*Original Article*

# The Relationship Between Family Support and Religiosity with Quality of Life in Breast Cancer Patients in Sukabumi, West Java Indonesia

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## Abstract

**Background:** As a major public health concern on a worldwide scale, breast cancer impacts not just the physical health of patients but also their mental, emotional, social, and spiritual well-being, frequently leading to a decline in QoL. Although both family support and religion are known to have a significant impact on quality of life, the combined impacts of these two characteristics have not been thoroughly studied, especially in the cultural setting of Indonesia.
**Objective:** The purpose of this research is to look at how breast cancer patients in Sukabumi, West Java, Indonesia, fare when it comes to family support, religious affiliation, and quality of life.
**Methods:** The 320 women diagnosed with breast cancer at four different Sukabumi hospitals participated in a quantitative cross-sectional study that took place in 2020 and 2021. To gather data, researchers used validated instruments such as the EORTC QLQ-C30 for quality of life, the Family Support Scale for family support, and the Duke University Religion Index (DUREL) for religiosity. The associations between variables were examined using descriptive and inferential methods, including multiple regression.
**Results:** The mean scores for family support, religiosity, and QoL were 12.51 (SD = 2.161), 22.89 (SD = 3.554), and 44.04 (SD = 8.556), respectively. Simple regression analysis revealed significant positive relationships between family support (B = 2.718, $p < 0.001$, $R^2 = 47.1\%$) and religiosity (B = 1.664, $p < 0.001$, $R^2 = 47.8\%$) with QoL. Multiple regression analysis indicated that family support and religiosity jointly explained 57.2% of the variance in QoL ($p < 0.001$). Quality of life (QoL), family support (12.51; SD= 2.161), and religion (22.89; SD= 3.554) had respective mean ratings of 44.04 (SD= 8.556). The results of the simple regression analysis showed that religiosity (B = 1.664, $p < 0.001$, $R^2 = 47.8\%$) and family support (B = 2.718, $p < 0.001$) were significantly positively correlated with quality of life (QoL). According to multiple regression analysis, 57.2% of the variation in quality of life (QoL) was explained by both family support and religion ($p < 0.001$).
**Conclusion:** Religion and the support of family members are important factors in determining quality of life for breast cancer patients. Their combined impact highlights the significance of care options that incorporate spiritual and familial support. These results give light on how to improve the quality of life and holistic treatment for breast cancer patients in Indonesia by creating interventions that are culturally specific.
**Keywords:** breast cancer, quality of life, family support, religiosity, Sukabumi, Indonesia

## INTRODUCTION

Worldwide, cancer continues to rank high among the top causes of death and disability. Nearly 9.6 million people lost their lives to cancer in 2018, with 18.1 million new cases reported worldwide. According to statistics, 1 in 6 women and 1 in 5 men will receive a cancer diagnosis at some point in their lives, and 1 in 8 men and 1 in 11 women will die from the disease (1). When looking at incidence and mortality rates worldwide, the three most common cancer types are colorectal, breast, and lung cancers (1).

About 2.1 million new instances of breast cancer were reported in 2018, making up 11.6% of all cancer cases globally (2). This makes it the most frequent disease among women. With 42.1 new cases per 100,000 people and 17 deaths per 100,000 (3), breast cancer is also the most frequent disease in Indonesia. These numbers highlight the absolute necessity of all-encompassing healthcare plans to deal with breast cancer, which affects individuals in more ways than one.

Patients with breast cancer commonly experience a decline in their quality of life (QoL) due to the disease's impact on their physical, mental, social, and spiritual aspects of their lives (4,5). Despite the fact that survival rates have been greatly improved by therapies including radiation therapy, chemotherapy, and surgery, these interventions often have major side effects that harm quality of life (6). Quality of life (QoL) is an important metric in cancer treatment as it gauges how well a person is doing in relation to their cultural values, aspirations, and expectations, as stated by the World Health Organisation (WHO) (7,8).

Breast cancer patients, like those with any chronic disease, greatly benefit from the emotional and practical support of their loved ones. It provides patients with emotional and material support, keeping them motivated and stable as they undergo therapy. Having loved ones around to help cope with the emotional and social difficulties brought on by a terminal or life-altering illness improves quality of life, according to a number of studies (9–11). Among the many factors that impact quality of life for those dealing with terminal diseases like cancer, religiosity stands out. Religion improves mental health and resilience by giving people reason to hope for a better future and practical tools to deal with the inevitable challenges that life inevitably brings. Believers in a higher power provide cancer patients with strength and solace, which in turn improves their quality of life (12–15). Research has demonstrated that being religious is a powerful coping mechanism for breast cancer survivors, improving their emotional and spiritual well-being (16,17).

There is a lack of data on the combined impact of religious affiliation and family support on quality of life in cancer patients, especially in the Indonesian setting, despite the fact that previous studies have investigated these factors independently. Research in Indonesia must take into account regional differences in religious practices and cultural norms; this is especially true in areas like Sukabumi, West Java, where strong ties to family and community run deep. In order to fill this knowledge vacuum, this study investigates the correlation between religious affiliation, family support, and quality of life (QoL) for breast cancer patients in Sukabumi. Patients with breast cancer in Indonesia might benefit from more holistic treatment and better overall health if we could better understand these links so that we could develop culturally appropriate therapies.

## METHODS

### Study Design

Research in Sukabumi Regency and the city of Sukabumi, West Java, Indonesia, using a quantitative cross-sectional design. There are seven districts in Sukabumi City and forty-five in Sukabumi Regency. The following four public hospitals in the aforementioned locations were surveyed for their data: R. Syamsudin, SH Hospital (Sukabumi City), Sekarwangi Hospital, Palabuhan Ratu Hospital, and Jampangkulon Hospital (Sukabumi Regency). The patients were all treating breast cancer. The years 2020 and 2021 make up the research time frame.

### Sample

Three hundred and twenty-two people, all diagnosed with breast cancer and treated at participating hospitals in Sukabumi City and Regency during the research period, make up the subject population. We recruit all eligible individuals who fulfil the inclusion criteria via non-probability total sampling. Women who met the following criteria were eligible to participate: they had to be 18 years old or older, have a confirmed diagnosis of breast cancer, live

with family, be aware and orientated, willing to participate, and give written informed permission. Patients who are unable to take part in the study due to mental health issues or significant cognitive impairment are not eligible to participate.

G*Power software was used to determine the necessary sample size for a multiple regression analysis. The dependent variable was quality of life, and the independent variables were family support, religiosity, and a medium effect size ($f^2$ = 0.10), a significance level (α) of 0.05, and a power (1-β) of 0.80. We determined that a sample size of 300 was necessary. This study surpasses the minimal criteria by including 320 individuals, which enhances dependability and generalisability.

**Instruments**

In order to measure quality of life, the EORTC QLQ-C30 was used. This questionnaire is developed and administered by the European Organisation for Research and Treatment of Cancer. The 30 items that make up the instrument were created by the European Organisation for Research and Treatment of Cancer. They evaluate global health status, symptoms, and functional abilities. After being changed to a scale from 0 to 100, scores indicate the severity of symptoms or the degree of functioning, based on the subscale. Both the original and Bahasa Indonesia versions of the EORTC QLQ-C30 have shown good reliability (Cronbach's alpha > 0.70).

Perceived emotional, instrumental, and informational support from family members is measured using the Family Support Scale from the Family Support Questionnaire. On this measure, 20 items are evaluated using a 5-point Likert scale, where 1 indicates a strong disagreement and 5 means a strong agreement. Greater family support is indicated by higher scores. The reliability and validity of the Bahasa Indonesia version of the original scale are comparable to its high level of internal consistency (Cronbach's alpha = 0.87).

In order to gauge religiosity, Koenig et al. created the Duke University Religion Index (DUREL). Intrinsic, non-organizational, and organisational religiosity are measured on this 5-item scale. Higher scores imply a higher level of religiosity on the Likert scales that measure these items. Both the original and Bahasa Indonesia versions of the scale have demonstrated satisfactory levels of reliability (Cronbach's alpha = 0.90).

**Procedure**

Institutional Review Board (IRB) permission was acquired for this study from STIKes Sukabumi. The hospital administration also gave its approval. Between 2020 and 2021, participants were enlisted and given information on the study's goals, methods, potential hazards, and advantages in order to get their signed informed consent. All steps of the procedure were designed to maintain confidentiality. Medical information, including tumour stage at diagnosis and beginning therapy, as well as sociodemographic data, were culled from hospital records. Participants were questioned for the former. Professional research assistants oversaw data collection and made sure it followed all protocol requirements. In order to make sure that no pain or annoyance was caused, when data collection was over, participants were asked for their thoughts on the experience.

**Data Analysis**

Descriptive and inferential statistics were used to examine the data. Using percentages, standard deviations, and means, descriptive statistics summarised the sociodemographic characteristics of participants as well as the research variables of family support, religion, and quality of life. We used multiple regression analysis to look for a connection between religious affiliation, familial support, and quality of life. A significance threshold of $p < 0.05$ was used in all analyses, which were carried out using SPSS (version 23).

## RESULTS

The respondent demographics are shown up in Table 1. Of the total participants, 164 (or 51.2% of the total) are into the 46-60 year old bracket, while 28.7% are in the 36-45 age bracket. When asked about their level of education, 50.3% of those who participated (161 people) said they had finished junior high. With 244 responders (76.3% of the total), the majority of the participants are jobless, and 233 (72.8% of the total) are married. More than eighty percent of those who took the survey had dealt with breast cancer for more than a year. This includes 258 people.

**Table 1. Characteristics of Respondents**

| Characteristics | f | % |
|---|---|---|
| **Age** | | |
| 17 – 25 | 18 | 5,6 |
| 26 – 35 | 46 | 14,4 |
| 36 – 45 | 92 | 28,7 |
| 46 – 60 | 164 | 51,2 |
| **Last Education** | | |
| No School | 25 | 7,8 |
| Primary School | 92 | 28,7 |
| Junior High School | 161 | 50,3 |
| Senior High School | 34 | 10,6 |
| College | 8 | 2,5 |
| **Marital Status** | | |
| Not Married | 42 | 13.1 |
| Married | 233 | 72.8 |
| Widow | 45 | 14.1 |
| **Job Status** | | |
| Employed | 76 | 23,8 |
| Unemployed | 244 | 76,3 |
| **Long Time Suffering From Breast Cancer** | | |
| < 1 Year | 62 | 19,4 |
| > 1 Year | 258 | 80,6 |

Table 2 displays the outcomes of the research variables' univariate analysis. Family support scores range from 6 to 15, with a mean of 12.51 and a standard deviation of 2.161. There is a wide range of religiosity, from 13 to 29, with a mean score of 22.89 and a standard deviation of 3.554. A quality of life score ranging from 21.28 to 71.84 with a mean of 44.04 and a standard deviation of 8.556.

**Table 2. Univariate Analysis of Research Variables**

| Variable | Mean | Standard Deviation (SD) | Max | Min |
|---|---|---|---|---|
| Family Support | 12,51 | 2,161 | 6 | 15 |
| Religiosity | 22,89 | 3,554 | 13 | 29 |
| Quality of Life | 44,04 | 8,556 | 21,28 | 71,84 |

The outcomes of the basic linear regression analysis are shown in Table 3. Results demonstrate that family support has a substantial impact on breast cancer patients' quality of life. The unstandardised coefficient (B) is 2.718, the p-value is 0.000, and the $R^2$ value is 0.471, which means that family support accounts for 47.1% of the variation in quality of life. An unstandardised coefficient (B) of 1.664, a p-value of 0.000, and a $R^3$ value of 0.478, explaining 47.8% of the variation, indicate that religion also strongly effects quality of life.

**Table 3. Simple Linear Regression**

| Variables | P-Value | Unstandardized Coefficients B | | R | $R^2$ |
|---|---|---|---|---|---|
| | | Constant | Variables | | |
| Family Support | 0.000 | 10.074 | 2.718 | 0.686 | 0.471 |
| Religiosity | 0.000 | 5.949 | 1.664 | 0.691 | 0.478 |

According to the findings of the multiple linear regression analysis, which are presented in Table 4, the quality of life of breast cancer patients is significantly affected by both family support and religion. Together, these factors account for 57.2% of the variation in QoL, as shown by the model's p-value of 0.000 and $R^2$ value of 0.572. With X1X1 standing for familial support and X2X2 for religiosity, the regression equation reads as follows: Y=0.370+1.624X1+1.020X2.

**Table 4. Multiple Linear Regression**

| Variables | *P*-Value | Unstandardized Coefficients B | R | $R^2$ | *P*-Value Anova |
|---|---|---|---|---|---|
| (Constant) | | 0.370 | | | |
| Family Support | 0.000 | 1.624 | 0.758 | 0.572 | 0.000 |
| Religiosity | 0.000 | 1.020 | | | |

## DISCUSSION

Findings from this study show that family support has a substantial impact on breast cancer patients' quality of life (QoL). Consistent with other studies, these results show that having supportive family members around improves the quality of life for breast cancer patients (11). Also supporting this idea was, who noted that patients' quality of life is greatly affected by the assistance they receive from their families (20).

Communicating verbally and nonverbally, providing material aid, and taking direct acts to show care and concern are all parts of family support (21). Family members are essential in giving stability and comfort to individuals with chronic or fatal illnesses, such as breast cancer. Since they know the patient well and are sensitive to their emotional needs and expectations, these people are in a prime position to provide positive reinforcement (10).

Support from loved ones throughout treatment can take many forms, including words of encouragement, physical aid, psychological solace, and the exchange of helpful hints and details. Patients may feel more comfortable talking about their problems and trying new, healthier ways of coping when they are engaged in this way because it promotes a feeling of love, care, and respect (22).

According to Yenni, a person's health and quality of life are affected by their lifestyle choices, which are influenced by their family's support. When patients have strong family backing, they are more likely to make positive lifestyle changes that benefit their mental and physical health (23). In addition, research has demonstrated that patients' quality of life is directly improved by receiving appropriate family support, which can take many forms including emotional comfort, acknowledgement, material aid, and knowledge (24).

Taking care of patients' emotional and spiritual well-being is crucial to raising their quality of life as they endure breast cancer. Family support, in addition to practical aid, helps alleviate psychological concerns like anxiety that breast cancer patients often face and have a detrimental effect on their quality of life. Families may aid their loved ones in overcoming the psychological challenges they face throughout therapy by being there for them emotionally and creating a supportive atmosphere (22, 25).

This study discovered that religion had a substantial impact on the quality of life of breast cancer patients, just as family support. These results are in line with those of a previous study by Cahyani that found a favourable correlation between religion and survival time in cancer patients (26). In a similar vein, Dewi shown that religious practice improves quality of life, especially for patients, by providing them with a feeling of direction and tranquilly (27).

One comprehensive component of palliative care for cancer patients is religiosity, which is the internalisation and practice of religious principles. It gives them emotional and mental fortitude, which improves their quality of life (QoL) considerably (28,29). Many of the women who participated in this study saw their breast cancer diagnosis as a spiritual test, and as a result, they accepted their disease and devoted themselves to their treatment as a way to honour God (30).

Spiritual health is more prevalent among breast cancer patients who keep an optimistic attitude about their prognosis, according to research by Seyedrasooly (31). From this vantage point, it is clear that religious practice helps cancer patients deal with the emotional and mental challenges they face. On top of that, having faith can help patients relax, which in turn makes it easier for them to cope with their illness and welcomes recovery more readily (32). Research has demonstrated that religious practice has a favourable impact on the physical and emotional well-being of breast cancer patients, suggesting that it might be a useful tool in managing the disease (33,34).

Additionally, this study found that religion and familial support interact to affect quality of life. Because spiritual habits and beliefs can be strengthened via familial encouragement, patients who have good family support tend to be more religious. Resilience and quality of life are both improved by the combined effects of these elements. The inverse is also true: when patients do not have the support of their loved ones, their religiosity may suffer, and they may be less able to face the difficulties of their sickness.

### Implications

This study highlights the critical role of both religiosity and family support in enhancing the quality of life among breast cancer patients. The findings emphasize that emotional and practical support provided by loved ones, reinforced by religious coping, significantly contributes to patient well-being. For nursing practice, these results suggest the importance of integrating psychosocial and spiritual support interventions into cancer care plans. Health institutions, particularly Sukabumi City and District Government Hospitals, are encouraged to prioritize structured patient and family education programs that incorporate religious, emotional, and practical support elements. By fostering stronger family involvement and addressing patients' spiritual needs, healthcare providers can enhance patient self-sufficiency and overall quality of life.

### Limitations

This study has several limitations that must be considered. First, the cross-sectional design limits the ability to infer causality between religiosity, family support, and quality of life outcomes. Second, the study was conducted within a specific cultural and geographic context (Sukabumi City and District), which may affect the generalizability of the findings to broader populations. Third, data were collected through self-reported measures, which may introduce bias related to social desirability or inaccurate recall. Future research employing longitudinal designs and diverse sample populations would strengthen the evidence base and enhance the external validity of the findings.

## CONCLUSION

Religiosity and family support play a significant role in improving the quality of life among breast cancer patients. Patients who receive strong emotional, practical, and spiritual support demonstrate better self-sufficiency and well-being. The findings underscore the necessity for healthcare systems to develop comprehensive support programs that address not only physical but also psychosocial and spiritual aspects of patient care. Further research and policy development are recommended to create sustainable models of support tailored to the cultural contexts of breast cancer patients.

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### Author Contribution

RD : Conceptualization and Study Design, Methodology, Data Curation, Writing – Original Draft, Writing – Review & Editing
SLP : Conceptualization and Study Design, Methodology
NSU : Data Curation, Methodology, Formal Analysis

### Conflict of interest

The authors declare no conflict of interest regarding the research, authorship, or publication of this article.

### Data availability statement

The data supporting the findings of this study are available from the corresponding author upon reasonable request. All shared data will be de-identified to ensure participant confidentiality.

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