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Seeking Social Support and Religious Spiritual Coping as Predictors of Posttraumatic Growth Among Egyptian Breast Cancer Survivors

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Abstract: The current study aims to identify the priorities for seeking social support among a sample of breast cancer survivors and to reveal to what extent seeking social support and religious spiritual coping can predict posttraumatic growth. Depending on the cross-sectional descriptive method, in a sample of 60 Egyptian female breast cancer survivors, the age ranged from 32 to 59 years, with a mean of "47.2 years" and a standard deviation of "6.6" years. 69% of the sample was from a medium socioeconomic level, and the number of education years ranged from 9 to 16 years. 80% of them were married. They have been diagnosed with breast cancer in stages I, II, and III. During the follow-up period, the time since diagnosis ranged from one to five years. By using the following tools prepared by the researchers: Posttraumatic Growth list, Seeking Social Support List, and Spiritual Religious Coping scale, the results find that support is sought mainly by the husbands and children of breast cancer survivors. The simple linear regression shows that religious spiritual coping was a significant predictor of posttraumatic growth, while the degree of seeking social support was not. The discussion was directed in light of Calhoun and Tedeschi's comprehensive model of posttraumatic growth, and the cultural factors of the phenomenon of posttraumatic growth.

Keywords: Posttraumatic Growth, Seeking Social Support, Religious Spiritual Coping, Breast Cancer Survivals, Breast Cancer, Support Resources

1. Introduction

New cancer cases accounts for 19.3 million cases in the latest statistics [27]. Breast cancer is the second after lung cancer presenting 11.6% new cases among cancer patients in all continents according to a global survey done by the World Health organization (WHO) in 2018 [32]. In Egypt breast cancer prevalence comes after liver cancer accounting for 17.9% of cancer cases and was the first among women consisting of 35.1%. Despite the high prevalence, the death rate was only 21.3% [33].

Breast cancer screening and early detection have evolved markedly especially in Egypt [11]. Target therapy and immunotherapy as well as new hormonal agents have been integrated in the treatment of breast cancer and have changed the paradigm of management and prognosis of breast cancer patient. The overall survival and the disease free survival have increased dramatically [18].

Breast cancer is considered a life crisis that causes severe distress during the periods of diagnosis, treatment, and after treatment, and threatens the psychological and physical integrity of women, and is a traumatic experience that affects all aspects of life, by disrupting the harmony in life [13, 26].

Despite defining cancer as a traumatic or distressing event and the development of cancer treatments, cancer diagnosis is still accompanied by a prolonged feeling of distress from

the effects of different treatment modalities, and a fear of tumor recurrence.

Although cancer is considered highly stressful, distracting, and distressing, in other cases it has the potential to lead individuals to re-examine their priorities, their relationships, and themselves, and to experience a sense of posttraumatic growth and positive change. A diagnosis of cancer is an existential challenge that can produce posttraumatic growth [35]. In a review study on PTSD and PTG in breast cancer patients, Darshit Parikh and colleagues concluded that PTG is more common than PTSD in breast cancer survivors [23].

Besides, "meaning making" and its importance in adaptation with the experience of cancer has also been studied, and despite the conflicting results of empirical studies on the role of meaning making in psychological adaptation with cancer. The search for new meaning is the basis for posttraumatic growth in most patients. Meaning making can be more adaptive and more constructive if it contributes to resolving the association of unconstructive ruminations, which may be for example about fears of recurring tumours or any other threats (symptoms of cognitive PTSD) [20].

In addition to the importance of meaning making in the emergence of growth, it is also an essential component of religiosity, as the process of searching for meaning is an old process as humanity, and despite the difference in the modern human view of the world in many aspects, many people still assume that the world is ordered and clear. All religions in the world share this hypothesis. Spiritual beliefs can support people, by providing them with a sense of control [21, 24].

During his speech about facilitating posttraumatic growth following cancer, Matthew J. Cordova mentioned that the experiences of positive and negative interpersonal relationships, prompt the cancer sufferer to re-evaluate their relationships with others, and it may strengthen their appreciation of some relationships and improve their satisfaction with them [7]. Beside that cancer experience "help patients clarify and live according to their values, priorities, and goals, through overt behavioural changes (e.g., spending more time with certain people or hobbies) and less observable shifts (e.g., greater spiritual engagement, more time spent "in the moment"), patients may emerge with a greater sense of meaning and clarity in their lives [7].

Therefore social support, besides meaning making, is one of the factors that contributes to improving the quality of life for individuals and leads to the emergence of growth. The results came out confirming the positive role of social support in the emergence of posttraumatic growth [1, 10, 9, 15], and on the other hand, the results also showed a relationship between the demand for social support and the posttraumatic growth of the same audience [4, 23].

Posttraumatic growth defined as the ability to experience positive life changes, rise above previous psychological functioning, and become aware of life as a result of conflict with traumatic events [31]. Also defined as the subjective experience of positive psychological change that individual reports as result of conflict with traumatic event [34].

Calhoun and Tedeschi developed a model to explain how growth appears, by reviewing posttraumatic distress literature; in its first form in 2004, which called the functional descriptive model, in this model they discuss how the cognitive, personal and social factors lead to the emergence of growth and wisdom, despite of distress feelings that exist. Posttraumatic growth appears in this model in two stages (automatic rumination and intentional rumination) [29].

They modified the model in 2006 as the comprehensive model of posttraumatic growth, represented in changing the stage of social support and coping methods (as a necessary stage for the emergence of growth), to become sociocultural factors, and clarified the idea of the mutual influence (expressed in two-way arrows) between these corresponding factors and phases in the model. They divided sociocultural factors into two types: the proximal cultural elements, and the distant cultural elements. Proximal cultural elements express small communities and social networks of people with whom the individual interacts, while distant cultural elements form the general cultural frameworks prevailing in large societies or large geographical areas such as countries [2].

In light of the foregoing, the current study tends to adopt the Calhoun and Tedeschi model to explain the growth process of recovering breast cancer survivorship, as it is a model that includes a visualization of the network of relationships between various variables that constitute posttraumatic growth, including variables which current study focused on; seeking social support, and religious spiritual coping.

Seeking social support is defined as a coping strategy adopted during stressful or difficult events, and accordingly, the support seeking must be classified as one of the elements of the coping strategies, and the coping includes two dimensions: problem centred and emotion centred. Seeking social support can be defined as both openness to accepting support and help, and the active efforts made by individuals in times of adversity to mobilize social relations network around them, in order to obtain various forms of support, emotional, informational, and instrumental, which enables them to deal with different forms of stress and distress they are experiencing.

Spiritual religious coping can be defined as the use of religious beliefs, attitudes or practices in order to reduce the existing psychological distress resulting from stressful life events such as loss or change, which gives meaning to suffering and makes it more bearable. Religious coping includes various aspects: cognitive aspects: the method we use to create meaning for the world around us, experiential aspects: related to communication and internal psychological strength, and behavioural aspects: related to the ways in which the individual's spiritual beliefs and inner spiritual state affect his behaviour and choices in life [24].

It is not possible to understand the religious spiritual coping, without understanding religion functions. There are five main functions that religion performs in individuals 'lives. First,

meaning: religion provides a framework for understanding and interpretation for suffering and perplexing life experiences. Second, Control: Religion provides many ways to deal with events that push individuals to exceed their own resources to achieve a sense of master and control. Third, Comfort/spirituality: the desire to connect to a power greater than the individual is an essential function of religion, and it is not possible to separate comfort centred religious coping strategies, of the methods that have an authentic spiritual function [22].

Fourth, Intimacy/Spirituality: Intimacy with others is often encouraged through spiritual means, such as offering spiritual support to others and spiritual support from religious symbols. Hence, it is difficult to separate the many ways to enhance intimacy from the ways to enhance closeness to a higher power. Fifth, Life Transformation: Religion can also help people make major life transformations, by letting go of old things of value and finding new sources of reference [22].

1.1. Goal of Current Study

The present study aims to determine the priorities for seeking social support among a sample of breast cancer survivors, and to reveal to which extent seeking social support and religious spiritual coping can predict posttraumatic growth.

1.2. Importance of the Study

Contribute to the consolidation of the concept of posttraumatic growth in Egypt and Arab culture, verifying the theoretical framework of posttraumatic growth, accessing a network of variables that contribute information posttraumatic growth within the Arab society, which helps in reinvestigate theoretical prospective in lights of culture factors.

2. Method

2.1. Participants

The sample contents of 60 breast cancer survivors, diagnosed with breast cancer stages (I, II, III) during follow up with a period ranging from one to 5 years (8.2 ± 1.2). The median age was 47.2 ± 6.6 (32 – 59) years. Educational level was calculated by number of educational years, and ranged from 9 to 16 and above. Socioeconomic state was calculated by this equation

(The woman's education + husband's education + income level + additional income + type of housing) /5[1].

The group were selected by meeting the following criteria: (1) Those who were diagnosed with breast cancer 1 to 5 years ago, (2) Those who have obtained a preparatory education (9 years of education as a minimum), (3) In follow up period, (4) No recurrence of the tumor occurred to them, and (5) Not to have been diagnosed with any other type of cancer.

[1] The equation was modified to (The woman's education + income level + additional income + type of housing) /4 ii divorced and unmarried women.

Table 1. *Description of socio-demographic and medical characteristics of the sample.*

socio-demographic and medical characteristics of sample			
socio-demographic characteristics	**N (%)**	**medical characteristics**	**N (%)**
Place		Cancer stage	
Kasr ElAiny Hospital	33%	I	38%
Attaa Elsamaaassociation	9%	II	43%
Sanosadahom Raghm Elalam Initiative	58%	II	16%
Marital state		Surgery	
Married		Breast removal	53%
Divorced	80%	Breast conservation	47%
Widow	19%	Family histor	
Education	3%	There is	53%
Prep & Secondary		There isn't	47%
High school< collage graduate	76%	Treatment protocol	
College graduate	7%	Chemotherapy	3%
Work	17%	Radiotherapy	17%
Working		Chemo & Radiotherapy	70%
Not working	17%	Chemo, Radio, and targeted drug therapy	5%
Children	83%		
Has children			
No children	95%		
Religion	5%		
Muslim	95%		
Christian	5%		

2.2. Measures

Pilot study (N=30) to verifying the standard efficiency of the tools. The final form of tools contained:

1) The socio-demographic and medical information list.
2) The posttraumatic growth list.
3) The social support request list.
4) The spiritual religious coping scale.

2.2.1. The Posttraumatic Growth List (PTGL)

The posttraumatic growth list consists of 31 items that are answered by choosing an alternative from four Likert scale. Items distributed into five dimensions: life appreciation (5 items), new possibilities (6 items), Personal strength (4 items), Spiritual change (8 items), and Personal relations (8 items).

The score on the scale is between 31 and 124, and the high score on the scale indicates experiencing positive changes in relationships, personality, spirituality, and perception of life, changes that represent a real increase and growth of what transcends the previous psychological performance before disease onset.

The list has Cronbach`s α (0.89), split half reliability (0.92), and for internal consistency; after item total score correlation statistics we had excluded 8 items (39 items at the beginning) which showed weak correlations, and for dimension total score correlations; life appreciation (0.65^{**}), new possibilities (0.69^{**}), Personal strength (0.71^{**}), Spiritual change (0.70^{**}), and Personal relations (0.78^{**}), $P< 0.01$.

Validity: we used content validity by calculating agreement ratio of arbitrators which was 80% and above to all Questionnaire's items, besides we measured Concurrent Validity by calculating the Spearman's rank correlation coefficient between Posttraumatic growth inventory (Calhoun

& Tedeschi 21 items), with Cronbach`s α "0.80"in this study for 18 items only after deleting items that have weak correlation to the total score, and the new scale "$r_s$= 0.731**"; which refers to a significant correlation between the new scale "The posttraumatic growth list" and Calhoun & Tedeschi`s inventory P< 0.01.

2.2.2. Seeking Social Support List (SSSL)

Seeking social support list consists of two parts; First: an ordinal scale for the available sources of support: husband, parents, children, friends, neighbours, therapists, other survivors, co-workers, so that the participation gives an ordinal number between "1" and "8" for each of the mentioned source in light of the priority of seeking help from him/ her, it is not required to choose all sources, though participants can choose only one or more of the eight mentioned sources, and arrange them according to the support seeking priorities. Second: The questions of the scale, which measure the extent of preparedness for support or seeking to various kinds of support, and they consist of 19 items that are answered by choosing an alternative from four Likert scale.

Items distributed on four dimensions are: Preparedness for support (7 items), Seeking instrumental support (5 items), Seeking emotional support (4 items), and Seeking informational support (3 items). The degree on the scale ranges between 19 and 76, and the high score on the scale indicates a person's increased tendency to seek support in order to cope with the experience of illness and the resulting distress.

The list has Cronbach's α (0.84), split half reliability (0.85), and for internal consistency; after item total score correlation statistics we had excluded 8 items (27 items at the beginning) which showed weak correlations, and for dimension total score correlations; Preparedness for support (0.82*), Seeking instrumental support (0.73**), Seeking emotional support (0.78**), Seeking informational support (0.70**), P< 0.01.

We used content validity by counting agreement ratio of arbitrators which was 80% and above to all questionnaires' items.

2.2.3. The Spiritual Religious Coping Scale (SRCL)

It consists of 17 items that are answered by choosing an alternative from four Likert scale. It has five dimensions; Meaning (3 items), Control (1 item), Comfort/Spirituality (3 items), Intimacy (5 items), Life transformation (5 items).

The score on the scale ranges between 17 and 68, and the high score on the scale indicates that a person use scoping strategies that based on religion and spirituality in confronting the disease.

Agreement ratio of arbitrators was calculated to verify content validity which was 80% and above to all Questionnaires' items.

2.3. Procedures

Application procedures were carried out between February 2020 and January 2021 due to the emergency conditions of the Corona pandemic, which led to hang the application for a period of six months during the mentioned period. Women got information about the aim of the research, and voluntarily participated in the research.

Individual interviews were conducted by organizing with external patient clinics at Qasr Al Ainy Center Of Radiation Oncology & Nuclear Medicine; Ataa El Smaa association, and Sanosaedhom Raghm Elalam Initiative. After getting a verbal agreement from the participants, the researcher began to collect the basic information, and then the answers of each questionnaire. The application took 30-40 minutes,

3. Results

First we are going to present means and standard deviation for study`s variables, presenting data about priorities of support seeking, and then simple linear regression for seeking social support, and religious spiritual coping on PTG. (table 2) will present basic statistics of variables.

Table 2. *Means and standard deviation of the study`s variables.*

Variables	Dimensions	Mean	SD
Posttraumatic Growth	life appreciation	15.4	3.4
	new possibilities	17.6	4.6
	Personal strength	11.7	3.2
	Spiritual change	28.7	4.4
	Personal relations	23.4	5.6
	Total score	69.9	15.9
Seeking Social support	Preparedness for supp.	16.2	3.8
	Seeking inst. Supp	9.6	3.3
	Seeking emot.Supp.	8.7	2.6
	Seeking infor.supp	6.5	2.7
	Total score	41.1	10.1
Religious spiritual coping	Total score	55.9	6.7

3.1. Priorities of Support Seeking Results

We will share the data about the priorities of support seeking; the first part of SSS List by two ways: percentage of each type of support, and the percentages of the numbers of support resources were determined by the participants.

Table 3. *Percentage of each of support resource.*

Support resource	First	Second	third	Fourth	Fifth	Sixth	seventh	Eighth	Not chosen
Husband	32%	10%	10%	3%	2%	2%	3%	2%	35%
Family	35%	17%	18%	2%	2%	3%	2%	-	21%
Children	20%	28%	13%	5%	-	-	-	-	34%
Friends	10%	12%	18%	13%	2%	3%	-	-	42%
Neighbours	-	5%	2%	2%	2%	3%	8%	-	78%
Co workers	-	2%	3%	5%	2%	-	3%	2%	83%
Other survivors	-	7%	2%	15%	8%	2%	1%	-	65%
Therapists	2%	7%	1%	2%	8%	8%	-	2%	70%

A number of observations can be collected from the previous table:

1) The priorities for support seeking were centred within the family; Parents (35%), husbands (33%) and children (20%) were identified as the first source that breast cancer survivors can turn to.
2) Sons also got the highest percentage, as they are the second source of support for breast cancer survivors, with a rate of (28%).
3) Friends are equal with parents in obtaining the third place in terms of priority for seeking support with a rate of (18%), and here we emphasize the reappearance of parents in the third place as an important source of support.
4) Although co-workers are the most excluded category (83%), by recalling information that 83% of the sample are not employed, which is the same percentage that did not choose co-workers as a source that can be returned to, it becomes clear to us that working survivors chose co-workers Work at 5% for the total group, which represent 30% of the percentage of workers participant within the group.
5) After co-workers, neighbours and therapists were the most excluded from choice.
6) Although long illness journey may provide opportunities for meeting with other survivors, the category of other breast cancer survivors was the fourth in terms of exclusion from selection, with a rate of 65%.

Table 4. *Percentages of the number of recorded sources of support.*

Number of resources	Percentages of the resources
One resource	13%
Two resources	18%
Three resources	24%
Four resources	20%
Five resources	5%
Six resources	8%
Seven resources	2%
Eight resources	10%

It is evident from the previous table that 44% of the sample resorts to three to four people in difficult times in order to obtain support or comfort during the illness journey. By re-checking the table, and adding the data of resorting to one person and two people to the previous ratio, we find that 75% of the survivors resort to one to four people during the illness journey, which gives us an indication of the nature of support seeking priorities in this group of breast cancer survivors.

3.2. Simple Linear Regression Results

In this part we are going to present results of simple linear regression analysis for predicting posttraumatic growth from each of seeking social support and religious spiritual coping.

Table 5. *Simple linear regression of posttraumatic growth on seeking social support.*

Predictor	Predicted	Constant	R^2	R^2 adjusted	B	f	df
SSS	PTG	82.17	0.052	0.036	0.360 (-0.042-, 0.761) P 0.078	3.21 P 0.078	1 58

A simple linear regression was carried out to test if seeking social support significantly predicted posttraumatic growth. The results of the regression indicated that the model explained (0.052*100) 5.2% of the variance and that the model wasn`t significant, F (1-58) =3.21, p>0.05. The regression coefficient (β = 0.360, p 0.078) indicated that seeking social support isn`t significantly predict posttraumatic growth, the prediction model was:

Posttraumatic growth degree= 82.17 + (0.360* seeking social support degree)

Table 6. *Simple linear regression of posttraumatic growth on Religious spiritual coping.*

Predictor	Predicted	Constant	R^2	R^2 adjusted	B	f	df
RSC	PTG	36.51	0.209	0.195	1.08 (0.524, 1.639) P 0.000	15.8 P0.000	1 57

A simple linear regression was carried out to test if religious spiritual coping significantly predicted posttraumatic growth. The results of the regression indicated that the model explained (0.209*100) 20.9% of the variance and that the model is significant, F(1-57)=15.8, p<0.001. The regression coefficient (β = 1.08, p 0.000) indicated that religious spiritual coping significantly predicted posttraumatic growth, the prediction model was:

Posttraumatic growth degree= 36.51 + (1.08* religious spiritual coping)

4. Discussion

In breast cancer survivor religious spiritual coping was a significant predictor of posttraumatic growth while the degree of seeking social support was not. Support seeking was mainly by parents, husband and children.

The current results are consistent with many of the results of previous studies, as some research reviews came out with the conclusion that there is a positive relationship between posttraumatic growth and religious coping or religiosity and spirituality [4, 23, 14, 15].

Other studies also showed that spiritual religious coping is an important strategy to confront cancer, and that women

show greater religious coping than men [17]. In addition, another study found that women emphasized that spiritual religious coping is primary source that enabled them to fight against cancer [5].

Despite this, the role of religious spiritual coping differed according to culture. Among the studies that dealt with the role of religious coping in adjustment with cancer, the European results showed that religious coping is not beneficial, while the results varied within American society between confirming the positive role of spiritual religious coping, and its harmful effect [30]. As for the current results, they indicated that the spiritual and religious coping could predict posttraumatic growth, which supports its role in positively dealing with the cancer experience within the Egyptian society.

On the other hand, current results support Calhoun and Tedeschi's comprehensive model of growth, which clarifies the role of religious aspects in the emergence of growth; it helps convert automatic rumination into reflexive rumination which in turn leads to growth.

Although the results didn`t support the hypothesis, we cannot ignore the amount of contribution that seeking social support in predicting posttraumatic growth, no matter how small it may appear in our results. Perhaps what reinforce this vision are the results of multiple previous studies that showed a positive relationship between posttraumatic growth and the seeking social support [23, 14, 9], this was also supported by meta-analysis in other study [4].

In the context of the theoretical framework of post-traumatic growth, we find that our results do not seem to support what was assumed by the "Comprehensive model of Posttraumatic Growth of Calhoun and Tedeschi", the model that the current study adopts, which shows the importance of social support in the emergence of growth, by providing the opportunity for self-disclosure, and obtaining support, and then contributing to changing schemes that contribute to the emergence of posttraumatic growth [3]. However, by contemplating what the model presented to explain posttraumatic growth as represented in “obtaining social support”, we find that it appears to be different from the “seeking social support” that our study was concerned with, which may explain our results not supporting the model, as well as its difference with the results of studies other.

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In addition to the above, Matsui and Taku [16] indicated in their review of the literature about posttraumatic growth and support seeking behaviour among cancer survivors, the existence of inconsistent outcomes in the literature between posttraumatic growth and support seeking behaviour. This inconsistence may be due to that existing model about both phenomena aims to limit a culturally fixed phenomenon, and thus assumes that cancer survivors, regardless their cultural background or personality, will perceive benefits from effective communication with others.

4.1. Calhoun and Tedeschi’s Model and Cultural Aspects

In lights of Calhoun and Tedeschi`s model, we can resonate current results to what they called cultural factors (proximal and distant cultural elements) [3]. Culture determines what a health problem is, how symptoms are expressed and discussed, how information is received from health provider and relationship between them and patients, what type of service that patient should receive, and how rights and protections issues are exercised [28, 7].

Usually the focus in research about cultural aspects in the cancer experience is on examining cultural determinant associated with beliefs about the origin of disease, about religious beliefs regarding divine control over life and death, and about supportive family relationships due to their role in disparities in cancer care [12]. Despite the development of cancer detection and treatment methods the experience of treating cancer still arduous, and causes continued stress for patients and their families. Cancer is still a disease of fear in both Western and non-Western societies, and stigma associated with disease has never decreased [19].

Cross-cultural differences in oncology also appear in the issues of information exchange and decision-making [28]. Cultural diversity can be seen in beliefs about the cause of illness, appropriate treatment, type of self-care and suitable prevention methods, and the acceptable manner of the doctor's behavior, and cultural differences affect the perception of symptoms and emotional states [25]. For example, we note that the focus in the Western biomedical model is on the individual, respect for the autonomy of the patient (who is asked for prior consent), and his participation in decision-making, while in the Arab countries the focus is on the family, where the achievement of family well-being is priority in the treatment plan [8].

In lights of the previous paragraphs in which we discuss the role of culture in oncology, we will explain number of important elements that constitute the role of culture in dealing with a medical problem, therefore it`s possibly

intervening in shaping the experience of posttraumatic growth.

4.1.1. Patient Independence

The way which the doctors deal with patients differs according to culture, In North America patient independence, immediacy of action (and a participatory health model of decision-making) are emphasized, while in France and in many other European societies, Japan, the Middle East and Africa the relationship with the patient is more hierarchical, protective and patriarchal [19].

The situation in Egyptian society is similar to the findings in European societies, Japan, the Middle East and Africa. The relationship between doctor and patient is hierarchical and patriarchal; Through the clinical interview with the members of the participants, it was possible to extract some observations about the medical practices received by the patients, which may control the way of dealing with the disease and managing the treatment and recovery journey, a method in which the treatment plan is determined and the therapeutic interventions arranged by the doctor, and the patients only have to follow a predetermined treatment plan in which they do not have a hand in choosing or determination.

In this case of the personal will being separated from the therapeutic will in Egyptian societies, the stress experienced by individuals is formed differently from that experienced by members of western societies, in which the treatment plan is developed in light of the medical choices and the patient's personal choices and priorities, and the patient is involved in setting the treatment plan. In addition, the patient is given accurate information about the nature of his health condition [8, 19, 28]. As if the patient in Western Societies, despite facing a life-threatening and confusing situation, is given some sense of control over the situation, which contributes to shape the experience of the disease in a different way from what is done in our society, as cancer diagnosis accompanied by a loss of control over the course of personal matters in the face of the disease, and subjecting self-will to the therapeutic will and surrender to all its aspects, what is also constitutes the disease experience in a different way.

4.1.2. Doctor-Patient Relationship

Cultural values and frameworks play a major role in defining the roles played by patients and physicians, also expectations of each of them differs cross cultures. Chinese patients often have a high regard for the expertise of doctors, so any ambiguity or uncertainty attached to diagnosis or treatment recommendations is seen as a lack of medical expertise [6, 19].

Empirical studies and narrative reports show fundamental cultural differences, in the methods and practices followed around the strategy of telling the truth to cancer patients across different countries of the world. Although from the beginning of the nineties a shift occurred all over the world, in the methods and practices of truth telling, in the direction of more disclosing the truth about a cancer diagnosis, partial disclosure or non-disclosure is still a common practice in cultures centered on family and community value [28].

In this context, the current research was able to collect a number of observations about the reality of communication between doctors and patients in the Egyptian society, during the clinical interview to collect basic information, the most clear one is the presence of varying experiences of communication with physicians, as if there was no clear definite way for all patients. Others observations:

1) The percentage of survivors who have complete data about their health status and the nature of the stage of the tumour in which the cancer was diagnosed are lower than who lack such data, although they are all aware of the nature of the health problem they suffer from in general.
2) As discussed above of seeking support statistics; 70% of the sample did not mention the therapist as a source of support, and 7% put the therapist in the second rank in terms of recourse, 8% chose him in the fourth rank, and 8% in the fifth rank.

Finally we can say that although doctor-patient communication was taken into account informing the patient of the nature of the problem, but the patient was not treated as an equivalent and independent individual with a role in the treatment process, but rather as an obedient patient, all she has to do is stick to the plan laid out for her by an expert therapist, which is a predetermined communication with medical priorities that lead all parties and oblige them to follow.

4.2. The Role of Religion

Divine control over life and death, is one of religious beliefs and cultural determinant of individual behaviour in some societies, and it influences survivors commitment tendency to treatment; survivors who take or stop treatment may express that the date of their death is predetermined and that humans have no will in that, but others may complete treatment because they believe that God has final control over the timing of death, and that stopping treatment is similar to excluding this control from God, which leads to conflict with their religious beliefs, or to be evidence of weak belief in God, or a manifestation of weakness [12].

There are a number of reasons why doctors need to consider the patient's spiritual needs and religious beliefs, including that many patients have an association with religion, and religious beliefs help them coping, and religious beliefs influence their medical decisions, especially when patients are seriously ill, in addition religious beliefs and activities are linked to better health and quality of life [8].

Given the significance of religious aspects in Arab societies, many individuals in these societies rely on their faith and spiritual aspects when facing the experience of illness. They are likely to experience positive results accordingly, including a lower degree of depression, a longer duration of survival, and a lower degree of problems after surgery, delayed onset of symptoms, slower progression of physical disabilities, and effects on serotonin pathways in the brain, which regulate mood and potential pain [8].

As for the religious and spiritual aspects within the sample, and by looking at the responses of the sample on the scale of spiritual religious coping, responses ranged between 38 and 67 with a mean of (55.9) and a standard deviation of (6.7), noting that the total degree ranged between 17 and 68, this may give an indication of the high tendency of response of the sample on this aspect, which shows the importance of this aspect to the sample community, and confirms what Michael Daher (2012) mentioned about the dependence of individuals in Arab countries on their faith in the face of disease.

On the other hand, we find that these current results support for Calhoun and Tedeschi's comprehensive model of growth, which clarifies the role of religious aspects in the emergence of growth; it helps transform automatic and intrusive rumination into reflexive rumination, which in turn leads to growth.

5. Limitations of the Study

The study was limited by a small number of non-randomized breast cancer patients with period of follow up (one to five years). It was an intentional cross section in an educated female (preparatory and university) in a limited age group ranging from 32 to 59 years. Most of these patients 53%underwent partial mastectomy, while 47% underwent a total mastectomy.

6. Conclusion

In a non-random sample of breast cancer survivors, we utilised simple linear regression to examine whether seeking social support and religious spiritual coping can predict posttraumatic growth. We discovered that posttraumatic growth was predicted by religious spiritual coping. Parents, husbands, and children were identified as the first sources of support that breast cancer survivors seek. The findings were discussed in light of Calhoun and Tedeschi's comprehensive model of growth, which helped in explaining the significant role of religious spiritual coping in posttraumatic growth. Besides we discuss how the cultural emic aspects that format the finding so.

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