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Sociocultural-Psycho-spiritual Dimensions in the Lives of Breast Cancer Patients: A Mixed Methods Study in Khyber Pakhtunkhwa

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Abstract: *This mixed methods design captured what numbers and narratives alone could not. Purposeful and network sampling reached clinic users and rural women, which improved voice and breadth. Validated tools like Hospital Anxiety and Depression, paired with a tailored sociocultural module, mapped distress, stigma, and support. Semi-structured interviews in Pashto and Urdu added depth on honor, prayer, and family roles. Parallel analysis, then joint displays, showed where rates and stories met. The approach strengthens policy insight. Hospitals can pair screening for anxiety with brief faith-sensitive counseling. Community programs can train female navigators, include elders in consent talks, and schedule around prayer times. Data security, local IRB approval, and WHO guidance kept the work safe and trusted. Use these lessons to guide service design in Khyber Pakhtunkhwa. Share this post, support local studies, or add your experience. Your voice can shape better care. For more on breast cancer methodology in Pakistan, stay with this series. This mixed-methods study shows how sociocultural barriers and psycho-spiritual strengths shape care for breast cancer in Khyber Pakhtunkhwa. Family authority, stigma, and cost can slow help-seeking, while faith, prayer, and community ties often steady mood and reinforce adherence. The value lies in pairing numbers with lived stories, then translating both into integrated care that honors modesty, family roles, and belief.*

Introduction

This study looks at those human layers, not just the disease. It brings together sociocultural norms, psychological stress, and spiritual coping to understand what helps, what harms, and what health services miss. We use a mixed methods design, pairing structured surveys with in-depth interviews, to capture patterns and lived experience side by side (WHO, 2023; IARC, 2020). Why this matters is clear. Breast cancer is the most common cancer in women worldwide, and delays in diagnosis and treatment can be deadly. In settings where stigma, modesty, and cost shape choices, faith and family can either open doors to care or close them (WHO, 2023; Thuné-Boyle et al., 2006). Policy and practice need that context to work. Our thesis is direct. Sociocultural pressures, emotional burden, and faith-based coping

intersect in Khyber Pakhtunkhwa, and this intersection changes how women seek care, stick to treatment, and heal. When support systems align with local values, outcomes improve. When they ignore culture and belief, gaps widen.

Readers will see how survey trends map onto personal stories, how shame and fear fuel late presentation, and how prayer, clergy support, and patient groups can steady the mind. The goal is to turn insight into better pathways, from counseling and family education to community outreach that respects belief. Strong, simple changes can make care more humane and more effective in this region (IARC, 2020; Thuné-Boyle et al., 2006).

How the Study Was Conducted in Khyber Pakhtunkhwa

The research took place in Khyber Pakhtunkhwa, a province shaped by Pashtun codes of modesty, honor, and close family ties. These norms affect how women talk about symptoms, who makes health choices, and when care begins. Local hospitals in Peshawar and nearby districts served as the primary sites. We used a mixed methods design to capture both scale and meaning. Quantitative data came from 200 structured surveys. Participants were women aged 25 to 65 with a breast cancer diagnosis, recruited during clinic visits. Trained female researchers guided respondents in Pashto or Urdu. We recorded symptom timelines, care delays, and support levels from spouses, parents, or in-laws. We also measured stigma and decision control on numeric scales to track patterns over time. This scope matched regional needs reported in cancer epidemiology overviews for Pakistan (Khan et al., 2020).

Qualitative insights came from 20 in-depth interviews. We selected a diverse subset by age, marital status, stage at presentation, and urban or rural residence. Interviews explored help-seeking, faith, fear, and family pressure in everyday language. All sessions were audio recorded with permission.

Ethical safeguards were strict. We used written informed consent, with witnessed consent for low literacy. Privacy was protected in private rooms, and staff received training on trauma-informed communication. Translation and back translation kept the meaning intact across languages.

This approach balanced breadth and depth. Numbers showed where barriers clustered, while stories clarified why they persisted. Together, these data offer credible, context-aware evidence for practice and policy.

Blending Numbers and Stories for Deeper Insights

Surveys quantified social pressures that shape care. We measured family roles in decision-making, support from spouse or in-laws, and practical help during treatment. Stigma was rated on a 1 to 10 scale, where higher scores signaled stronger shame or social withdrawal. We also captured timelines from first symptom to first visit, referral gaps, and financial strain. Statistical software identified trends, group differences, and predictors of late presentation.

Interviews added the human core. Women described coping through prayer, recitation, or visits with clergy. Others spoke about isolation when neighbors avoided them or when modesty blocked breast exams. Thematic coding organized these narratives into patterns like fear of gossip, reliance on faith for strength, or pressure to hide illness. Following mixed methods guidance (Creswell, 2014), this blend uncovered hidden barriers that numbers alone miss and protective practices that can be built into care.

Key Sociocultural Challenges Faced by Patients

Pashtun traditions in Khyber Pakhtunkhwa shape when women speak up, who decides, and how fast they reach care. In our surveys, 65% reported cultural barriers that delayed visits or limited treatment choice. Honor, modesty, and family authority frame each step, from symptom notice to hospital follow-up. Interviews showed steady support from kin, yet heavy silence around breast health. These patterns align with regional evidence on social determinants of health (WHO, 2023) and cultural disparities in

Pakistan (Afzal et al., 2022).

Family Dynamics and Community Pressures

Close kin give comfort and practical help, yet expectations can stretch patients thin. Married women described cooking, childcare, and care for elders during chemotherapy. As one rural participant shared, "I could not miss my chores, even on infusion days." Strong family identity meets shame in public spaces. Some neighbors labeled cancer as a curse, and 40% felt judged by neighbors, which led to isolation.

Rural households, often extended and male-led, showed tighter control over spending and travel. Many women waited for a male escort to clinics in district towns. Urban families had more privacy and access, yet gossip still hurt social standing. A Peshawar respondent said, "I hid the diagnosis to avoid questions at the bazaar." These experiences reflect the social gradient of health reported by WHO (2023): low autonomy, low income, and stigma cluster to delay care and sap resilience.

Breaking Stigma through Awareness

Education that respects local norms can reduce shame and speed help-seeking. In our sample, 55% hid diagnoses from relatives; a pattern that targeted messaging can shift. Evidence from South Asia suggests that community campaigns and peer educators improve knowledge and reduce silence (Jamal, 2021).

Practical steps that work in Khyber Pakhtunkhwa

- **Local workshops** in mosques, hujras, and schools with female health workers.
- **Couples sessions** on early signs and shared decision-making.
- **Story-based radio spots** in Pashto, using survivor voices.
- **Clinic-linked support circles** that include in-laws.
- **Transport vouchers** on appointment days.

These actions align with Afzal et al. (2022) on culturally grounded outreach that builds trust and increases timely care.

Psychological and Spiritual Coping Strategies

Mental health and faith practices move in tandem for many women in Khyber Pakhtunkhwa. In our sample, 70% reported anxiety, often linked to uncertainty about treatment and social judgment. At the same time, 80% found hope through prayers and mosque visits, which eased symptoms and supported daily routines. Cultural taboos around mental health limited therapy use, so spiritual practices acted as buffers. Mixed data show a tight link between the psyche and the spirit, with prayer and family-led rituals steadying emotions during long treatment cycles.

Emotional Toll and Daily Battles

Survey data showed an average depression score of 6.5 out of 10. Fear of death surfaced in early conversations, and then shifted to body image stress after surgery. Mastectomy scars and hair loss changed how women felt at home and in public. One interviewee shared, "I stopped going to the market. People stared at my scarf." Another said, "Nights are long. I feel alone when the house sleeps." These feelings tracked with validated trauma scales used in cancer care (Kessler et al., 2005). Loneliness rose when modesty norms curbed open talk about breast health, and when travel for care cut time with friends. Household roles also weighed on mood. Women often kept chores and caregiving, even during chemotherapy, which drained energy and reduced recovery time.

Faith as a Source of Strength

Spiritual routines provided calm and direction. Recitation of the Quran, dua after Fajr, and short visits to the mosque offered a sense of safety and control. Seventy-five percent used religion over counseling, citing comfort, privacy, and trust. Evidence supports faith-based coping in Muslim contexts, with

positive effects on mood and adherence (Koenig, 2012). Pargament's model frames this as positive religious coping, which channels stress into meaning and hope (Pargament, 1997). Integrating faith with medical care improved follow-through on appointments and symptom reporting.

Practical steps for providers

- Ask about faith routines in intake, and then document preferences.
- Offer brief Qur'anic reading space or quiet rooms.
- Invite trained chaplains or local imams for optional support.
- Pair psychoeducation with faith-consistent language about patience and action.
- Use female counselors to reduce stigma and increase uptake.

Lessons and Ways Forward for Better Care

Care improves when services meet people where they are. In Khyber Pakhtunkhwa, this means care that honors modesty, family roles, and faith, while keeping treatment timely and evidence-based. Global data point to large gains from earlier diagnosis and steady follow-up (IARC, 2024). The path forward blends clinic skill with community trust.

Culturally Grounded Care Models

Build programs that pair medical treatment with spiritual support. Offer private breast exams by female staff, brief counseling, and optional chaplain or imam visits. Use simple language in Pashto and Urdu, and include spouses or elders when patients agree. Link support groups to clinics, so advice and transport help sit beside chemotherapy and surgery. Faith-aligned messages can invite earlier care without fear or shame.

Policy and Workforce Steps

Health systems can act now with focused steps that fit local practice.

- Train clinicians in local dialects, modesty norms, and stigma-aware communication.
- Fund female-led screening days in district hospitals and mobile units.
- Integrate brief mental health screening into oncology visits, with referral options.
- Add transport and small cash support for low-income patients on treatment days.
- Standardize referral paths from rural centers to Peshawar hubs, with tracked timelines.

These measures align with global calls to cut delays and support continuity of care (IARC, 2024).

Study Limits and Future Work

This mixed-methods study used a modest sample and clinic-based recruitment. Results may not capture women outside hospital settings or those using only traditional care. Larger, community-based cohorts and follow-up after treatment would strengthen estimates and test program impact over time.

Community Calls to Action

Families, faith leaders, and local groups can shift norms.

- Share survivor stories on the radio in Pashto.
- Host women-only workshops in mosques, hujras, and schools.
- Encourage couples to attend first visits together.
- Form neighborhood transport pools for clinic days.

Small, steady steps build trust. When care respects culture and spirit, more women arrive earlier, stay on treatment, and heal with dignity.

Mixed Methods Study

Breast cancer in Khyber Pakhtunkhwa sits at a hard crossroads of culture, mind, and faith. Families often guide care decisions, stigma shapes disclosure, and spiritual beliefs carry weight in coping. To understand real needs, we have to look beyond the clinic and into daily life.

This post introduces the breast cancer study methodology used in a mixed-methods research in Pakistan. You will see how qualitative and quantitative strands come together to map sociocultural norms, psychological distress, and spiritual coping. We outline the design, sampling, data collection tools, and analysis steps that make the findings trustworthy.

The methodology chapter covers site selection across public and private oncology units in Khyber Pakhtunkhwa, participant inclusion criteria, and ethical safeguards. It explains semi-structured interviews and focus groups for depth, plus structured surveys for breadth. It also describes data handling, translation, and back translation, and how the team checked reliability and consistency.

On analysis, the chapter walks through thematic coding for interviews and descriptive and inferential statistics for surveys. It explains how the team integrated both strands to answer the same core questions. This approach strengthens credibility and shows where numbers and narratives align or diverge.

References that frame this chapter include WHO breast cancer fact sheets, the Pakistan Demographic and Health Survey 2017–18, mixed methods standards by Creswell and Plano Clark, and reporting checklists such as COREQ and STROBE. Together, they guide transparent reporting and help you judge study quality. If you care about sound breast cancer study methodology, this guide is your roadmap.

Understanding the Mixed Methods Approach in This Breast Cancer Study

This study uses a mixed methods design to see both the numbers and the stories behind them. Guided by Creswell and Plano Clark (2017), we combined a survey of 150 patients with 30 in-depth interviews. The work took place from 2023 to 2024 across oncology units in Peshawar. This approach fits Khyber Pakhtunkhwa, where family norms, honor, and faith strongly shape care seeking and coping.

- **Why mixed methods**: Numbers show patterns, interviews explain why those patterns exist.
- **Integration**: We compared survey rates with repeated themes in interviews. For example, 65% reported spiritual coping in the survey, and many interviewees described prayer guiding daily routines.

Quantitative Methods: Surveys and Statistical Insights

We used purposive sampling to recruit 150 women, aged 25 to 65, from public and private hospitals in Peshawar. Trained researchers conducted structured interviews lasting 20 to 30 minutes in Pashto or Urdu. Tools included the Hospital Anxiety and Depression Scale (HADS), validated by Zigmond and Snaith (1983), and a custom sociocultural questionnaire adapted for Pashtun culture.

Data were entered and cleaned in SPSS. We ran descriptive statistics and correlations. Family support showed a small but significant link with lower anxiety scores, $p < 0.05$. Results were kept simple for clinical use and community dialogue.

Here is a quick snapshot of key indicators:

Indicator	Value
Sample size (survey)	n = 150
Age range	25 to 65 years
Reported spiritual coping	65%
Mean spiritual well-being	M = 4.2 on a 5-point scale
HADS use and validity	Zigmond and Snaith, 1983

What this means: The survey maps prevalence and correlations. It signals where support systems, like family and faith, may reduce distress.

Qualitative Methods: In-Depth Interviews on Personal Experiences

We held semi-structured interviews with 30 participants to explore stigma, faith, and emotion. Sessions were recorded with consent, transcribed, translated, and checked by participants for accuracy. Analysis followed Braun and Clarke's (2006) steps for thematic analysis. We coded data in NVivo, and then grouped codes into themes.

Emergent themes: tribal stigma, family honor, prayer as routine, fear of disclosure, role of elders.

Salient pattern: 70% mentioned prayer as a spiritual anchor during treatment.

Sample quotes:

- "My family's honor made me hide my diagnosis."
- "I felt calmer when I prayed before each chemo session."
- "My mother-in-law decided when I could tell others."

How does this complement the survey?

The numbers show that spiritual coping is common. The interviews explain how prayer fits into daily life and decision-making.

Quant links family support with lower anxiety. Qual data shows what support looks like in a Pashtun home, from a sister's care to an elder's approval.

Sampling Strategies and Ethical Practices in the Study

Strong sampling and clear ethics made this study feasible in a sensitive setting. We recruited across busy oncology units, reached rural women through trusted networks, and built consent around language and privacy. These choices improved participation and the honesty of responses.

Participant Recruitment

We recruited participants at three major tertiary hospitals in Peshawar. Clinic staff introduced the study during routine visits, then researchers screened for eligibility. To reach women outside city centers, we used snowball sampling through community health workers and survivor networks.

Here is a quick view of reach and response:

Metric	Value
Recruitment sites	Three tertiary hospitals in Peshawar
Response rate	85%
Rural participants	40% of the total sample

This blend of site-based and network-based recruitment increased access, especially for women who avoid hospitals unless very ill.

Inclusion Criteria and Access Challenges

We applied simple, consistent criteria to keep the sample focused.

Inclusion: diagnosed breast cancer, resident of Khyber Pakhtunkhwa for 5 or more years, age 25 to 65, able to speak Pashto or Urdu.

Exclusion: acute medical instability that prevented the interview.

Low literacy was the main barrier. We addressed it with short, plain-language forms, verbal explanations, and time for questions. Travel and stigma also affected attendance, so we offered flexible interview times and private settings.

Ethical Approvals and Informed Consent

The study received approval from a local institutional review board. Procedures followed the World Health Organization guidance for ethical research in low-resource settings (2020).

Consent was offered in Pashto and Urdu, read aloud when needed. Participants chose written or audio-recorded consent. Female interviewers conducted all interviews in private rooms. Participants could pause, skip items, or stop without any effect on care. These steps built trust, which reduced social desirability bias and led to more candid accounts of stigma and coping.

Data Security and Cultural Sensitivity

We assigned coded IDs, stored the key file separately, and kept data on encrypted devices with restricted access. Audio files were transcribed, de-identified, and deleted after quality checks. Only the core team handled raw data.

Cultural respect guided fieldwork. Female staff led all contact, dress matched local norms, and scheduling avoided prayer times. Family presence was allowed at the participant's request, not by default.

Practical Tips You Can Apply

Partner with oncology nurses to screen and invite participants.

Use community health workers to seed snowball sampling in rural areas.

Translate and back-translate all tools, and then pilot them with 5 to 10 patients.

Offer short consent scripts and visual aids to support low literacy.

Train female interviewers on trauma-informed listening and privacy.

Store data with coded IDs, separate keys, and encrypted drives.

Align protocols with WHO 2020 guidance and your local IRB.

Data Analysis Techniques and Key Findings Preview

Here is how the study turns stories and numbers into clear, usable findings. We run both strands in parallel, compare results at the end, and highlight where they match or disagree. You will see what tests we used, what themes stood out, and how we merged them into one picture of breast cancer experiences in Khyber Pakhtunkhwa.

Convergent Parallel Analysis

We analyzed survey and interview data separately, and then merged them for interpretation. Following Tashakkori and Teddlie's Sage handbook of mixed methods (2010), we aligned variables and themes by shared questions on stigma, distress, family roles, and faith. The team combined matrices, joint displays, and side-by-side summaries to spot convergence and gaps.

Quantitative Techniques

We kept the statistics focused on practical signals:

- **t-tests** compared HADS depression scores by stigma level, urban or rural residence, and treatment stage.
- **Regression** modeled depression on sociocultural stigma, family support, age, and income. Stigma predicted higher depression, beta = 0.32, controlling for covariates.
- We checked assumptions, multicollinearity, and outliers before final models.

What it suggests: higher perceived stigma tracks with worse mood symptoms, even when support and money are considered.

Qualitative Techniques

We coded 30 interviews in two cycles. Fifteen descriptive codes rolled up into five core themes:

1. Faith as resilience
2. Family honor and disclosure
3. Elder gatekeeping in care
4. Embodied anxiety and sleep loss
5. Financial strain and treatment delay

Analytic memos captured how prayer routines, blessings, and Quranic recitation shaped daily coping.

Triangulation and Integration

We used method triangulation, investigator cross-checks, and quote audits to boost validity. One integrated insight:

- Surveys showed 55**%** reported spiritual coping in this wave.
- Interviews explained how Quranic verses, tasbih, and scheduled prayers reduced fear before chemo.

Numbers mapped prevalence, narratives explained practice.

Visuals to Use

Clustered bar charts for stigma levels vs mean HADS depression.

A regression plot with confidence bands.

A theme prevalence chart with short quotes as callouts.

This approach yields robust, culturally relevant insights that speak to clinicians, families, and policy teams alike.

Conclusion

This mixed methods design captured what numbers and narratives alone could not. Purposeful and network sampling reached clinic users and rural women, which improved voice and breadth. Validated tools like Hospital Anxiety and Depression, paired with a tailored sociocultural module, mapped distress, stigma, and support. Semi-structured interviews in Pashto and Urdu added depth on honor, prayer, and family roles. Parallel analysis, then joint displays, showed where rates and stories met.

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Use these lessons to guide service design in Khyber Pakhtunkhwa. Share this post, support local studies, or add your experience. Your voice can shape better care. For more on breast cancer methodology in Pakistan, stay with this series.

This mixed-methods study shows how sociocultural barriers and psycho-spiritual strengths shape care for breast cancer in Khyber Pakhtunkhwa. Family authority, stigma, and cost can slow help-seeking, while faith, prayer, and community ties often steady mood and reinforce adherence (WHO, 2023; IARC, 2020; Thuné-Boyle et al., 2006). The value lies in pairing numbers with lived stories, then translating both into integrated care that honors modesty, family roles, and belief.

Next steps are clear. Build clinical pathways that include female-led services, brief mental health screening, and optional faith support. Advocate for transport aid and referral tracking, and back community education in Pashto. Share this summary with a colleague, invite a local leader to your next workshop, or explore the references below for program design ideas. When care respects culture and spirit, more women reach treatment sooner and heal with dignity.

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