prayer and faith. Thus, this study deepened the contemporary knowledge on the given subject and set directions for further research.

Situation to Self

This research was based on my motivation to establish knowledge of the role of faith, prayer, and other CAM treatments among breast cancer patients. Although seeking the truth is a noble goal, cancer and its treatment is a complex and complicated issue; thus, the main focus was on the epistemological and ontological assumptions. I learned about the effects of these practices as key elements of CAM and revealed the intricacies of its implementation in the daily lives of

breast cancer patients. Therefore, it is evident that the paradigm of such an approach was manifested in pragmatism, where CAM practices were not viewed as a sole cancer treatment procedure but rather as complimentary and practical measures for improving coping mechanisms.

This study utilized two key frameworks—the CAM decision-making process and the CAM modality integrated decision-making model. The choice of frameworks was based on the decision tree model, which describes alternative healthcare options among patients with oncological complications (Chowdhuri & Kundu, 2020). These frameworks provided invaluable insight into how cancer patients proceed with adhering to or dismissing faith and prayer as CAM methods.

Problem Statement

The problem statement of the proposed research is rooted in the fact that many breast cancer patients and cancer patients use or adhere to CAM widely. This phenomenon is persistent across various cultures and practices among the most dominant religions. The current literature revealed the prevalence of these practices, where cancer patients complement their traditional treatments with various rituals, prayers, and even herbs (Bahall, 2017). In other words, the notion is not a unique or isolated incident but rather a highly prevalent occurrence. Therefore, the problem lay in the fact that there is little to no understanding of the driver and catalyzers of such behavior. It is also not clear whether there is a strict relationship between various stages of cancer and one's willingness to adhere to prayer and faith as the sole explicit forms of CAM. In addition, the problem was also manifested in the lack of sufficient knowledge on the effects of faith and prayer on a person's physical, mental, emotional, and social health.

Purpose Statement

The purpose of this phenomenological study was to understand the role of faith and prayer as forms of CAM for breast cancer patients at various stages of the disease's progression, and to identify key driving factors behind the overall adherence to the practice. Alongside the main purpose, this research illuminated the overall effect of faith and prayer on an individual's physical, mental, emotional, and social health. The theory guiding this study is based on two key frameworks: the CAM decision-making process and CAM modality integrated decision-making model, as they explain the general decision-making elements of a patient under severe stress, such as cancer (Chowdhuri & Kundu, 2020). Therefore, this research was based on the provisions of the regulatory approach to the analysis of stress, the conceptual paradigm of individual diagnosis and correction of stress, and an initiative-taking approach to the study of coping behavior.

In addition, it is important to improve the understanding of the functional system model of conscious regulation of activity and the idea of the role of effective psychological self-regulation in stressful conditions in forming a person's adaptive potential. Therefore, this study was conducted to analyze the initiative-taking resources for overcoming chronic stress in patients with breast cancer diagnosis undergoing therapy.

Significance of the Study

The significance of the study can be described as a contribution to the current understanding of the importance of CAM among cancer patients. Although there is some research data on the prevalence of CAM, there is little to no succinct knowledge on the impact of prayer and faith among specific cancer types, such as breast cancer. This study revealed the key driving factors behind a patient's choice to adhere to CAM in conjunction with the traditional

treatment procedures. The research illuminated the overall impact of CAM on a person's social, emotional, mental, and physical health. One might also argue that faith and prayer are among the most common CAM practices due to the sheer prevalence of followers of Abrahamic religions, such as Christianity, Islam, and Judaism. All these major world religions put prayer and faith as the central pillars of their religious practice, and thus, it is useful to deepen the current understanding of CAM within the context of faith and prayer.

There is also a practical use for the study results because they guide physicians, oncologists, and nurses in their overall understanding of the role of CAM in the cancer treatment process. For example, faith-based educational programs showed a high level of success in promoting cancer awareness and the key mechanisms behind preventing and proceeding with the treatments (Brown & Cowart, 2018). Therefore, one might argue that CAM might lead to an improved experience throughout the breast cancer treatment procedures due to the overall effect in the emotional aspects. In addition, the study is significant because it illuminates the critical pitfalls of using CAM in conjunction with traditional treatment practices (Buckner et al., 2018).

Breast cancer is among the most aggressive and widespread types of oncological issues; thus, this research will have value in improving the existing form of care delivered to patients. The main effect might enhance breast cancer treatment procedures by integrating various CAM options or even programs where patients are allowed to access faith-based or prayer-based services. Moreover, the study revealed the relationship between particular breast cancer stages and CAM use, and illuminated the main driving factor behind the overall adherence. This will allow medical experts to derive invaluable data about the patients' decision-making process under such stress. By understanding the general role of the most common CAM practices—faith

and prayer—it will be possible to design better cancer treatment programs where the process is not merely focused on one's physical state.

The research will enable the implementation of improvements in a cancer patient's emotional, social, and mental health, which are critical in the healing and recovery process. It is also more ethical to ensure that the potentially last days of a person's life are spent in a state of happiness and satisfaction rather than fear and dread. In other words, regardless of whether there are direct improvements of CAM practices on the overall breast cancer survival rates, it is moral and ethical to implement changes which lead to an enhanced emotional and mental well-being.

Research Questions

1) *How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?*
2) *How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?*

The first research question focused on how the severity of stress from cancer can affect the adherence rate toward CAM in the form of prayer and faith. It was revealed that faith-based education can effectively bring awareness (Brown & Cowart, 2018). However, there is no specific study on breast cancer stages and their relationship with CAM. In addition, it is important to note that there are several manifestations of CAM, but one might argue that faith and prayer are the most explicit forms. This is why it is critical to understand the key driving factors behind CAM among cancer patients. The last research question sought to illuminate the general effect of faith and prayer on one's physical, mental, emotional, and social health. An indication of improvement can enhance the traditional treatment process.

Definitions

1. *Cancer* – a set of diseases caused by an uncontrolled and abnormal cell division with their subsequent spread (American Cancer Society [ACS], 2019a).
2. *CAM* – complementary alternative medicine is a set of cultural and religious practices excluded from the traditional cancer treatment approaches (Bahall, 2017).
3. *Mammography* – a low-dose X-ray procedure needed to detect the presence of breast cancer and useful for identifying the disease during the early stages (ACS, 2019a).
4. *Metastasis* – is a part of the primary tumor that spreads to another site within the body (ACS, 2019b).

Summary

The study's key problem statement was based on the fact that CAM is prevalent across cultures and religions, and takes a wide range of forms. However, there is little to no understanding of the essential driving factors that make a breast cancer patient adhere to these practices. Therefore, the research deepened the current knowledge on the issue by revealing the relationship between breast cancer-based stress or cancer stage and motivation to integrate CAM. It also identified the overall impact of faith and prayer on one's health elements.

CHAPTER TWO: LITERATURE REVIEW

Breast cancer is the most commonly diagnosed life-threatening cancer in women and the leading cause of cancer death (ACS, 2019a; BCRF, 2020). The survival rates for breast cancer and remission length, particularly in younger women, have improved significantly (Brenner et al., 2016; Sharma et al., 2010). Patients diagnosed with breast cancer primarily engage in traditional medicine for treatment (Adams et al., 2015; Bellavance & Kesmodel, 2016; Gall et al., 2018; Tolson, 2019). However, many women diagnosed with breast cancer also rely on one or more forms of CAM to tend to their physical, cognitive (mental), affective (emotional), social, and spiritual health, healing, and well-being (Adams et al., 2015; Bellavance & Kesmodel, 2016; Gall et al., 2018; Tolson, 2019).

Among these CAM forms are religiousness, spirituality, and the use of faith and prayer. Neuhouser et al. (2016) found that approximately 50% to 75% of all breast cancer patients use at least one form of CAM. Despite these numbers, forms of CAM are understudied, and little is known about their interactions with traditional cancer treatments or their correlative outcomes (Buckner et al., 2018; Neuhouser et al., 2016; Porter et al., 2019; Tolson, 2019). The purpose of this study was to further explore whether forms of CAM, including prayer and spirituality add value, and can help heal and even cure women with breast cancer (Kuhl, 2015).

The research questions used to guide this study included the following:

1) *How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?*
2) *How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?*

Breast Cancer Overview

There are several types or common forms of breast cancer, including non-invasive ductal carcinoma *in situ* (at the original site), invasive ductal carcinoma, inflammatory breast cancer, and metastatic breast cancer (Akram et al., 2017; Feng et al., 2018; NBCF, 2019; Siegel et al., 2019). These types are commonly grouped into one of three categories: non-invasive, invasive, or metastatic (Feng et al., 2018). Furthermore, the four stages of breast cancer include metastatic breast cancer (Feng, et al., 2018).

Stages of Breast Cancer

Kuhl (2015) maintained that breast cancer is not a single disease and that tumor biology beats staging or classification of breast cancer; however, treatment has typically been based on the Tumor, Node, Metastasis (TNM) classification system. This system is maintained by the American Joint Committee on Cancer (AJCC) and the International Union for Cancer Control (UICC)—given T: the size of the tumor, N: the presence or absence of lymph node metastases, and M: the presence or absence of distant metastases (spread; ACS, 2020a; Kuhl, 2015). The stages are numbered and lettered 0, I, II, III, and IV (ACS, 2020a; Akram et al., 2017; see Appendix I).

Breast Cancer Signs and Symptoms

Feng et al. (2018) explained that, “Breast cancers can begin in different areas of the breast such as the ducts, the lobules, or the tissue in between” (p. 77). Signs and symptoms of metastatic breast cancer can include a breast lump or lumps, non-lump breast symptoms such as nipple abnormalities and breast pain, and non-breast symptoms such as back pain and weight loss (Koo et al., 2017). However, additional symptoms may occur when metastatic breast cancer has spread to the bones, liver, lungs, or brain. For example, when the metastatic breast cancer has

spread to the bones, there may be severe pain, swelling, or breakage of bones (ACS, 2019a; NBCF, 2019).

Stage IV of breast cancer is metastatic. If it spreads to the liver, there may be yellowing of the skin (jaundice), skin itchiness or skin rash, elevated liver enzymes, stomach pain, loss of appetite, nausea, and vomiting (ACS, 2019a; NBCF, 2019). If the metastatic breast cancer has spread to the lungs, there may be an abnormal chest X-ray, chest pain, chronic (ongoing) coughing, and/or inability to take deep breaths (ACS, 2019a; NBCF, 2019). If the metastatic breast cancer has spread to the brain, there may be persistent, worsening headaches, vision problems, nausea, vomiting, seizures, and behavioral or personality changes (ACS, 2019a; NBCF, 2019).

Breast Cancer Screening

Recommendations are made to women for early detection. If detected, the individual is advised to get breast exams, mammograms, ultrasounds, and breast biopsies and to continue education and research (Akram et al., 2017; Lewis, 2017; Nederlof et al., 2019; Scheel et al., 2017; Sun et al., 2017). Mammogram screening is of vital importance as women with dense breast matter mammograms have a higher risk (1.5 to two times higher) than women with average breast density (Feng et al., 2018). Breast cancer screening is considered a life-saving strategy that, combined with treatments, can extend life five or more years for patients who are diagnosed at early stages (ACS, 2019a; Gochett, 2015; Scheel et al., 2017).

Breast Cancer Risk Factors

There are molecular, genetic, and cellular risk factors for breast cancer (Feng et al., 2018; Momenimovahed & Salehiniya, 2019; Sun et al., 2017). Genetic predispositions that create risk factors for breast cancer can include gene mutations in BRCA1 and BRCA2 (genes that make

proteins that function as tumor suppressors) and inherited mutations in other genes (Feng et al., 2018; GHR, 2020; Sun et al., 2017). Non-genetic risk factors for breast cancer can include demographics (female gender, age and aging, and possibly, even blood type); reproductive factors (age of menarche, late age of menopause); positive family history of breast cancer; race-ethnicity; certain benign breast conditions; and lifestyle and personal behavior-related risk factors (Feng et al., 2018; Hai-Long et al., 2016; Lewis, 2017; Momenimovahed & Salehiniya, 2019; Sun et al., 2017).

Risk Factors

The authorities (e. g., Lewis, 2017; Sun et al., 2017) asserted that women with risk factors may develop breast cancer more often than others without these factors. However, these risk factors do not necessarily mean every woman will develop breast cancer. Nevertheless, as Lewis (2017) also pointed out, while some risk factors are unavoidable (genes, family history), other risk factors such as alcohol consumption and dietary fat intake are avoidable risk factors (Prince, 2019). Nevertheless, of specific relevance to this study are demographic risk factors, including gender, age, and race factors.

For instance, Caucasian women are slightly more likely to develop breast cancer than African American women; however, breast cancer among African American women under 45 is more prevalent (Feng et al., 2018). Furthermore, for African American women, breast cancer death rates are still elevated—despite a decline in all breast cancer death rates—and African American women are more likely to die from breast cancer than are their Asian, Caucasian, Hispanic, and Native-American counterparts (ACS, 2019a; Feng et al., 2018; Tolson, 2019).

Breast Cancer Survival Rates

Breast cancer is the most common cancer in women worldwide (Akram et al., 2017; Feng et al., 2018; Lewis, 2017; Sun et al., 2018; Tolson, 2019; Zujewski et al., 2018) and is the second leading cause of cancer deaths among women (after lung cancer; ACS, 2020b; Breastcancer.org, 2022a; Tolson, 2019). In 2018, breast cancer accounted for 14.7% of all cancer deaths (Sun et al., 2018), and in 2020, accounting for about 15.5 percent of all new cancer cases, breast cancer in women accounted for 98.78 % of breast cancer deaths (ACS, 2020c). The 5-year relative survival rate of breast cancer patients is about 80%, provided there is early detection; this is relevant to this study. However, the lack of prevention, awareness, and early detection results in a low survival rate of 27% of all women diagnosed with stage IV breast cancer (Sun et al., 2017). Younger women (under 40 years of age) make up 7 % of all breast cancer diagnoses (Brenner et al., 2016). Between 1975 and 2000, the 5-year relative survival rate was 80% among women aged 35–39, 76% among women aged 30–34, 72% among women aged 25–29, and 75% among women aged 20–25 years (Brenner et al., 2016). However, the 2019 survival rate for young women (under 30) with Stage IV breast cancer was only 16%, compared to a 97% 5-year survival rate for young women with Stage I breast cancer, an 83% survival rate for young women with Stage II breast cancer, and a 54% survival rate for young women with Stage III breast cancer (DeMarco, 2019).

African American women younger than 60 years old have higher breast cancer incidence rates and higher mortality rates than Caucasian women (ACS, 2019a; Feng, et al., 2018; Richardson et al., 2016; Tolson, 2019). Breast cancer is less likely to be found earlier among African American women than among Caucasian women (Richardson et al., 2016). Survival rates for African American women with stage IV breast cancer are lower than women of other

races (Enewold et al., 2018). A specific study by Arciero et al. (2017) revealed that African American women have worse overall survival rates, and worse breast cancer cause-specific survival in HR+/HER2− stages III and IV breast cancer and HR−/HER2+ stage IV cancer. They had worse overall survival but not breast cancer cause-specific survival in HR+ /HER2− stage II cancer and HR−/HER2− stage II cancer. Such statistics highlight the need for further research such as the one this study provides.

Standard Medical Treatments for Breast Cancer

Standard or traditional medical treatments typically target the cancer in order to physically treat the patient. These standard medical treatments can include surgery, radiation therapy, hormone therapy, chemotherapy, targeted therapy, and clinical trials. The first standard medical treatment for breast cancer is surgery (ACS, 2019a; Feng et al., 2018; Richardson et al., 2016; Tolson, 2019).

Surgery

Surgery, either breast-conserving, to remove the tumor and a margin of healthy tissue surrounding it (lumpectomy), or surgery involving the removal of the entire breast (mastectomy), is still the most common treatment for patients diagnosed with breast cancer (Bellavance & Kesmodel, 2016; Johnson et al., 2015; Lewis, 2017). Physicians typically recommend surgery for ductal carcinoma *in situ* (DCIS) and early-stage invasive breast cancer (Mayo Clinic Staff, 2020). Lumpectomy and mastectomy have similar survival outcomes (Mayo Clinic Staff, 2020). However, specific to this study, surgical resection of the primary tumor among women with stage IV breast cancer remained controversial (Lane et al., 2019).

Radiation Therapy

Radiation therapy uses high-energy X-ray or proton beams to destroy cancer cells (Mayo Clinic Staff, 2020). Radiation therapy after a lumpectomy reduces the chance that the cancer will recur or progress to an invasive form of cancer (Horton et al., 2018; Mayo Clinic Staff, 2020). Also, to reduce the need for mastectomy, radiation therapy is used for the early stages of breast cancer and affects only the cells tested, but may be used after breast cancer surgery to destroy the remaining cells in the chest area (Akram et al., 2017; Horton et al., 2018).

Hormone Therapy

Hormone therapy is used only in hormone receptor-positive breast cancers—estrogen-receptor-positive cancer, progesterone-receptor-positive cancer, and HER2-positive cancer (Breastcancer.org, 2022b; Loibl & Giannis, 2017; Mayo Clinic Staff, 2020). With hormone therapy, hormone-blocking drugs (e. g., tamoxifen for blocking estrogen) prevent the cancer cells from using the body's natural growth hormones (Breastcancer.org, 2022b; Lewis, 2017; Mayo Clinic Staff, 2020). Hormone therapy is only used for hormone-positive cancers (ACS, 2019b; Mayo Clinic Staff, 2020). Dembinski et al. (2020) found that hormone therapy is associated with increased overall survival for up to 10 years of follow-up. However, the efficacy of hormone-blocking therapy remains debatable (Dembinski et al., 2020).

Chemotherapy

Chemotherapy is a process of killing cancer cells by using a series of medicines specific to the breast cancer patient, the stage of cancer, and specific characteristics such as hormone receptor-positive characteristics (Breastcancer.org, 2022b). In stage I, stage II, and sometimes stage III cancers, chemotherapy is used post-surgery to remove the cancer by destroying any residual cancer cells and reduce the risk of the cancer reoccurring (Breastcancer.org, 2022a).

Chemotherapy is almost always recommended when cancer has the potential to invade other parts of the body and when cancer has already spread as it does in stage IV cancer; however, it is not typically recommended for non-invasive cancer types (Breastcancer.org, 2022b).

Clinical Trials

Clinical trials are offered as available experimental treatments that help doctors and researchers evaluate new cancer treatments, test new ways to find, diagnose, and manage cancer, and test ways to prevent cancer (NCI, 2020). The trials consist of subjects with cancer who will receive either the drug/drug combination being tested or no drugs (a placebo). Therefore, clinical trials may or may not be effective in treating breast cancer and may or may not have additional risk factors (Lewis, 2017).

Alternative Medicine and Treatments

Many women diagnosed with breast cancer also rely on one or more forms of CAM to tend to their physical, cognitive (mental), affective (emotional), social, and/or spiritual health, healing, and well-being. Neuhouser et al. (2016) showed that following diagnosis, approximately 50% to 75% of all breast cancer patients use at least one form of CAM. Alternative, non-medical options for treating breast cancer are categorized under the CAM heading (Bahall, 2017; Buckner et al., 2018; Eckard Lambe, 2013; Greenlee et al., 2016; Hajian et al., 2017; Johnson et al., 2018; Jones et al., 2019; Lyman et al., 2018; Neuhouser et al., 2016; Ogunkorode, 2019; Porter et al., 2019; Tolson, 2019), and involve alternative medical systems that include: 1) Ayurvedic medicine (Cassileth, 2008; Subramani & Lakshmanaswamy, 2017); 2) traditional Chinese medicine (Cassileth, 2008; Porter et al., 2019; Sun et al., 2016); 3) indigenous health practices (Adams, et al., 2015; Gall et al., 2018); 4) naturopathy and homeopathy (Cassileth, 2008; Greenlee et al., 2017; Sharma & Sharma, 2019); and 5) religiousness and spirituality

(Akram et al., 2017; Buckner et al., 2018; Cardoso, et al., 2017; Carlson, 2012; Clinton & Hawkins, 2011; Holt et al., 2008; Hulett & Armer, 2016; Koenig, 2012; Kuhl, 2015; Levers, 2012; Neuhouser et al., 2016; Paredes & Pereira, 2018; Porter et al., 2019; Puchalski et al., 2019; Rao et al., 2015; Sabado et al., 2010; Salsman, et al., 2015; Sharma et al., 2010; Steinhorn et al., 2017; Tolson, 2019; Williams & Jeanetta, 2016). Each of these systems offers non-medical treatments for the physical, cognitive (mental), affective (emotional), social, and spiritual health, healing, and well-being of patients diagnosed with cancer—such as diet and supplements (such as antioxidants); body, mind, and soul therapies (such as acupuncture, biofeedback, homeopathy, massage, meditation, osteopathy, Reiki, relaxation, therapeutic touch, and yoga); and depression, anxiety, and stress (Buckner et al., 2018; Greenlee et al., 2017; Neuhouser et al., 2016; Prince, 2019; Seiler & Jenewein, 2019).

Ayurvedic Medicine

Ayurvedic medicine, or Ayurveda, originated in India (Cassileth, 2008; Subramani & Lakshmanaswamy, 2017). From the Sanskrit words “ayur” (life) and “veda” (knowledge), Ayurvedic medicine is a holistic approach that focuses on a mind-body system for healing. Ayurveda centers on consciousness, or mindfulness—achieved through yoga or meditation (Cassileth, 2008; Subramani & Lakshmanaswamy, 2017) and physical cleansing and detoxification (Cassileth, 2008; Subramani & Lakshmanaswamy, 2017). It is not documented how many cancer patients use Ayurvedic clinics and spas for healing (Cassileth, 2008).

Traditional Chinese Medicine

Like Ayurveda, traditional Chinese Medicine (TCM) also takes a holistic approach to healing the mind and body and achieving balance or harmony (NCCIH, 2013). TCM treatments target underlying patterns of disharmony in each individual patient and are based on three main

diagnostic tools and therapeutic modalities: 1) acupuncture, which targets the body's Chi (life force) that flows through 12 meridians dotted with acupoints; Zhu, 2014); 2) massage and manipulation; and 3) the wide array of natural ingredients comprising the Chinese *Materia Medica*, which provides treatments for most human ailments, including cancer (Cassileth, 2008; Porter et al., 2019; Sun et al., 2016). The study by Sun et al. (2016) revealed that breast cancer treatment using CHM has been described in Chinese medical texts for more than 2,000 years.

Indigenous Health Practices

Traditional indigenous and complementary medicines are also rooted in a holistic approach incorporating physical, cultural, and spiritual well-being (Adams et al., 2015; Gall et al., 2018). Indigenous health practices include bush medicine, healers, singing and chanting, and other external herbal remedies that indigenous peoples use to connect or reconnect to their land, spiritual, and ancestral roots (Gall et al., 2018). While there is limited research literature on traditional indigenous and complementary medicine use with indigenous cancer patients (Gall et al., 2018), the role of CAM, in general, has increased for cancer patient issues, experiences, perceived benefits, decision making, and patient-practitioner interaction and communication (Gall et al., 2018).

Naturopathy and Homeopathy

Practitioners of naturopathy and homeopathy also tend to be holistic and based on the nature and natural remedies—herbs, botanicals, enzymes, amino acids, vitamins, minerals, etc.—to treat many ailments (Cassileth, 2008).

Naturopathy. Naturopathy is a system of healing that considers illness the result of a body imbalance in the processes the body typically uses to heal itself. Restoring these imbalances is based on a modification of diet; use of herbal medicine(s), acupuncture,

hydrotherapy, and massage; and application of six principles: 1) the healing power of nature; 2) the identification and treatment of the cause of disease; 3) the concept of 'first do no harm'; 4) the notion of doctor as a teacher; 5) the treatment of the whole person; and 6) the prevention of occurrence or recurrence of the disease (Poorman et al., 2001). Naturopathy supports cancer treatment and prevention by boosting and sustaining the immune system, minimizing inflammation after surgery, reducing the side effects of radiotherapy, chemotherapy, and other drug therapies, and, among others, supporting coping with mental and emotional stresses (Rothenberg & Barrett, 2020).

Homeopathy. Homeopathy is also a complete system of medical theory and practice. Based on the law of similars—that like cures like (Hahnemann, in Samuels et al., 2018)—homeopathy is thought to work on physical and psychological levels to "…. restore the body's 'vital force'" (Samuels et al., 2018, p. 487). Homeopathy "…uses both 'low potency' (i.e., <12C, or a dilution $<10^{-24}$) and 'high potency' (i. e., >12C, or a dilution $\geq 10^{-24}$), with the former used for acute and physical symptoms, the latter for chronic and psychological symptoms" (p. 487). Homeopathic medicine is increasingly used in the United States for cancer patients, is one of the most popular forms of CAM used for cancer patients in one out of every two European countries, and is gaining popularity for cancer treatment in India and South America (Sharma & Sharma, 2019). However, Samuels et al. (2018) explained, "Because homeopathy uses highly diluted compounds, as well as its homeopathic approach to patient care (*vs.* the allopathic paradigm of conventional medicine), this complementary medicine therapy remains one of the most debated modalities in integrative oncology" (p. 487). Yet, homoeopathy is used in cancer diagnosis about 6% of the time and for breast cancer specifically about 24% (Sharma & Sharma, 2019).

Cancer patients have reported several reasons for the use of complementary alternative medicines and therapies including “increasing one's chances of survival, alleviating adverse treatment effects, detoxifying the body, boosting immunity, enhancing quality of life, fostering a sense of control, and aiding conventional treatment” Gross et al., 2007, p. 293). Documentation of the use of CAM therapies for advanced stage cancer ranges from 45% to 88% (Gross et al., 2007).

Religiousness and Spirituality

Among CAM forms are religiousness, spirituality, and the use of faith and prayer. Faith and prayer are the cornerstones of religion and spirituality. Indeed, Lewis (2017) asserted that faith and prayer are some of the most common forms of CAM. However, as forms of CAM, faith and prayer are not well understood (Buckner et al., 2018; Neuhouser et al., 2016; Porter et al., 2019; Tolson, 2019). This is because the relationship between health and religiousness or health and spirituality is still fairly elusive in the empirical world. Puchalski et al. (2019) asserted, “Man is not destroyed by suffering; he is destroyed by suffering without meaning” (p. 352). For women with stage IV breast cancer, a cure is not always possible; however, there is a belief that there is room for healing (Puchalski et al., 2019). A position holds that spirituality and practices help a cancer survivor to live longer by coping (Puchalski et al., 2019). Patients who are spiritual and have spiritual practices use beliefs in coping with their illnesses and life stressors—leading to depression, anxiety, and stress—associated with their breast cancer diagnoses (Ahmadi et al., 2019; Buckner et al., 2018; Greenlee et al., 2017; Hajian et al., 2017; Movafagh et al., 2017; Neuhouser et al., 2016; Puchalski et al., 2019; Roh et al., 2018; Seiler & Jenewein, 2019). It is noted that spirituality is an essential part of life (Clinton & Hawkins, 2011; Puchalski et al.,

2019). Spiritual commitment tends to enhance recovery from illness and surgery; it results in higher levels of self-esteem (Clinton & Hawkins, 2011; Puchalski et al., 2019).

Aspects of Spiritual Care

There are specific aspects of spiritual care that help the breast cancer survivor after her breast cancer diagnosis (Steinhorn et al., 2017). The research listed these aspects, including practicing compassionate presence; listening to patients/clients' fears, hopes, pain, and dreams; obtaining a spiritual history; being attentive to all dimensions of patients and their families including their faith; and when appropriate, incorporating and integrating spiritual practices with the patient/client (Clinton & Hawkins, 2011; Holt et al., 2008; Hosseini et al., 2016; Hulett & Armer, 2016; Jim et al., 2015; Koenig, 2012; Movafagh et al., 2017; Park et al., 2015, 2018; Pearce et al., 2018; Peteet & Balboni, 2013; Puchalski et al., 2019; Rao et al., 2015; Roh et al., 2018; Sabado et al., 2010; Salsman et al., 2015; Steinhorn et al., 2017; Wright, 2019; Xing et al., 2018). It is important to note that there is a link between spirituality, health, and healing, which is well-established as contemporary spirituality is marking its territory in today's healthcare arenas (Puchalski et al., 2019). The counselor or caregiver must emphasize the importance of spiritual care and the spiritual needs of the patient/client (Puchalski et al., 2019).

Faith and Breast Cancer Treatment

Faith is an essential element in guiding most aspects of Christians' lives, who make up 79.5% of the American population (Lewis, 2017). However, faith is also considered a powerful resource that alleviates stress and brings real comfort, which can be effective in adapting, and returning to life (Brown & Cowart, 2018; Clinton & Hawkins, 2011; Lewis, 2017; Nakane & Koch, 2017; Roh et al., 2018; Saunders et al., 2017). Deuteronomy 31:6 states, "Be strong and bold; have no fear or dread of them, because it is the Lord your God who goes with you; he will

not fail you or forsake you" (New International Version). The research is limited on the actual faith of breast cancer survivors; however, faith is a part of the healing process of women who have been diagnosed with breast cancer (Clinton & Hawkins, 2011).

The Use of Prayer in Breast Cancer Treatment

Research in the United States indicates that 64.1% of communities use prayer (Rao et al., 2015). Rao et al. elaborated, saying, "Spiritual healing is systematic and purposeful intervention by one or more persons aimed to help another person by focused intention to improve their condition" (p. 1). Research has shown that spirituality plays a prominent role in the lives of most palliative patients, whether or not they adhere to a specific religion or belief (Steinhorn et al., 2017). Focused hope with prayer centers on the cancer cure, which is on a different spectrum of intrinsic hope, offering a more realistic and resilient emotional foundation (Steinhorn et al., 2017).

The Use of Spiritually Based Support in Breast Cancer Treatment

A spiritual support team, which could include church leaders and members, family, and/or friends, can make a difference in the overall quality of life of the breast cancer survivor (Akram et al., 2017; Mclaughlin et al., 2016; Sabado et al., 2010; Sharma et al., 2010). For example, incorporating spiritually based content into church-based breast cancer education could be a promising health approach for women (Brown & Cowart, 2018; Clinton & Hawkins, 2011; Holt et al., 2008; Koenig, 2012; Kuhl, 2015). Another research points out that spirituality supplies considerable emotional and logistical assistance to survivors and their support team (Sabado et al., 2010). The use of spirituality for guidance and coping affects the quality of life for the cancer survivor as well as for the support team (Sabado et al., 2010). Other studies reiterate that support is an important role and multi-dimensional need that should frequently be

provided to breast cancer patients, which impacts the entire family and can cause a disruption in the daily lives of the caregivers (Williams & Jeanetta, 2016).

Conceptual Framework

Schreiber and Edward (2015) asserted, “Religion and spirituality are much studied coping mechanisms; however, their relationship to changes in behaviors, relationships, and goals is unclear” (p. 612). Given that this study focused on faith and prayer for women with stage IV breast cancer, the pursuit of theory on behavior changes (and decision making) was deemed necessary. In addition, it was necessary to take consider more than just patient demographics and physical needs and instead to include demographic, cognitive, social, and personality trait factors that inform cancer patient CAM form decision-making. Therefore, the conceptual models used to frame this study are 1) Balneaves et al.’s (2012) CAM decision-making process model and 2) Chowdhuri and Kundu’s (2020) CAM modality integrated decision-making model. Both of these are based on Montbriand’s (1995) decision tree model describing alternate health care choices made by oncology patients.

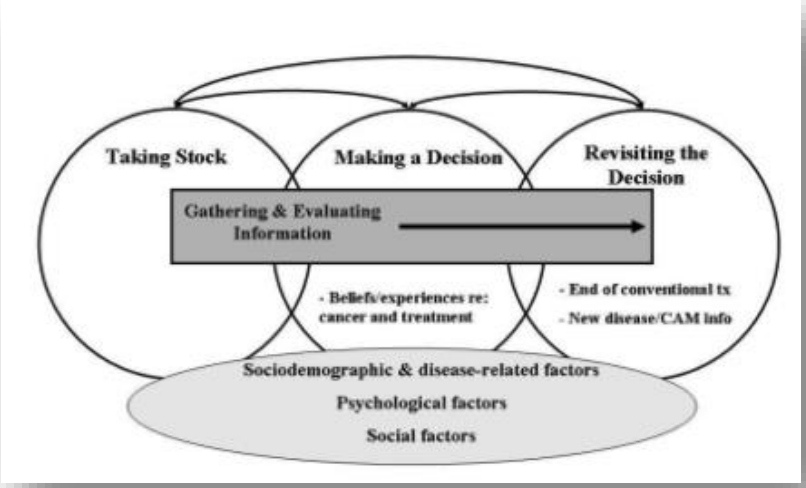
General Patient CAM Decision Making

Several authorities (e. g., Balneaves et al., 2012; Chowdhuri & Kundu, 2020; Jones et al., 2019; Weeks et al., 2014) have outlined patient decision-making regarding CAM use. In such models, patient behavior is explained as covering three phases: early, middle, and late. The early phase of CAM decision-making begins when the cancer is diagnosed; the middle phase supports a decided-upon CAM protocol based on the individual cancer patient’s beliefs, needs, and unique experiences; and the late phase occurs as the individual cancer patient becomes a survivor. In general, the CAM decision making for the cancer patient involves four behaviors: 1) taking stock of the [alternative] treatment options; 2) gathering and evaluating cam information; 3) making

CAM decisions; and 4) revisiting the CAM decision (Balneaves et al., 2012, p. 74). Figure 1 below demonstrates.

Figure 1

Complementary and Alternative Medicine (CAM) Decision-making Process



(SOURCE: Balneaves et al., 2012, p. 75)

As Balneaves et al. (2012) explained, "Unlike many rational treatment decision-making models presented within the health care literature, the CAM decision-making process has been described as a dynamic and iterative process that is highly variable across individuals" (p. 74).

Decision-Making Factors for Cancer Patients

The four-phase process outlined by Balneaves et al. (2012) includes social, demographic, disease-related, psychological, and social factors that influence cancer patients' CAM decision-making. In addition to going through phases of CAM decision making, cancer patients have been identified for what factors affect their CAM form decision making. Chowdhuri and Kundu (2020) considered demographic, cognitive, social, disease burden, and personality trait factors that influence treatment decisions. These factors contribute to cancer patients' behavior that, in

turn, affects outcomes of well-being and quality of life (Akram et al., 2017; Levers, 2012). Akram et al. (2017) characterized the individual's perception of her position in life in the context of the culture and value systems in which she lives and in relation to her goals, expectations, standards, and concerns. Improvement and sustenance of the quality of life of breast for cancer patients is the primary objective of medical and therapeutic careers (Akram et al., 2017; Levers, 2012). The CAM decision-making models reflect the complex, interactive, integrated process for patients diagnosed with breast cancer who turn to traditional medicine to target the cancer and treat the physical body but who also rely on one or more forms of CAM to tend to their physical, cognitive (mental), affective (emotional), social, and/or spiritual health, healing, and well-being (Gochett, 2015; Hawley et al., 2016; Lane et al., 2019; McVeigh & Kerin, 2017; Youl et al., 2019).

Related Literature

Partial answers to the research questions that guided this study can be found in some current research literature. Three themes are reflected: 1) the influence of breast cancer stage diagnosis on the choice of treatment options (Bellavance & Kesmodel, 2016; Gochett, 2015; Hawley et al., 2016; Lane et al., 2019; McVeigh & Kerin, 2017; Youl et al., 2019); 2) forms of CAM used by breast cancer survivors (Bahall, 2017; Buckner et al., 2018; Eckard Lambe, 2013; Gall et al., 2018; Greenlee et al., 2016; Johnson et al., 2018; Jones et al., 2019; Neuhouser et al., 2016; Ogunkorode, 2019; Porter et al., 2019; Sun et al., 2016; Tolson, 2019); and 3) the effects of faith and prayer on health (Ahmadi et al., 2019; Buckner et al., 2018; Carlson, 2012; Clinton & Hawkins, 2011; Greenlee et al., 2017; Hajian et al., 2017; Hulett & Armer, 2016; Neuhouser et al., 2016; Roh et al., 2018).

Influence of Breast Cancer Stage Diagnosis on Choice of Treatment Options

Some researchers maintained, "[Breast cancer] tumor characteristics, including tumor size, lymph node involvement, and stage, have all been shown to influence treatment decisions" (Bellavance & Kesmodel, 2016, para. 9). However, while research into how breast cancer stage influences treatment decisions for all stages and treatment modes are scarce, some researchers have investigated certain treatment decision-making factors (Gochett, 2015; Hawley et al., 2016; Lane et al., 2019; McVeigh & Kerin, 2017; Youl et al., 2019).

The literature has focused on treatment decisions for patients with early-stage (I or II) breast cancer. For instance, Hawley et al. (2016) found that patients newly diagnosed with early-stage breast cancer face a series of complex decisions across their care continuum. Loco-regional treatment plans are typically the first, most difficult, and perhaps most significant decisions they make because the decision will be based on either breast conservation therapy (lumpectomy with radiation) or total breast removal treatment (mastectomy; Gochett, 2015; Hawley et al., 2016; Lane et al., 2019; McVeigh & Kerin, 2017; Youl et al., 2019). When the treatment option was surgery such as mastectomy, Youl et al. (2019) noted that breast cancer surgery eligibility depended upon several factors—clinical factors (including stage, tumor size, grade, previous history of breast cancer or breast disease) and non-clinical factors (including age, socioeconomic status, and geographical location).

Other research has focused on treatment decisions for patients with stage IV breast cancer, which, to an extent, is relevant to this study. For example, Lane et al. (2019) conducted a study with 24,015 women with breast cancer. The researchers reported that of the total number of participants, 13,505 women (56.2%) underwent systemic therapy alone, and 10,510 women (43.8%) underwent surgical resection. The authors noted that "Treatment with systemic therapy

before surgery was associated with larger tumor size" (p. 537). Other research include treatment decisions for specific stages and characteristics, such as ER-positive early-stage breast cancer—while pointing out the importance of getting the proper care for severe stages but avoiding that same treatment and sparing the fallout of intensive traditional treatment for low-risk patients (McVeigh & Kerin, 2017). For instance, McVeigh and Kerin wrote:

> Implementation of the Oncotype DX assay has led to a change in the manner in which chemotherapy is utilized in patients with early-stage, estrogen receptor (ER)-positive, node-negative breast cancer; ensuring that patients at highest risk of recurrence are prescribed systemic treatment, while at the same time sparing low-risk patients' potential adverse events from therapy unlikely to influence their survival (p. 393).

Similarly, Gochett (2015) studied the factors that influence the transition from primary treatment to early survivorship for 56 middle-aged Caucasian breast cancer survivors diagnosed at an early stage and who had opted for treatment with either radiation therapy alone, chemotherapy alone, or combined treatment modality with both radiation therapy and chemotherapy. While the research focused on transitioning factors, the researcher discussed psychological well-being as important in terms of survivors being engaged in activities of life associated with being independent, having a purpose in life, self-acceptance, personal growth and development, having positive relationships with others, and mastering one's environment. The findings implied that choices made were based on such factors that go beyond physical well-being alone.

Forms of Complementary Alternative Medicine (CAM) used by Breast Cancer Survivors

A good amount of research has been done to discern what forms of CAM have been used by women diagnosed with breast cancer (Bahall, 2017; Buckner et al., 2018; Eckard Lambe,

2013; Gall et al., 2018; Greenlee et al., 2016; Johnson et al., 2018; Jones et al., 2019; Neuhouser et al., 2016; Ogunkorode, 2019; Porter et al., 2019; Sun et al., 2016). Much of the research was acknowledged earlier in this chapter, but evidence-based literature should be further discussed (manual therapies such as chiropractic or massage services for urban residents).

A daunting report was made by Johnson et al. (2018), who studied refusal of conventional cancer therapy and survival among 1,901,815 patients from 1,500 Commission on Cancer–accredited centers across the United States. They were diagnosed with [curable] non-metastatic breast, prostate, lung, or colorectal cancer. The researchers found that of those patients who received traditional cancer treatment and used CAM, those who received traditional cancer treatment and CAM but refused additional traditional cancer treatment had a higher risk of dying. However, a study by Neuhouser et al. (2016) revealed that of 707 women diagnosed with stage I-IIIA breast cancer, 60.2% reported using one or more forms of CAM post-diagnosis. Of all 707 women in the study, only 70 breast cancer-specific deaths were reported. The most chosen form of CAM (51%) was natural products, 42% of whom also chose plant-based estrogenic supplements (42%). Twenty-seven percent of the participants chose manipulative and body-based practices, and 13% chose alternative medical systems. However, no connections were made between CAM use and breast cancer-specific mortality.

Greenlee et al. (2016) focused a pilot study on breast cancer treatment initiation and adherence using combined chemotherapy and CAM. To determine whether CAM use is associated with decreased breast cancer chemotherapy initiation, the team recruited and interviewed 685 women under the age of 70 diagnosed with non-metastatic invasive breast cancer from Columbia University Medical Center, Kaiser Permanente Northern California, and Henry Ford Health System. Focused on five forms of CAM (vitamins and/or minerals, herbs

and/or botanicals, other natural products, mind-body self-practice, mind-body practitioner-based practice), the researchers found that a) 598 women (87%) reported CAM use at baseline; b) when chemotherapy was indicated, 272 women (89%) initiated chemotherapy, compared with when chemotherapy was discretionary, and 135 women (36%) initiated chemotherapy; c) when chemotherapy was indicated, dietary supplement users and women with high CAM index scores were less likely than non-users of dietary supplements to initiate chemotherapy; d) there was no significant relationship between mind-body practices usage and chemotherapy initiation; and e) there was no significant relationship between CAM use and chemotherapy initiation when chemotherapy was discretionary.

Some of the literature were focused on one form of CAM or alternative medical system, such as traditional Chinese medicine. Porter et al. (2019) conducted studies focusing on Chinese herbal medicine, specifically in the treatment of hot flashes and night sweats—a side-effect of breast cancer endocrine therapy. To collect qualitative data, including narrative data of women's experiences of hot flashes and night sweats and results from participating in a Chinese Herbal Medicine (CHM) trial to alleviate the side effects, the researchers conducted semi-structured focus groups with eight breast cancer survivors. Analysis of the quality of life data and data related to the acceptability and feasibility of CHM as a management option for hot flashes and night sweats revealed that women disliked the taste but were motivated to reduce side effects of endocrine therapy, and that despite the psychosocial and physiological implications of side effects, women were motivated to "…'give it [CHM] a go', [while struggling with] "avoidance and acceptance", "routine and reward", and the "transitioning to survivorship" (n. p.).

Bahall (2017) studied who, among all cancer patients, used some form of CAM. Of the cross-sectional, convenience sample of 350 patients from the Oncology Department of San

Fernando General Hospital in Trinidad and Tobago, 138 (39.6%) had been diagnosed with breast cancer. Among the 137 patients who used at least one form of CAM, it could be concluded that a little over half of these women (about 54% of the women), as breast cancer patients, used at least one form of CAM. Important reasons for CAM use were reported by breast cancer patients (n) as including a) disappointment with conventional medicine (11); b) conventional medicine being too toxic/damaging (4); c) CAM was more aligned with the patient's personal belief systems (38); d) the patient desired to take control of her own treatment (20); e) conventional medicine lacked the personal touch (4); the patient wanted to try everything that would help with (45); and f) conventional medicine was too expensive (32). Consistent with the themes of this study, the findings regarding reasons for using forms of CAM led in three areas: cost, taking control of one's own treatment, and having treatment that aligns with personal belief systems. Moreover, of all patients who used one or more CAM forms, more breast cancer and prostate cancer patients indicated that they were satisfied to very satisfied with CAM results compared to other groups (Bahall, 2017).

Some of the literature selected considered the use of faith, religion, spirituality, and prayer in the post-cancer diagnosis phases. For example, Ogunkorode (2019) conducted a study with Nigerian women who sought divine intervention, given their mistrust of traditional medicine. To investigate women's health-seeking behaviors with advanced-stage breast cancer and examine factors that motivate their specific health-seeking behavior, the researcher recruited and interviewed 30 Southwestern Nigerian women diagnosed with advanced-stage breast cancer. The findings revealed five themes: 1) that breast cancer is life-threatening, and few survive it; 2) that the enemy inflicts breast cancer; 3) that support is crucial; 4) that major barriers prevent seeking help; and 5) that making decisions of seeking help for cancer amounts to distrust, on the

part of the person living cancer and her family, of traditional medicine (Ogunkorode, 2019). The researcher concluded that for 20 participants (67%), opting for divine intervention, turning to religion, and using their strong faith in God's ability to see them through the advanced stages of breast cancer was an emotional, psychological, social, physical, and experiential coping mechanism (Park et al., 2015).

Effects of Faith and Prayer on Health

Spiritually based interventions could help the woman who has been diagnosed with breast cancer with mindfulness-based reduction, prayer, mediation, and religious coping (Ahmadi et al., 2019; Buckner et al., 2018; Carlson, 2012; Clinton & Hawkins, 2011; Greenlee et al., 2017; Hajian et al., 2017; Hulett & Armer, 2016; Movafagh et al., 2017; Neuhouser et al., 2016; Puchalski et al., 2019; Roh et al., 2018). The literature emphasized that religious coping has shown an association with spiritual/faith growth, which results in better mental health and positive outcomes following breast cancers (Ahmadi et al., 2019; Buckner et al., 2018; Carlson, 2012; Clinton & Hawkins, 2011; Greenlee et al., 2017; Hajian et al., 2017; Hulett & Armer, 2016; Neuhouser et al., 2016; Roh et al., 2018). Among the most commonly reported psychosocial interventions in breast cancer literature is mindfulness-based stress reduction and mindfulness-based cognitive therapies, which have become significant as an alternative for post-cancer treatment-related symptoms (Hjeltnes et al., 2015; Hulett & Armer, 2016; Lancaster et al., 2016; Paredes & Pereira, 2018; Pearce et al., 2018; Sapolsky, 2004; Slavich, 2016).

Furthermore, spirituality is an essential ingredient of person-centered care and is considered a critical element in the ways patients with breast cancer cope with illness, diagnosis, and treatment (Puchalski et al., 2019). Moreover, some recent research has considered the effect(s) of dimensions of religion, such as faith and prayer, as forms of CAM, on physical,

mental, emotional, and social health domains (Ahmadi et al., 2019; Hosseini et al., 2016; Lewis, 2017; Mclaughlin et al., 2016; Nakane & Koch, 2017; Park et al., 2015; Roh et al., 2018; Sajadi et al., 2018; Saunders et al., 2017).

Park et al. (2015) conducted a comprehensive meta-analysis to investigate whether there is a relationship between a) the beliefs, feelings, and practices of religion/spirituality and b) the physical, mental, and social health of cancer survivors. After a quantitative synthesis of their findings, the researchers identified three dimensions of religion/spirituality (cognitive, affective, and behavioral) and the impact on three health domains (physical, social, and mental): the cognitive (and "other") dimension of religion/spirituality consistently related to physical, mental, and social health (Ahmadi et al., 2019; Buckner et al., 2018; Carlson, 2012; Clinton & Hawkins, 2011; Greenlee et al., 2017; Hajian et al., 2017; Hulett & Armer, 2016; Movafagh et al., 2017; Neuhouser et al., 2016; Puchalski et al., 2019; Roh et al., 2018). The behavioral dimension of religion/spirituality had a small association with social health and was not significantly related to physical or mental health. The affective dimension of religion/spirituality more strongly impacted mental health outcomes and was also significantly related to physical and social health (Park et al., 2015).

Hosseini et al. (2016) conducted a pilot study of the Islamic perspective of the effectiveness of spiritual intervention on physical and psychological (bio-psychological) health in breast cancer patients. The researchers collected blood samples from 57 volunteer females with early breast cancer before and after spiritual intervention to analyze the changes in dopamine gene receptor expressions as the main site of effect. These spiritual interventions included prayer, patience, reliance, self-sacrifice and forgiveness, altruism and kindness, remission and repentance, thankfulness, *zikr* (mantra), meditation, and death concepts backed by

the Quran, Islam, and international standards emphasizing peace, human growth and perfection, and accepting God as an eternal source of power and kindness. These spiritual interventions build trust and reduce stress. The researchers found that peripheral blood mononuclear cell samples analyzed by real time-PCR showed significant reductions in dopamine gene receptor (DRD1-5) expressions compared to baseline/pre-test scores and the control group scores. They concluded,

> Spiritual intervention based on Islamic principles can bring back mental health, increase hope and quality of life and eventually change dopamine gene receptor expressions resulting in the reduction of cell proliferation, thus better prevention and management in breast cancer patients compared to other forms of treatment (p. 930).

Ahmadi et al. (2019) also focused on Islamic religion and mental health (meaning-making coping) with cancer patients in Malaysia. The researchers emphasized the influence of culture on coping method choice. Interviews with 29 Malay patients, ages 29 to 60 and with up to 25 years of survival longevity from different types of cancer, uncovered four kinds of coping resources, including (1) relying on transcendent power, (2) supernatural or mystical beliefs, (3) finding oneself in relationships with others, and (4) nature. The researchers concluded that strong Islamic culture strongly impacts coping methods and attitudes to being cancer patients.

Nakane and Koch (2017) believed in faith and religiosity, which includes the impact on spiritual well-being, as indicated by coping with breast cancer. Following interviews with 28 breast cancer patients who also completed a Spiritual Well-Being Scale, the researchers found spiritual well-being was positively associated with spirituality/religiosity as it lent to a) acceptance of diagnosis, b) treatment adherence, and c) prospects for the patient diagnosed with

breast cancer. The researchers concluded that faith and religiosity "present themselves as the determinant, potent, and active factors in their clinical treatments and in their lives" (p. 103).

Sajadi et al. (2018) also investigated the spiritual well-being of cancer patients as it is influenced by spiritual counseling. Sajadi et al. conducted a randomized clinical trial with 42 female cancer patients in Iran. The researchers implemented either eight weeks of a spiritual counseling intervention (for 21 participants) or routine education and care (for the control group of 21 participants) and assessed spiritual well-being using the Spiritual Well-Being Scale. Findings included that, at baseline before the intervention, there was no significant difference in scores for religious and existential well-being. However, following the intervention, there was a significant difference between the two groups' scores in all three subscales—religious, spiritual, and existential well-being. The researchers concluded that spiritual counseling does have a significant, positive impact on spiritual well-being in Iranian women diagnosed with breast cancer.

Roh et al. (2018) also focused on prayer and faith as they lent to spiritual coping for Native American or American Indian women who were cancer survivors. The researchers conducted a qualitative study with a community-based participatory research design with 43 American Indian women survivors of breast cancer (n = 14), cervical cancer (n = 14), and colon and other types of cancer (n = 14). The researchers found a) that prayer was an important part of cancer coping and recovery for 32 (76%) of the women in the study and b) that faith was an important part of cancer coping and recovery for 15 (36%) of the participants. The research findings led them to conclude that spiritual faith and traditions provided women with cancer with a reliable source of comfort, strength, hope, and relief.

Summary

Women diagnosed with breast cancer turn to traditional medicine to target the cancer and treat the physical body (Nakane & Koch, 2017). Nevertheless, many women diagnosed with breast cancer also rely on one or more forms of CAM to tend to their physical, cognitive (mental), affective (emotional), social, and/or spiritual health, healing, and well-being. Among these CAM forms are religiousness and spirituality and the use of faith and prayer. This chapter comprised a review of the literature. The research questions guiding the study were identified as follows:

1) *How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?*
2) *How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?*

A conceptual framework for the study was discussed, which included two conceptual models used to frame this study: 1) Balneaves et al.'s (2012) CAM decision-making process model and 2) Chowdhuri and Kundu's (2020) CAM modality integrated decision-making model. These models were chosen to align with the research on faith and prayer for women with stage IV breast cancer, as theory on behavior changes (and decision making) was considered imperative and necessary to take into account more than just patient demographics and physical needs by including demographic, cognitive, social, and personality trait factors that inform cancer patient CAM form decision-making as well.

A review of the related literature was performed that revealed research supporting each of the three major themes in the research questions: 1) the influence of breast cancer stage diagnosis on the choice of treatment options (Bellavance & Kesmodel, 2016; Gochett, 2015; Hawley et al.,

2016; Lane et al., 2019; McVeigh & Kerin, 2017; Youl et al., 2019); 2) CAM forms used by breast cancer survivors (Bahall, 2017; Buckner et al., 2018; Eckard Lambe, 2013; Gall et al., 2018; Greenlee et al., 2016; Johnson et al., 2018; Jones et al., 2019; Neuhouser et al., 2016; Ogunkorode, 2019; Porter et al., 2019; Sun et al., 2016; Tolson, 2019); and 3) the effects of faith and prayer on health (Ahmadi et al., 2019; Buckner et al., 2018; Carlson, 2012; Clinton & Hawkins, 2011; Greenlee et al., 2017; Hajian et al., 2017; Hulett & Armer, 2016; Neuhouser et al., 2016; Roh et al., 2018). The recent and related research yielded important findings that led to significant conclusions as follows: (1 The stage of the cancer may influence decisions regarding the use of one or more forms of CAM; (2) The use or combined use of CAM therapies and forms may help to reduce side effects of traditional medical treatments for breast cancer; and (3) Religion and spirituality, including faith and prayer and involving the breast cancer patient's attitudes, values, beliefs, and practices, have been evidenced to be positively associated with the breast cancer patient's physical, mental, emotional, social, and spiritual well-being (Bellavance & Kesmodel, 2016; Gochett, 2015; Hawley et al., 2016; Lane et al., 2019; McVeigh & Kerin, 2017; Youl et al., 2019); forms of CAM used by breast cancer survivors (Bahall, 2017; Buckner et al., 2018; Eckard Lambe, 2013; Gall et al., 2018; Greenlee et al., 2016; Johnson et al., 2018; Jones et al., 2019; Neuhouser et al., 2016; Ogunkorode, 2019; Porter et al., 2019; Sun et al., 2016; Tolson, 2019); and the effects of faith and prayer on health (Ahmadi et al., 2019; Buckner et al., 2018; Carlson, 2012; Clinton & Hawkins, 2011; Greenlee et al., 2017; Hajian et al., 2017; Hulett & Armer, 2016; Neuhouser et al., 2016; Roh et al., 2018).

CHAPTER THREE: METHODS

Overview

The purpose of this phenomenological study was to understand the role of faith and prayer, as forms of CAM, for breast cancer patients at various stages of the disease's progression and to identify key driving factors behind the overall adherence to the practice. Alongside the main purpose, the proposed research illuminated the overall effect of faith and prayer on an individual's physical, mental, emotional, and social health. It is important to note that this study used two key frameworks, the CAM decision-making process and the CAM modality integrated decision-making model. This chapter describes the research design, research questions, discussion of the setting, the participants selected for this study, and my role as the researcher. Finally, a discussion of the data collection and analysis methods to ensure the trustworthiness of the phenomenological study, and the ethical considerations are included.

Design

This study was designed to obtain the extraordinary and lived experiences of women who use CAM while facing breast cancer at different stages of recovery/healing. The general design of the qualitative phenomenology study is appropriate because the focus is on women who have been diagnosed with breast cancer at different stages. Additionally, the design focused on the actual lived experiences of these survivors who implemented prayer, faith, and spirituality into their CAM and traditional cancer treatments.

Phenomenology

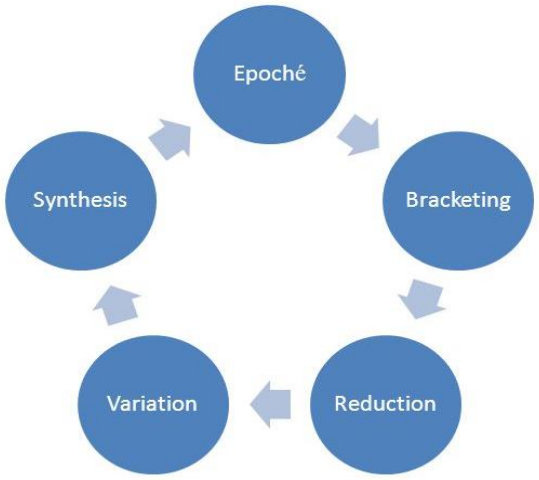
The phenomenological research approach is commonly known and originally used by Husserl in philosophy, developed by others who have integrated phenomenology within psychology and sociology (Giorgi, 2012). This specific study qualified as a transcendental

qualitative study of the participant and researcher in the participant's world (Giorgi, 2012). Furthermore, in contrast to hermeneutic phenomenology, which claims that knowledge is connected to conscious awareness, Heidegger's hermeneutic phenomenology focuses on interpretation (Giorgi, 2012). Heidegger's hermeneutic phenology rejects 'epoche' or a judgmental study, as it claims that interpretation is a requirement before understanding (Giorgi, 2012).

A transcendental phenomenological study was chosen to purposefully set aside the researcher's current thoughts, beliefs, and judgments, which lend themselves to a bias called epoche (Sheehan, 2014). Moustakas (1994) noted that epoche is a means to stay away from or abstain and a conscious process of identification and "subsequently quarantining of naturally occurring thought patterns" (p. 1032). Furthermore, phenomenology is a form of inquiry that aspires to understand the human experience (Sheehan, 2014). See figure 2.

Figure 2

Transcendental Phenomenological Analysis Main Processes



Research Questions

Curry (2018) explained that research questions are formulated to explain the purpose of the research, identify the gap in the literature, decide the method to best answer the research questions, guide the planning of the study, and help frame the analysis and findings. Furthermore, the research questions identify the complex familial, social, spiritual, emotional, and mental processes involved in the women's experiences using CAM to help recover and heal from breast cancer (Curry, 2018). The research questions used to guide this study included the following:

1) *How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?*
2) *How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?*

Setting

The setting for the phenomenological transcendental qualitative research focused on the living experiences of the women who live throughout the United States. The participants agreed to meet with me, as the researcher, through video/audio Zoom interviews due to COVID-19 protocol requirements. I conducted the Zoom interviews in Durham, NC. The participants of this study and the setting in which the interviews, cognitive representation, and focus groups were conducted provided the researcher with access to an adequate and balanced population of women recovering from breast cancer throughout the United States, which the researcher supplied a safe and secure setting through the Zoom interview, to allow the participants express themselves freely without judgment.

Participants

The sampling method for the phenomenological study ensured that the individuals/participants selected were representative of the entire population. The sampling method for this study was purposeful, criterion-based, homogenous sampling, which is appropriate when the research questions are specific to the group of interest, in this case, women who have lived experiences with breast cancer, while using CAM that may include prayer, faith, and spirituality in their overall cancer treatment (Palinkas et al., 2015). Furthermore, purposeful sampling is usually customary when a study focuses on qualitative research (Palinkas et al., 2015). Curry (2018) emphasized that the sampling site cannot be determined in advance; however, the sample size can be determined by the principle of theoretical saturation, or the point at which there were no more unique concepts noticed during the interview process. It was estimated that saturation would be established and reached by the 10th interviewee; however, the researcher determined that saturation was reached by the eighth participant.

The participants and survivors in the sampling process for this study were selected from a subset of the targeted research population: women breast cancer survivors who incorporated faith, prayer, and spirituality into their CAM cancer treatment. The participants/survivors were solicited by word-of-mouth through social media, and the researcher had a wide influence on women who were healed from breast cancer. I collaborated directly with these women to establish trust, as I recruited them as appropriate participants in this study. I used Zoom to conduct the interviews with the participants/survivors during COVID-19 restrictions.

Procedures

I, as the researcher, had approval from Liberty University's Institutional Review Board (IRB) before initiating the study (Appendix B). After obtaining IRB approval, I developed and

completed contact with the participants, some of whom I have known throughout my military and civilian career, and other acquaintances in my neighborhood. The potential participant's contact information was obtained through email as the COVID-19 pandemic continued. Furthermore, a recruitment letter (Appendix C) and screening questionnaire (Appendix D) was sent to the potential participants by email, explaining the purpose and requirements for their participation in the study and the screening questionnaire (Appendix D). The screening questionnaire was used to determine the participant's potential to meet the criteria for the study and make certain that the potential participant was living in the United States.

The Researcher's Role

Because the researcher is the instrument in a semi-structured or unstructured qualitative interview, the researcher should develop competence in methods that include explaining the study without biasing the potential participants (Pezalla et al., 2016). Most of the potential participants are known to me through my military career, counseling career, and ministry. Furthermore, according to the transcendental approach to the study, the importance of keeping a journal of my interaction with the potential participants will help with recording my responses, thoughts, and feelings to limit my own biases as a cancer survivor (Pezalla et al., 2016). Thompson (2018) recognized that the researcher's interpretations are a spirited and lively part of building meaning throughout the study.

As a woman who was a stage IV breast cancer patient and who has recovered from breast cancer, I have experienced the trauma, pain, loneliness, sorrows, stressors, and heartache that comes with cancer treatment. As a breast cancer survivor, I know my own biases and perspectives on treatment; however, it was important to allow the participants share their lived and spiritual experiences during the cancer treatment. There was a level of curiosity to

understand whether they implemented CAM into their treatment or whether they went the traditional science route to their cancer treatment. Finally, I hold a spiritual and Christian perspective on healing and recovering from breast cancer; however, some patients focus solely on the traditional methods of cancer treatment, so research is needed to validate the importance of both.

Data Collection

The qualitative data collection methods most used in health research are document study, observations, semi-structured interviews, and focus groups (Busetto et al., 2020). The required data collection method was interviews; therefore, a pilot study was implemented to test the validity and relevance of each interview question. Busetto et al. (2020) believed a focus group is needed to ensure cognitive representations were reviewed. On completing the pilot study, I developed and established a focus group and the interview questions, and after receiving IRB approval I conducted an unstructured interview. Busetto et al. (2020) noted that cognitive representation and interpretation by participants were conducted at the end of unstructured interviews to help the researcher understand participants' lived experiences during breast cancer treatment.

Interviews

Effective interviewing is a data collection method that broadens the interviewer's professional knowledge of the lived experiences of the interviewee (Quinney et al., 2016). Phenomenological interviews have implications of an interactive and informal approach that produce a specific understanding of the phenomenon studied (Moustakas, 1994). Quinney et al. (2016) proposed at least one semi-structured interview to be conducted to ensure that the potential participants' have the freedom to share their lived experiences. Before the interviews

began with each participant, the purpose of the study was explained to ensure they felt safe and feel comfortable with sharing their lived experience. Furthermore, confidentiality is crucial to the participants' feeling comfortable enough to be candid (Quinney et al., 2016). As a licensed counselor, it is necessary to begin each session with:

> There are some questions that may be too difficult for you to answer, as it may bring back your trauma; however, please take as much time as you need, and we can take a break to grab a snack/water and get some fresh air.

Self-Identification and Breast Cancer Baseline:

1. Please introduce yourself to me as if we just met one another.
2. When were you diagnosed with breast cancer, and what stage of breast cancer were you diagnosed with?
3. How was the breast cancer originally detected?
4. Express how you felt when you received the news of your breast cancer diagnosis.
5. What is the first thought that comes to mind when you think of your experiences with breast cancer?

Support:

6. What was your support system during your recovery from breast cancer; family and/or friends?
7. Can you please share the people and organizations who made up your personal support system/team during your CAM treatment?

The Treatment Process:

8. Can you please tell me about your treatment process?
9. How did you come to the conclusion of choosing the traditional treatment vs. CAM treatment when treating the breast cancer?

10. What type of CAM treatment did you decide to use as an alternative to traditional treatment?
11. Can you please share with me what made you seek other alternative forms of treatment for the breast cancer?

The Road Less Travelled:

12. Please describe your experience and tell me more about your journey as a recovering breast cancer survivor.
13. Do you incorporate prayer, scripture, mediation, or any other forms of spirituality into your CAM treatment?
14. Did you face any obstacles during the treatment process? If so, how did you overcome those obstacles?
15. Which aspect of treating the breast cancer was the most rewarding?
16. Can you please describe any and all milestones in choosing the CAM treatment vs. traditional chemo treatment?

Psychological and Emotional Outcomes:

17. What events or experiences were the most difficult for you during your treatment of choice?
18. What were the biggest challenges for you during your recovery from breast cancer; you can include mental and emotional as well as physical.
19. What do you feel are some emotional or psychological effects of facing these challenges?
20. Describe how you have thought about your overall condition through the treatment process.

21. Were there any time of depression? List those symptoms of depression you may have experienced during your journey.

Adjustment:

22. How have you coped with depression as a healthier measure to a full recovery from breast cancer? How has CAM helped in this endeavor?

Conclusion:

23. Thank you very much for being willing to participate in this interview and this study. You have given me a lot of information, and it is greatly appreciated. I have one more question before we finish today: Do you have anything that you want to add so that I have a better picture of your experiences with breast cancer and your treatment of choice?

Questions one through five were intended to have the survivor give a history and baseline of the cancer diagnosis. Furthermore, it was necessary to use introductions to build a safe environment for the survivor and build their trust with warmth and empathy (Vilet, 2019). These five questions made the survivor comfortable during the virtual interview, as they provided me with a sense of the survivor's context while establishing a sense of comfort in the interviewer and interviewee relationship. Finally, the five specific questions focused on the baseline for the survivor's breast cancer diagnosis and overall choice of treatment.

The survivor and breast cancer patient has a treatment choice; however, it is important to have a support system in their family, friends, organizations, and other resources to help them become a survivor of breast cancer (Ahmadi et al., 2019). Questions 6 and 7 allowed me the opportunity to learn of any organization and resources the survivor has used to add to the study and how the support team affected the overall treatment and choice of treatment.

Questions 8 through 11 focused on the survivor's treatment choice and process, which helped the survivor process their what's, why's, and when's of the treatment of choice (Ahmadi et al., 2019). One should not ignore that CAM practice revolves around various religious and cultural practices, deeply ingrained within the diagnosis, treatment, and post-survival phases. Although a wide range of cultures utilize CAM differently, the monotheistic Abrahamic religions primarily adhere to prayer and faith (Ahmadi et al., 2019). The corresponding structure of this chapter primarily focused on outlining the purpose and significance of the study and its problem statement with an emphasis on the background of the issue. It is necessary to increase the overall understanding of the role of CAM among breast cancer patients and identify the key motivating factors, where the prime manifestations of the phenomenon are faith and prayer.

Many travel a similar road when diagnosed with breast cancer—surgery, chemo, radiation, and all that goes with it. Eventually, they reach the end of active treatment. For some, the road has a different course—more aggressive treatment, harder choices to make, and active treatment that continues indefinitely (Ahmadi et al., 2019). Questions 12 through 16 were necessary to increase the overall understanding of the role of CAM among breast cancer patients and identify the key motivating factors, where the prime manifestations of the phenomenon are faith and prayer. Finally, these questions helped me understand the survivor's journey and how their faith was beneficial to their treatment outcome.

Breast cancer is a potentially traumatic event associated with psychological symptoms, but few studies have analyzed its impact on CAM treatment (Martino et al., 2019). Questions 17 through 21 focused on the emotional processing of the survivor of breast cancer. As the interviewer, it was essential to understand the emotional processing of the survivor being interviewed, and it was a successful function in integrating their traumatic experiences into their

prayer life and choice of CAM (Martino et al., 2019). The psychological and emotional outcomes of suffering from breast cancer can be traumatic and may cause depression and symptoms of depression. In addition, one's psyche can alter the success of their treatment (Marino et al., 2019).

Question 22 allowed the survivor to adjust to their traumatic diagnoses, mainly if they were in stage IV of breast cancer. Therefore, it allowed the survivors time to process their journey through breast cancer treatment and the healthy measures to overcome the horrific disease. The ideology of being an overcomer incorporates the coping skills used, including prayer, faith, positivity, and the choice to use CAM.

Question 23 concluded the interview and summarized the survivor's testimony about using CAM as a breast cancer treatment. Furthermore, it was essential for me to gather any additional information on the survivor's journey and lived experiences through breast cancer. These questions prompted the creation of a focus group that emphasized flourishing and thriving after breast cancer because the survivor chose a treatment that was not a common, such as chemo and radiation.

Cognitive Representation

At the end of each interview, the survivors/participants were asked to generate a cognitive representation of their thoughts and feelings about surviving breast cancer and their treatment choice. I provided each survivor a piece of paper and writing materials to list three positive adjectives to describe themselves as a survivor of breast cancer, to understand their perception of themselves after the rigorous treatment journey. They could provide a favorite scripture or quote that encompassed their strength. Each survivor interviewed was given 10

minutes to perform this cognitive activity and then describe who they were now after battling and surviving breast cancer. Their comments were recorded with their permission.

Data Analysis

After the interviews were completed and transcribed, as listed in the documented data analysis, I reread the transcriptions from the interviews and cognitive representations. I used the NVivo software to identify repeated words and phrases, coded the words and phrases, and counted the number of times the words and phrases were used by an individual/survivor. This included the meaning of words and phrases that were the same and/or similar. Curry (2018) believed that coding is an iterative process and recommended the following steps: a) read the transcript fully before coding; b) create initial codes and properties; c) code two or three transcripts initially; d) negotiate, revise; e) code three to five transcripts; f) repeat the steps; g) create the final code structure, and apply it to all transcripts (Curry, 2018). I used the NVivo software to help identify repetitions of phrases and/or words that were used by the survivor. With the NVivo, it is easier to code plain text and word documents than PDFs (Curry, 2018). Moreover, an integrated approach to coding was needed, as each transcribed line was coded, while I continually searched for new de novo themes that appeared as the code structure developed (Curry, 2018; Heppner et al., 2016).

Where multiple versions of the codes appeared and developed, I started with as many as 30 codes across the 10-15 survivors/participants. Furthermore, a rather deductive approach based on my own expertise was the line for line approach; however, I had full awareness and documented my own responses, reactions, challenges, benefits, and relevant biases as they arose. Curry (2018) noted that the initial codes are developed from the deductive approach and the secondary sub-codes are developed from the emerging data. Heppner et al. (2016) addressed the

code structure adjustment process as the recorded and transcribed interview data was analyzed and then reanalyzed. I compared the interview data with previous literature, discussed any differences and any stand-out information that seemed to be missing with Dr. Volk, my chair.

Document Analysis

Neubauer et al. (2019) believed the necessity of data analysis is essential to the overall phenomenological purpose of this study, as it seeks to describe the essence of the phenomenon by focusing on the perspective of lived experiences of the women who have integrated CAM into their treatment plan for breast cancer. Furthermore, the data analysis included identifying, examining, and interpreting patterns and themes in the textual data (Neubauer et al., 2019). It is important to emphasize that the specific goals of the data analysis included the connections and interrelations concurrent with the data collection, constituting a cyclic process that involves continual reflection (Data Analysis: Analyzing Data in Qualitative Research, n.d.). The same author maintained that sorting and coding data can result in distortions or misunderstandings.

The major problem with sorting and coding is that, at times, when organizing the data, breaking it up into segments can potentially obliterate the intended meaning as conveyed by the interviewee—the survivor and her story—making it less related to the specific goal of the study that informed the data analysis (Data Analysis: Analyzing Data in Qualitative Research, n.d.).

After personally transcribing each interview, the completed transcripts from the interviews were used to note any relevant expressions of each survivor interviewed. Transcribing the interviews is the first step in the data process to help understand the survivors' lived experiences (Curry, 2018). Any statement that drew significance to the survivor's overall lived experience was important to the interview and data collected. Significant statements are the

second step to data analysis, which explain how the survivors experienced the phenomenon (Curry, 2018; Heppner et al., 2016).

Heppner et al. (2016) illustrated the importance of qualitative data analysis and the five phases, which include compiling data into a database; however, in this case, it involved recording and transcribing the interviews, cognitive representations, disassembling or coding the data, or finding the themes, and reassembling the data as patterns were discovered. The third step of data analysis examined the connections and correlations in the survivors' experiences (Curry, 2018; Heppner et al., 2016). These included core themes, reflecting a higher level of abstraction and allowing for comparison between different texts (Curry, 2018). Finally, it is imperative for the interviewee to minimize or reduce the data to meanings that are approached with an open mind to the experience of the phenomenon (Neubauer et al., 2019). Content analysis was used to categorize the collected data to classify, summarize, and record/tabulate the data (Neubauer et al., 2019).

Curry (2018) highlighted that qualitative research acknowledges the positionality or the researcher's standpoint as an important validity standard. Furthermore, as the interviewer who performed the interviews, I must understand my own personal journey which I underwent with breast cancer, as it may present challenges/barriers and benefits. Curry noted that a researcher's own lived experience can lead to bias in the interview and data analysis phase. Neubauer et al. (2019) identified these challenges by ensuring that the validity of the results and the interpretation were grounded in direct quotes from the data. Therefore, to address these transference challenges, I will keep a journal to help me with my own emotional self-awareness and the pain/suffering I have gone through so as not to create biases in the interview and data analysis process.

Epoche

Berger (2015) mentioned that applied skills to the qualitative process are necessary. Furthermore, Berger explained that the goal of epoche or reflexibility is to allow the researcher to be aware, monitor, and account for their values, beliefs, knowledge, and biases that may impact the data generation, relationships with the researchers and participants/survivors, and data analysis. Therefore, implementing mindfulness skills and the explicit development of bracketing and reflexibility is very important to qualitative research (Berger, 2015). This allowed me achieve a sophisticated level of research reflexibility/epoche. Researcher reflexibility is not an automatic skill; therefore, it was a conscious choice on my part, which had to be practiced before the interview process began and for awareness to develop (Berger, 2015).

Phenomenological Reduction

The shift, known as the reflexive researcher stance, embodies the 3rd stage, which is phenomenological reduction and is essential for understanding phenomenological research (Berger, 2015). It is imperative, in this stage, to develop an understanding of the meanings of the phenomenon. Thus, phenomenological reduction is the phase where the researcher sees things as they are described (Berger, 2015; Moustakas, 1994). Furthermore, phenomenological reduction or bracketing must follow to observe the phenomena from all perspectives and draw together a pure subjectivity as much as possible (Berger, 2015).

The interview and cognitive representation experiences were reduced to language that describes both actions and inward consciousness (Moustakas, 1994). Phenomenological reduction is required in the graded pre-reflection, reflection, and reductions, with the goal of getting to the main essence of the experiences (Berger, 2015). After fulfilling the reduction

process, I journaled my own ideologies, biases, and pains; as a way to record and reflect on these areas and my reactions, responses to, thoughts, and feelings regarding the process of, experience within, and the reflections after the interviews, and cognitive process.

Variation and Synthesis of Meanings

The last step in qualitative data analysis is variation and synthesis of meanings. This last step uses the imaginative variation and synthesis of meaning to explore the various possible meanings of the breast cancer survivors' experiences and synthesize the data that generates a continuous statement highlighting the quintessence of the full picture (Berger, 2015; Moustakas, 1994). Therefore, the last step in the qualitative data analysis was to synthesize the meanings of each survivor's statements and finalize the data by using re-reflection, journaling, and transcriptions from the interviews, the cognitive representation, and NVivo.

Trustworthiness

Trustworthiness addresses credibility, dependability, transferability, and confirmability. Elo et al. (2014) established that trustworthiness should be scrutinized at every phase of the data analysis process, including the preparation, organization, and reporting of results. Furthermore, these phases should give the researcher and the reader a clear indication of the overall trustworthiness of the study (Elo et al., 2014). Improving the trustworthiness focuses on the researcher and can be verified by providing accurate details of the sampling method and participants' descriptions of their lived experiences with breast cancer (Elo et al., 2014). The current study achieved credibility by using a pilot study with methodically recorded interviews, following a specific protocol, and cognitive representations.

Credibility

Credibility refers to the extent to which the findings accurately describe reality. Credibility depends on the richness of the information gathered and the analytical abilities of the researcher; therefore, credibility is ascertaining the degree to which the data is representative of the larger population of homogeneous participants (Curry, 2018). It is understood that credibility is the first aspect or criterion that must be established (Connelly, 2016). Therefore, credibility primarily asks the researcher to link the findings with reality in order to demonstrate the truth of the study findings (Connelly, 2016). It is understood that the researcher's analytical abilities are accurate as a means of finding similarities within each survivor participant and the participant sample, which will create proficient interviewer techniques, checking the accuracy of all the transcripts and using actual quotes from the participants/survivors (Curry, 2018). Additionally, having several means of collecting data helped me to add credibility to this study. Finally, it is imperative to conduct peer reviews and member-checking to ensure accurate interpretation of the data, including the use of NVivo to analyze the correlated findings and overall data.

Dependability and Confirmability

Dependability and confirmability are similar to reliability in quantitative studies and deal with consistency, addressed by providing rich detail about the context and setting of the study (Curry, 2018). Importantly, as the researcher, I ensured dependability by providing an audit trail that described the purpose of the study, discussed the selection of participants/survivors of this study, described the process of collection, explained the reduction of the data for analysis, and discussed the techniques used to establish data credibility (Curry, 2018). Finally, dependability was established by allowing and inviting my peers to participate in the analysis stage of the

study, and a comprehensive description of the methods was provided accurately (Connelly, 2016).

Curry (2018) indicated that confirmability is the last criterion of trustworthiness and must be exhibited throughout the study. This last criterion is that the confidence level of my study findings is based upon the participants/survivors' narrative and the words rather than my biases (Connelly, 2016; Curry, 2018). The two techniques used during confirmability were an audit trail and reflexivity. These techniques helped me provide a rationale for my decisions during the research process. I adapted to my own biases, experiences with breast cancer, and potential preconceptions as they have evolved over the research process.

To make certain that I established confirmability, I journaled by recording my observations regarding each of the interviews within 48 hours after the interview and cognitive representation. Furthermore, I wrote about any of my own biases as a breast cancer survivor, as my own insights and observations. Importantly, I allowed each of the participants/survivors to lead the direction of how the interview flowed and asked for specific clarification with each interview question. This included encouraging each survivor interviewed to use their own words rather than the words used in the initial questions.

Transferability

Transferability is another aspect of qualitative research that should be considered; it refers to the possibility that what was found in one context applies to another context (Curry, 2018). Leung (2015) considered transferability as the validity of the research providing the readers with evidence that the study findings could apply to other contents, situations, and times. It is imperative to provide a dense description of the demographic boundaries of the research and

the use of the same data collection, procedures, methods, and the same inclusion criteria, to enable the research to achieve a high degree of transferability.

Ethical Considerations

In the counseling field, confidentiality, compassion/empathy, doing no harm, beneficence, justice, professionalism, nonmaleficence, and autonomy are important to protect the client—in this case—the breast cancer survivor. The ACA Code of Ethics requires that these ethical considerations are used and honored with every participant of my study (ACA, 2014). To ensure these ethical goals were established, I acquired permission from the Liberty University Institutional Review Board (IRB), prior to initiating contact with the survivors. Furthermore, each participant/survivor was advised regarding the potential emotionality of the topics to be explored and were made aware that they had the right to learn or discontinue the interview and their participation at any time. Additionally, each of the participant/survivor read, reviewed, and signed the confidentiality agreement as I was present to ensure all their concerns and/or questions were met.

Personal information about the participants/survivors' place of residence were not mentioned, nor were the clients' real names used without their permission. The participants/survivors' transcribed interviews, journals, recorded data, demographical, coding, and other pertinent information are locked in the interviewer's home in an undisclosed dislocation. Finally, the participants' identities and data were protected by not adding their names to the data. The interviews were deleted after the data was collected from each participant and the participants' names were not entered into the data.

Summary

This study was a transcendental phenomenological study regarding the lived experiences of breast cancer survivors and how they implemented faith, prayer, and spirituality into their CAM treatment. It is important to note that multiple types of data were collected and used, including semi-structured interviews and cognitive representations. My role as the researcher-participant was recorded via a research journal. Furthermore, the data was reviewed to find common themes and experiences of those women survivors of breast cancer and their treatment of choice. The data were analyzed in multiple ways, including personally completing the transcriptions, re-reading the transcriptions, and using the NVivo software. Finally, the transcriptions were reviewed with the participants/survivors to ensure accuracy.

Chapter Three provided specific details about the design and rationale, participant selection process, research questions, interview questions, site description during COVID-19 restrictions, procedures for the study, my role as the researcher as a tool in the study, as well as the data collection and analysis techniques. As a note, all specific portions of the study mentioned above were selected specifically to achieve the goal of grasping a grander understanding of the lived experiences of the women who survived breast cancer and used CAM as a way to incorporate faith, prayer, and spirituality into the cancer treatment process. Furthermore, the above-described transcendental phenomenological approach provided participants/survivors with the opportunity to describe their experiences with depth and provide a fuller understanding of the lived experiences of the women who have survived breast cancer, so that compassion, understanding, empathy, and assistance can be offered to these women.

CHAPTER FOUR: FINDINGS

Overview

The fourth chapter of the study contains the results of the thematic analysis of the interviews with the study participants. The purpose of this study was to further explore whether forms of CAM, including prayer and spirituality, add value and can help heal and even cure women with breast cancer (Kuhl, 2015). Along with the purpose, I also sought to address the following research questions:

RQ1. How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?

RQ2. How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?

To address the research purpose and questions, I performed a thematic analysis on the six interviews conducted using NVivo12 by QSR. In this chapter, I first provide the six participants' backgrounds and demographics. This section will be followed by a brief explanation of the data analysis performed to establish the research themes from the participants' responses. The next section contains the results of the thematic analysis, comprising complete themes addressing the two research questions, supported by the participants' actual responses. Finally, the chapter will conclude with a summary.

Participants

The study participants were six women breast cancer survivors who incorporated faith, prayer, and spirituality into their CAM cancer treatment. Of the six participants, only three shared their ages which ranged from 50 to 75 years old. Two participants were African Americans, and four did not share their race during the interview. Three participants were retired

army veterans, and the three other participants did not discuss their profession. Their years of diagnosis varied, and the stages were from 0 to III. Table 4.1 contains the breakdown of the participants' backgrounds.

Table 4.1

Display of the Participants' Demographics

	Age	Race	Profession	Year Diagnosed	Stage Upon Diagnosis
Participant 1	75 years old	NA	Retired	2017	Stage III (Late)
Participant 2	51 years old	African American	NA	2018	NA
Participant 3	50 years old	NA	Retired Military	NA	Stage II
Participant 4	NA	NA	Retired Veteran	2013	Stage 0
Participant 5	NA	NA	NA	2005, 2007, 2010, 2015	Stage II
Participant 6	55 years old	African American	NA	2016	Stage I

Results

To address the study's purpose and research questions, I performed a thematic analysis of the participants' interviews. NVivo12 by QSR also helped me determine the participants' most significant experiences. From the analysis, Research Question 1 had three underlying themes, and the second research question had four corresponding themes. It must be noted that I presented the study themes based on their importance or number of references shared by the participants. The themes with the most references per research question were labeled as the

major themes or the most significant/valuable study findings. The themes that followed were the other imperative experiences or the minor themes of the research. Additional themes or subthemes were also incorporated to better explain the major and minor themes. The subthemes pertain to the thorough examples of the parent or major and minor themes. Table 4.2 contains the breakdown of the number of themes generated from the thematic analysis of the six interviews.

Table 4.2

Breakdown of the Total Number of Themes

Research Question	Number of Major Themes	Number of Minor Themes	Number of Subthemes	Total Number of Themes
RQ1	1	2	0	3
RQ2	3	0	1	4
Total	4	2	1	7

Research Question	**Major and Minor Themes**	**Subthemes**	**Number of Participants**	**Number of References**
RQ1. How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?	Using one's faith as defense to breast cancer		6	20
	Receiving support from church family and faith		5	16

	community through their prayers			
	Having doctors who strongly believe that God can save them		1	2
RQ2. How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?	Believing that God made them to have a purpose in life	Being an instrument to others	6	17
	Praying constantly to survive the most difficult times during their sickness		6	15
	Having a strong faith in God that they would be healed completely		6	10

Following the breakdown of the total number of themes are the actual study themes per research question. As seen in Table 4.3, all women described their experience in seeking to engage faith and prayer praxis as a form of CAM in breast cancer treatment by using their faith as their defense against breast cancer. Five other participants added that the support from their church family and faith community through their prayers guided and helped them as they coped with their sickness. One participant shared how she had a doctor who strongly believed that God

would make a way and save her from cancer. When asked about how women describe their decision process in choosing faith and prayer as a form of CAM in their breast cancer treatment, three major themes emerged. Participants believed that God made them have a purpose in life; they prayed constantly to survive the most difficult times during their sickness, and had a strong faith in God that they would be healed completely. Table 4.3 contains the display of the complete study themes.

Table 4.3

Breakdown of the Study Themes Addressing RQs 1 and 2

Research Question 1. How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?

The first research question explored how women described their experiences in seeking to engage faith and prayer praxis as a form of CAM in breast cancer treatment. With the analysis of the interviews, one major theme and two minor themes were established. All participants held on strongly to their faith after their diagnosis and treatment. Another five participants acknowledged the role of their family and friends in faith as they went out of their way to help and pray for them. The last minor theme received just one reference and may need further research to solidify its trustworthiness. Table 4.4 contains a breakdown of all the themes under the first research question.

Table 4.4

Breakdown of the Study Themes Addressing RQ 1

Research Question	Major and Minor Themes	Subthemes	Number of Participants	Number of References
RQ1. How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?	Using one's faith as defense to breast cancer		6	20
	Receiving support from church family and faith community through their prayers		5	16
	Having doctors who strongly believe that God can save them		1	2

Major Theme 1: Using one's faith as defense against breast cancer. The first major theme of the study highlighted the role of the participants' faith as they struggled and worked to beat cancer. According to Inez, she has always had a strong faith that upon diagnosis, this was the first thought that she had. Inez was surrounded by faithful believers that she would be able to survive and be healed after her treatment. Furthermore, her doctor also reiterated how along with the traditional way of treatment, faith and prayers must always be present. The participant stated the following:

> I, you know, my first thought was through my faith. I was going to make it through this. That was my first door. And then my second thought was that, you know, again, I had the support of my husband, which was so important to me. Okay. And so, between the both of us and cause he's a deacon, and I'm a deaconess in our church, and through both of us having the faith that we have, um, I knew that I was going to come through. Um, you know, when I spoke with Dr. [name], he made me understand that I needed to go the traditional way in addition to my faith and my prayers because I was so far along. Okay. And, um, and he asked me to have faith in him that he would do the right thing by me. And I did, and I prayed to God. And I asked him to give me the strength and wisdom and the knowledge that I needed in order to pursue the best method and the best way.

Janice shared her initial reactions and feelings upon being diagnosed with breast cancer. She then added that after some time, she realized the need to seek for help and guidance from God. Upon doing so, she became more honest with herself and was able to adjust and move on from one of the most difficult moments of her life. The participant narrated:

> Um, my first thought is I'm going to die of breast cancer, or I'm going to die of cancer. Um, that's my first thought. Um, and I am continually training my mind and my faith and my belief to not speak it. But I have to be honest with myself, and that's how I get, how I'm honest to God so that He can then give me what I need to move on. And I asked God to deliver me from my thoughts. And I think, I think more so for me, um, because I'm reminded every day. Because of all the things that happened to me, my body is not the same anymore. So, I'm reminded every day of what happened

> to me. Um, so it's not just, oh, you know, I had this or I did this, it's my body literally had to get back in alignment.

As for Kerry, she needed to be reminded that as a Christian, she must go through trials and challenges in life that would test her faith in God. However, she also noted that she has a strong faith, believing that God has prepared and equipped her to survive whatever battle she is faced with. The participant discussed during the interview:

> Most definitely. I was like, nothing caught You by surprise. I put my trust in You. Nothing. It caught me off guard, not You. And it shows me that just because I'm a Christian, I'm not exempt from trials and tribulations. Because as a Christian, I can go through it. God equipped me to go through it. A lot of people, like, even if God chose to hear me on the other side, I'll still be here. But some people think, oh, she lost her battle. No, I didn't lose my battle. That's how I got my healing.

Meechie shared her experience upon learning that she was treated and healed. She expressed that upon learning, she was "so amazed" by the mercy and power of God, saying: "The lymph node biopsy was negative. The marginal biopsies were negative. Based on those things, there was no need for the other traditional forms of treatment that most people associate with. Wow. That's, I'm just so amazed by God." Further, Neddi looked back at her experience and shared the following:

> That's just the end. But I had to encourage myself in the Lord, especially after my mother said, don't you claim it? Don't you claim it? What comes to mind is survivor, that God brought you through it. And it was about me putting my trust in Him and that guy can bring you through no matter what. If you just put your trust in Him. When I look back, I can say some other stuff, but I'm going to get to that.

Finally, Vanessa identified herself as a Catholic and mentioned how early on, she had already learned about health and healing through the Bible. She also noted how the diagnosis changed her as a person, saying:

> I'm a cradle Catholic, my born Catholic. And I just started going through the Bible in my prayer closet. And if it was talked about health and healing and, um, it changed me. I remember one day, and I'm a youth minister in my church. Right. And it was one of the Sundays I'm still carrying this diagnosis by myself.

Minor Theme 1: Receiving support from church family and faith community through their prayers. The first minor theme discussed the support received by the women participants from their faith community. According to the five participants, their journey was made manageable by having strong and encouraging prayer warriors around them. Inez shared the people and groups who supported her when she was diagnosed and was being treated for cancer. She shared how they gave her the support she needed to help her get through her sickness:

> Well, my husband was my first. And then, of course, my daughter, um, my sister, my stepchildren, they were all very supportive of me. And then last but not least was my church family. Oh yeah. Um, they rallied around me. Like I like, they were my family. Um, and they gave me all of the support that I needed. Uh, well, A lot. Um, there were times that I had to speak directly with my pastor. He prayed for me, and there were other members of my church who would call me and also. And that helped get me through.

As for Janice, she added: “Um, my, uh, church support, um, amazing prayer.” Furthermore, Meechie also echoed having a strong support system through her prayer group. She then shared an example:

> She was definitely there, even though she wasn't here in person physically, she was still back in our homes. She was there. She was praying for me. She told other people about me and had them pray for me. Um, so I, I did have a lot of strong support around. You know, God, I'm telling you. So, um, my intercessory prayer group, we actually went on a fast last year, a 40-day fast, uh, November 21st, I think until December 31st. And during that time, I was just being very. Um, conscious about what I was eating. And one of my predecessors said, you know, during this time of fasting, you know, the Lord is actually preparing us to go into places of darkness, and He's strengthening us.

Neddi then narrated and described how the people around her "prayerfully" lifted her up during her sickness. This participant shared how she was faithfully supported by her family as well as her church, saying:

> Well, I was at my moment during the initial diagnosis. I was like, what when the doctor called me and told me that it wasn't malignant. But I just thank God that I do have family and the support system that lifted me up in prayer, their faith. My mother, such a prayer warrior. And she had a prayer warrior group, and they bombarded heaven, and they interceded on my behalf because I have grown so much since then. I did not know as much as I do now when I am still continuing to grow. Mostly. What I use is Church, the Prayer Warriors. I call them the Prayer Warrior Group. You tell them any prayer request; they will take it up. The rewarding thing for me is that I had people in my life to prayerfully lift me up. And I do believe that my faith became stronger. It takes our faith. I was going to say just like it took my faith to become a

child of God, by his Grace, alone by our faith alone. It took my faith to believe that I'm healed.

Research Question 2. How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?

The second research question asked about how women describe their decision process in choosing faith and prayer as a form of CAM in their breast cancer treatment. From the analysis of the six interviews, three major themes emerged. All participants had the same experiences or decision processes as they chose faith and prayer for their breast cancer treatment. Although the women were shocked as they discovered their diagnoses, they admitted that they needed to fight and move on as they believed that God made them to have a purpose in life. To do this, they prayed constantly to survive the most difficult times during their sickness. At the same time, they needed to maintain or even develop their strong faith in God that they would be healed completely. Table 4.5 displays the themes in response to the second research question.

Table 4.5

Breakdown of the Study Themes Addressing RQ 2

Research Question	Major and Minor Themes	Subthemes	Number of Participants	Number of References
RQ2. How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast	Believing that God made them to have a purpose in life	Being an instrument to others	6	17

cancer treatment?			
	Praying constantly to survive the most difficult times during their sickness	6	15
	Having a strong faith in God that they would be healed completely	6	10

Major Theme 2: Believing that God made them to have a purpose in life. The second major theme of the study reported the participants' belief that God created them as they have a purpose in life. Specifically, participants noted how they could be an instrument to help others with their sickness, experiences, and values learned in their journey. Inez shared how she realized that she needed to go through the trial of being diagnosed with breast cancer to bring her to where she is today. With her sickness, she felt that she needed to do more for herself and for the people around her, saying:

> I feel that, that it was a trial and attributed that I needed to go through in order to bring me to where I am emotionally now. And like I said, emotionally, I feel that my purpose is to do something here on earth. God, that God has put me here to do. So, I do. Um, I do a lot of community work. Um, I work with the food pantry.

Similarly, Kerry also used her sickness to learn more about her faith and influence the people around her. She noted how it became easier for her to connect with others, especially those going through the same ordeal and how she tried to help them as much as she could. The participant narrated:

> So, it has allowed me to be a blessing to other people. See, it's not about me. And like this young lady at work, she is in her early mid-40s, and she was diagnosed with breast cancer about 10 years ago. She had a double mistake. We would just have general conversation. And then when the beginning of October, because October, I always wear pink every day, wear pink. And she said, oh, yes. And then she would come back every day and just talk a little bit. And then she shared with me that she was about because she was embarrassed.

Lastly, Vanessa described her sickness as a "gift from God." Similar to the participants above, her sickness solidified her faith and changed her life completely. The participant expressed:

> Got it was, it was a gift. It was a gift. It was a gift in a time of my life that forced me into a decision point about my spirituality. Okay. And the rest of my life. And it changed. Trajectory of my life. I guess you hear that a lot cancer, I guess, has a way of doing that.

Major Theme 3: Praying constantly to survive the most difficult times during their sickness. The third major theme of the study was the finding that in the process of their journey, these women prayed constantly in order to survive the most difficult moments of their sickness. All the participants interviewed reported this theme. According to Inez, there were many times during her treatment that she wanted to give up. Through her pain, she prayed harder and sought the Lord's mercy and guidance:

> Yeah, you really have to rely on your faith during that time because that is the time and what you would really want to give up… Yes. Yes. Um, at that time, at that point, when I was going through chemo, there were times when I just, I really did want to

> give up. And I, and I said to my, and I, I prayed to the Lord, and I said, Lord, I can't take this burden any longer.

For Janice, her treatment also made the process more difficult. The only answer for her was to fervently pray to God and ask for guidance and enlightenment to understand why she needed to go through such difficulties. She then received answers from God, saying:

> Yeah, and I definitely want to make sure I stay on course too, because that was the hardcore treatment. Now me, what I did in addition to that hardcore treatment was I prayed. You know, I fasted, I, you know, went before God and asked, you know, every step of the way of what was happening to me too. It revealed to me why it was happening to me and what it is that He wanted me to get out of what was happening to me.

Kerry surrendered her sickness to God. She noted that she just needed to pray and have faith, saying:

> So, I said I didn't do anything to get it. I can't do anything about it. So, God, I'm putting this in Your corner. You go. I tell people. I say it's like a boxer in a ring. My trainer was the Holy Spirit. I really didn't have to fight this thing… Just pray and have faith.

Finally, Neddi believed that without prayers and her faith in God, she would not have realized the power of God in her life. Neddi then expressed her openness to sharing her worries and burdens to God, knowing that He is present and listening at all times.

> If I didn't pray, if I did not have that, I guess you have to start off with the belief in God and who you are for me. I just believe that if you know who you are in Christ, if you were a believer, you've been reconciled. You've been raised up a new creature in

> Christ. Then you can go. I believe in prayer that we can go before the throne by the blood of Jesus. And I have that time with God to go and cast my cares on Him and tell Him about it.

Major Theme 4: Having a strong faith in God that they would be healed completely. The fourth major theme of the study was the belief that the women's strong faith in God would be the answer to their prayers and they would be healed completely. Again, all six participants shared the final major theme of the study. Janice stated: "The God that we serve is awesome." As a human being, she stated that it is normal to have fears and doubts; however, at the end of the day, one's faith will always be the answer:

> Does it matter though? Yeah. It, it, it has its challenges. Yes. I have my days, yes. I still do cry because I'm human and the human side of me and the effects that it has happened. But as far as the strength and the faith that it's given me. It's second to none. Second to none. Amen. The God that we serve is awesome.

For Kerry, she was confident that God would heal her from her sickness. During that time, she was still unsure of how she would be healed but was already certain that God was listening and that her prayers and request would be delivered:

> I know You're going to heal me. How are You going to do it? I don't know whether You heal me on this side or the other side. I know I will get healed. And so, I say, we're not going to cry by. We're not going to have a pity party. So, wherever You want me to, however You want to do this guy, just let me know what I need to do. And I told my husband that we would not cry. We would not have any pity parties.

Similarly, Neddi believed that she has always been a survivor and that with God, she can go through anything in life. Neddi stated that trust in God is the answer to one's fear and doubts,

saying:

> What comes to mind is survivor, that God brought you through it. And it was about me putting my trust in Him, and that guy can bring you through no matter what. If you just put your trust in Him, when I look back, I can say some other stuff, but I'm going to get to that.

Finally, Vanessa narrated how she has always been confident that God would heal her from cancer. However, she also emphasized that she needed to do her part to keep herself healthy, saying:

> You know, you get real clear about what's important and what it is. I think God uses cancer to change this, to change our thought process about face, right? Because you know, the Bible says that the enemy makes things for our bad, but God takes that bad thing and turns it around for our good. So, we, we were afflicted with the cancer. I knew I had beat this thing. I knew I had beat this thing. It wasn't coming back, you know, and it was my job. It was my job, you know, uh, Romans where it says faith without works is dead. I had the faith that God was gonna heal me, but I have to do the work to keep myself healthy and keep my body inhospitable to cancer.

Summary

The fourth chapter of the study contained the results from the thematic analysis of the six interviews with the study participants. Again, the purpose of this study was to further explore whether forms of CAM, including prayer and spirituality, add value and can help heal and even cure women with breast cancer (Kuhl, 2015). The six interviews were analyzed, resulting in four major themes that addressed the two research questions of the study. These themes are further

discussed in detail in the final chapter of the research. The fifth chapter will also include my recommendations, research implications, and study conclusions.

CHAPTER FIVE: CONCLUSION

Overview

The fifth and final chapter of the study contains the discussion of the study's findings in relation to the literature, the implications of and recommendations based on the findings, and the conclusions of the research. The purpose of this study was to further explore whether forms of CAM, including prayer and spirituality, add value and can help heal and even cure women with breast cancer (Kuhl, 2015). To address the purpose and research questions below, I performed a thematic analysis of the interviews collected with the participants. The research questions were:

RQ1. How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?

RQ2. How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?

I employed NVivo12 by QSR to analyze the six transcripts of the study participants. The software was helpful in methodically organizing and coding the interviews. The thematic analysis was then key to searching for and reporting the most common but meaningful themes across the data. In this chapter, I discuss the findings in relation to the previously reported literature, followed by the limitations observed upon completing the study. I also present the recommendations for future research and practice. Finally, I conclude with a summary of the study.

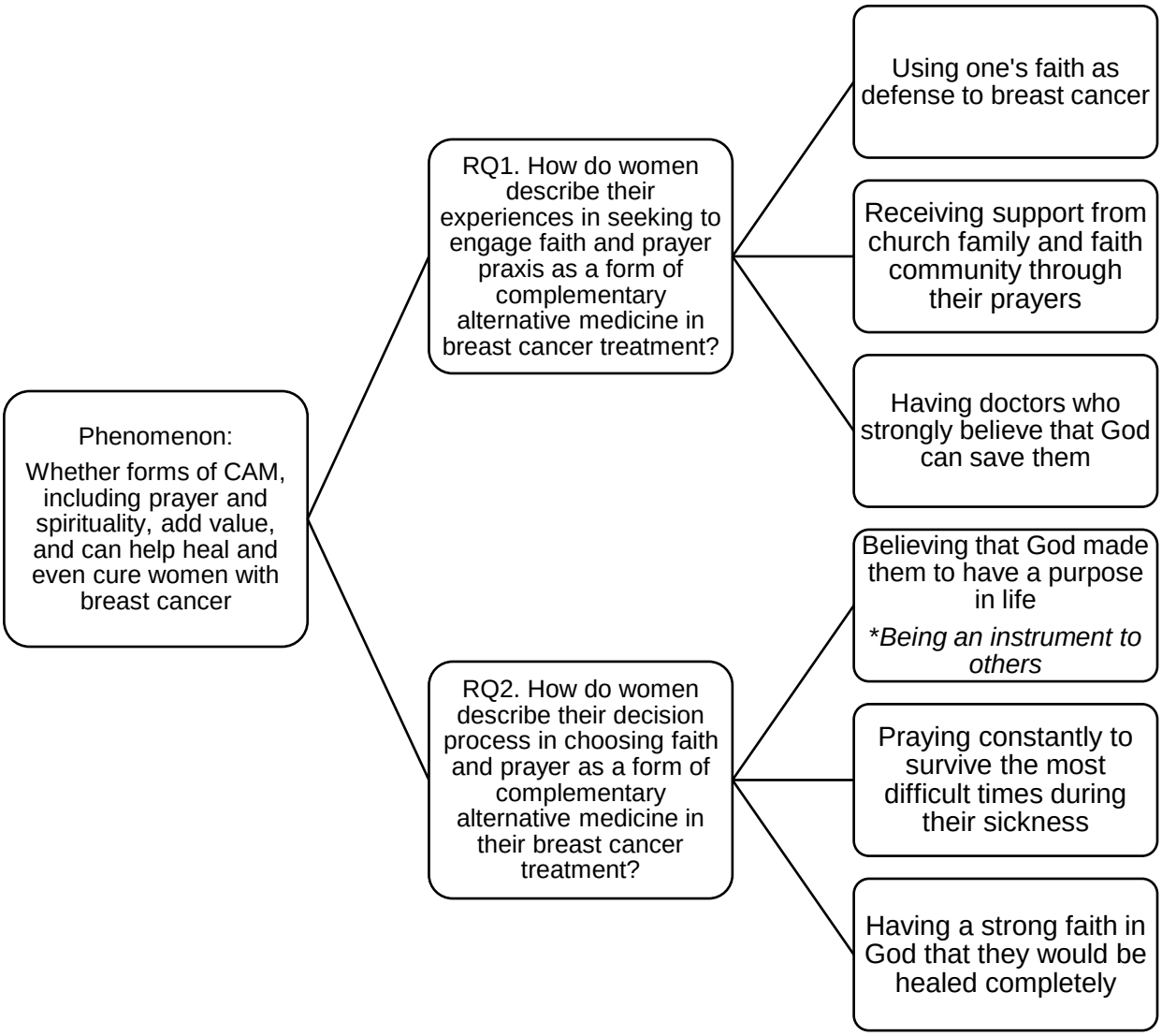
Summary of Findings

As presented in the previous chapter, seven themes were generated from the analysis. Research Question 1 had three underlying themes, while the second research question had four themes. All of the participants described their experiences in seeking to engage faith and prayer

praxis as a form of CAM in breast cancer treatment wherein they used their faith as a defense against breast cancer. Five other participants shared how they received support from the church family and faith community through their prayers. One participant noted that they engaged in CAM for their treatment as she had doctors who strongly believed that God could save them. Meanwhile, I also explored how women described their decision process in choosing faith and prayer as a form of CAM in their breast cancer treatment. From the analysis, I that all participants believed that God made them have a purpose in life. All six interviewed women also prayed constantly to survive the most difficult times during their sickness. Finally, all of the six interviewed participants had a strong faith in God that they would be healed completely. Figure 5.1 contains the display of the research findings per the research question.

Figure 5.1

Display of the Study Findings



Discussion

This section of the study contains the discussion of the study themes and the literature reports that confirm or disconfirm the results of the current research. The section will be

organized based on the research questions, and the themes will be explained in detail after. Along with the themes, relevant literature reports will also be incorporated.

RQ1. How do women describe their experiences in seeking to engage faith and prayer praxis as a form of complementary alternative medicine in breast cancer treatment?

The first research question explored the women's descriptions of their experiences in seeking to engage faith and prayer praxis as a form of CAM in breast cancer treatment. From the analysis of the interviews, I found that all six of the women interviewed had a strong faith in God that they would be healed and survive their cancer. For these participants, they used their faith as a defense against breast cancer. This experience was earlier reported in the literature, emphasizing that spirituality is an indispensable part of life (Clinton & Hawkins, 2011; Puchalski et al., 2019). According to Clinton and Hawkins (2011) and Puchalski et al. (2019), spiritual commitment tends to enhance recovery from an illness or surgery; it results in advanced levels of self-esteem. These statements indicate the power and impact of one's spirituality, especially as they go through a difficult or challenging phase in life.

Puchalski et al. (2019) further discussed how there is indeed a connection between spirituality, health, and healing, which has been deemed to be well-supported given that contemporary spirituality is marking its ground in today's healthcare setting. Consequently, faith is also considered a powerful resource that eases stress and carries real comfort to the believers (Brown & Cowart, 2018; Clinton & Hawkins, 2011; Lewis, 2017; Nakane & Koch, 2017; Roh et al., 2018; Saunders et al., 2017). Given the statements by the scholars, it could be reported that one's spirituality and faith can indeed transform how a person views or perceives their life, especially during the most challenging times. In this case, the women interviewed engaged in faith and prayer as they strongly believed that their religion and spirituality could heal them.

Indeed, the first major theme of the study is a solid piece of evidence that faith is an integral part of the healing journey of women who have been diagnosed with breast cancer (Clinton & Hawkins, 2011).

Another theme uncovered was seeking to engage in faith and prayer praxis as a form of CAM in breast cancer treatment with the support from the church family and faith community through their prayers. In the literature, the theme was again corroborated as many scholars highlighted the value of prayer and support to the breast cancer patient and even their families. In the United States alone, 64.1% of communities use prayer or spiritual healing (Rao et al., 2015). At the same time, spiritual support teams also play a huge role in assisting, guiding, and motivating breast cancer patients as they fight their sickness. Akram et al. (2017), Mclaughlin et al. (2016), Sabado et al. (2010), and Sharma et al. (2010) described a spiritual support team as one that includes church leaders and members, family, and friends; these individuals and groups have been shown to make a difference in the overall quality of life for the breast cancer patient or survivor. As Sabado et al. (2010) noted, the use of spirituality for direction and coping or surviving impacts the quality of life for the cancer patient or survivor and their support team. Williams and Jeanetta (2016) explained how support has a crucial role and a need for the breast cancer patient or survivor, their families, and caregivers to guide them as they face disruptions and difficulties brought by the sickness. Various literature reports again supported the minor theme, where support is felt and provided through the prayers of their faith groups and communities.

RQ2. How do women describe their decision process in choosing faith and prayer as a form of complementary alternative medicine in their breast cancer treatment?

The second research question centered on women's descriptions of their decision process in choosing faith and prayer as a form of CAM in their breast cancer treatment. For the interviewed study participants, their decision process could be summarized into three phases. Although they all admitted the difficulty in terms of accepting their breast cancer diagnosis, all six of them noted how these three experiences were present: (1) believing that God made them have a purpose in life; (2) praying constantly to survive the most difficult times during their sickness; and (3) having a strong faith in God that they would be healed completely. These three themes or experiences also reflect the previous themes found in the first research question. At the same time, Balneaves et al.'s (2012) CAM decision-making process model was also observed in the perceptions and experiences expressed by the study participants.

The first experience during the decision process of the participants was having the belief that God made them have a purpose in life. Again, this theme is an example of the strong spirituality and faith of the six participants in the research. Although they initially struggled to accept their diagnosis, and some even questioned God, they held on to their faith and practiced the words and teachings of God, understanding that God made them have a purpose in life. The literature has continuously accentuated that religious or spiritual coping has shown a significant association with spiritual or faith growth; resulting in better mental health and more positive outcomes as patients face their breast cancer sickness (Ahmadi et al., 2019; Buckner et al., 2018; Carlson, 2012; Clinton & Hawkins, 2011; Greenlee et al., 2017; Hajian et al., 2017; Hulett & Armer, 2016; Neuhouser et al., 2016; Roh et al., 2018).

The statement from the literature implies the change in mindset and outlook of breast cancer patients as they continued to believe and trust in God. Another interrelated theme was the experience and practice of praying constantly to survive the most difficult times during their sickness. For all six participants, prayer was again highlighted as a key factor in their breast cancer treatment. These participants reiterated how their prayers have always worked especially when they wanted to surrender their battle. Similarly, they also entrusted their conditions and lives to God, such that despite the pain they were experiencing, they still believed that God would heal them completely.

Implications

Based on the findings or themes presented above, I believe that there could be a practical use for the research results, as the perceptions and experiences shared by the women participants could guide medical practitioners such as physicians, oncologists, and nurses in their general understanding of the role of CAM in the cancer treatment process. Aside from the medical practitioners, breast cancer patients and survivors, and their family members, relatives, and friends could also benefit from the stories and themes shared in this study. First, the medical practitioners could benefit from the current study by becoming more aware of the actual and more concrete effects of prayer and spirituality as CAM on the treatment of breast cancer patients. The medical practitioners could then incorporate such alternative practices in their traditional treatment procedures as stories and narrations of breast cancer survivors themselves have established and confirmed the role and effectiveness of spirituality and faith in their breast cancer journey.

Meanwhile, this study's findings could also guide and enlighten other breast cancer patients or survivors as well as their family members, relative, and friends as they fight to live

their daily lives despite the pain and changes caused by their sickness. As the current study continuously stressed the importance of faith and prayer, the themes also noted the value of showing support to the cancer patient. In this case, prayer groups were appreciated as the prayers coming from the loved ones or other supporters of the patients motivated them to continue, especially during their darkest times. The current study's findings serve as concrete pieces of evidence that CAM, including prayer and spirituality, add value and can help heal and even cure women with breast cancer by enhancing their emotional and mental well-being.

Delimitations and Limitations of the Study

With the completion of the current study, I observed several limitations which may have impacted the overall results of the research. First, the study was limited to the experiences of the six women breast cancer survivors who incorporated faith, prayer, and spirituality into their CAM cancer treatment. The study was purely qualitative in nature, focusing on the participants' lived experiences. Hence, the single and exclusive approach and the limited number of participants, may have influenced the density of the data collected. To address this limitation, I stated that the interviews of all six participants covered and discussed the most crucial points and areas of the phenomenon being explored. I maximized the interviews with the six participants, following the interview guide and integrating additional questions as deemed necessary to help gather as much information and details as possible about the participants' experiences.

Another limitation observed was that with the limited number of participants, the themes presented could not be generalized given the small sample size. However, given that the current research study is phenomenological in nature, and the participants' most common and significant experiences are the focus of the study, I was still able to minimize the effect of the second limitation. As seen in the fourth chapter and the discussion of themes above, most of the themes

were shared and expressed by all six study participants. The similarities traced from these themes indicate the commonality and relevance of the established themes or findings.

Recommendations for Future Research

Based on the findings and limitations presented above, I formed several recommendations for future research and practice. I will first present the recommendations that future researchers may consider as they perform a similar study. The second set of recommendations would be useful in the behavioral field or practice.

1. The first recommendation is for future researchers to consider performing a mixed-methods approach where secondary sources could be collected to support the primary data sources or the interviews with the study participants. As stated, the single qualitative research approach of the study with a small number of participants may have limited the overall findings. In this regard, I suggest that future researchers search for and analyze secondary data sources that could support their initial findings despite the small sample size of the primary data source. By gathering data from secondary sources, the researcher will be able to balance the strengths and weaknesses of the two data sources, and produce trustworthy findings that could be applied in larger settings.
2. The second recommendation is for future researchers to consider gathering data from other stakeholders, such as the medical practitioners and families of the breast cancer patients and survivors. The additional interviews could serve as another data source that researcher could use to confirm or disconfirm the primary study findings as shared by the breast cancer patients or survivors themselves. The perceptions and experiences of the other stakeholders would provide context and background on how

the breast cancer survivors were helped and saved by their chosen CAM, such as prayer and spirituality.

3. The third recommendation is for the stakeholders of the phenomenon or the breast cancer patients and survivors, their families and friends, and medical practitioners. These stakeholders may consider integrating CAM in form of prayer and spirituality to assist the patients in enhancing their emotional and mental well-being. The family members and their friends could transform their roles as prayer support groups and warriors to motivate the breast cancer patients and survivors to continue fighting their battle despite the pain and difficulties. The medical practitioners could be more understanding and compassionate of the breast cancer patients, allowing them to integrate CAM to treat their sickness as they have witnessed through the current study how effective and powerful faith and prayers are to the breast cancer warriors.

Summary

The fifth chapter of the study contained the final discussion of the findings and their relationship to the previously reported literature. Again, the purpose of this study was to further explore whether forms of CAM, including prayer and spirituality, add value and can help heal and even cure women with breast cancer (Kuhl, 2015). With the analysis of the six interviews with the participants, I was able to show that CAM, including prayer and spirituality, could indeed add value to the experiences of women with breast cancer in terms of enhancing their overall well-being. With the positive acceptance and effect of the said forms of CAM, it can be concluded that women with breast cancer can indeed have an improved quality of life despite their diagnosis and sickness. Such improvement in their quality of life may stem from their

strong and powerful belief and confidence in God that despite having cancer, they know that God is there to protect and guide them until they are healed or treated completely.

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APPENDICES

Appendix I

Stages of Breast Cancer

Stage 0

Stage 0 cancer is *carcinoma in situ*. The cancer is at a very early stage, with abnormal cells lining the breast duct(s), existing only in the area where it first developed, and not spread to other tissue nearby (ACS, 2020a; Akram et al., 2017).

Stage I

Stage I breast cancer is also identified as early-stage breast cancer (Hawley et al., 2017), which is the second-least-advanced cancer with a better outlook than it is for the later stages: the tumors are less than two centimeters (3/4 of an inch) across and still have not spread to lymph nodes (ACS, 2020a; Akram et al., 2017).

Stage II

Stage II tumors are larger, between two and five centimeters across, and typically have spread to the nearby (underarm) lymph nodes but not to other parts of the body (ACS, 2020a; Akram 2017; Lewis Jr., 2017).

Stage III

Stage III tumors are the larger Stage II tumors, but they have spread to underarm lymph nodes, have grown more deeply into the breast tissue, and could be attached to each other as well (ACS, 2020a; Akram et al., 2017).

Stage III breast cancer is also divided into subcategories IIIA, IIIB, and IIIC.

Stage IIIA. Stage IIIA cancer is invasive and may be a tumor of any size, may be absent from the breast but found spread to four to nine auxiliary lymph nodes or lymph nodes near

the breastbone, or, is invasive cancer that is of any size larger than 5 centimeters and is spread to one to three axillary lymph nodes or lymph nodes near the breastbone (Breastcancer.org, 2022a).

Stage IIIB. In Stage IIIB breast cancer the tumor is larger than 5 centimeters across, has spread to four to nine axillary lymph nodes or to the lymph nodes near the breastbone, is estrogen-receptor-positive (has receptors for estrogen which means cancer cells could be signaled to grow), is progesterone-receptor-positive (has receptors for progesterone which means cancer cells could be signaled to grow), and is HER2-positive (*has human epidermal growth factor receptor 2 proteins that can also signal growth*; Breastcancer.org, 2022a; Loibl & Giannis, 2017).

Stage IIIB. In Stage IIIB breast cancer, there may be no tumor found or if present is of any size and may have spread to the chest wall or the skin of the breast and has spread to 10 or more axillary lymph nodes, to lymph nodes above or below the collarbone, or to lymph nodes near the breastbone (Breastcancer.org, 2022a).

Stage IV

Stage IV tumors are of any size and have spread to other parts of the body, including the liver, lungs, bones or the brain (Akram et al., 2017; Sun & Zhao, 2017). Of relevance to this dissertation, metastatic breast cancer is stage IV cancer (NBCF, 2019), which spreads in up to five ways:

1) cancer cells invade healthy cells, which then reproduce more cancer cells;

2) cancer cells travel through lymph vessel walls or blood vessel walls to invade the circulatory system or the lymph system, respectively;

3) cancer cells migrate by way of the circulatory system or the lymph system to other parts of the body;

4) cancer cells get lodged in capillaries and stop moving, dividing and migrating into the immediately surrounding tissue where they sit; and/or

5) cancer cells form new, small tumors at the new site called micro-metastases, which perpetuate the process (NBCF, 2019).

Breast cancer that is metastatic commonly transfers to distant organs such as the bones, liver, lungs, and brain—which often accounts for the cancer's incurability (Sun & Zhao, 2017).