

The Psychosocial Experiences of Cancer Patients During Treatment in Eastern Türkiye: A Phenomenological Study

Türkiye'nin Doğusundaki Kanser Hastalarının Tedavi Sürecindeki Psikososyal Deneyimleri: Fenomenolojik Bir Çalışma

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ABSTRACT

This study aimed to explore the psychosocial experiences of cancer patients during treatment within the unique socio-cultural context of eastern Türkiye. A qualitative phenomenological design was employed with 15 participants receiving chemotherapy at Muş State Hospital between February and September 2025. Data were collected through semi-structured interviews, analyzed using Colaizzi's seven-step method, and reported in accordance with the COREQ checklist. The analysis revealed four interrelated themes capturing the essence of the participants' lived experiences. Shock of Diagnosis: First Encounter with Death reflected existential disruption and cognitive-emotional numbness following diagnosis. The Invisible Burden: The Grip of Body–Time–Space described the intertwined physical, economic, and spatial challenges faced during treatment. The Social Pendulum: Withdrawal or Support? illustrated oscillation between isolation and the need for social connection. Reconstruction of Hope: Rebuilding Through Meaning emphasized psychological resilience regained through spiritual anchoring, micro-goals, and self-therapy strategies. Cancer was experienced not only as a biological illness but also as an existential, social, and spiritual phenomenon. The strong family ties, communal solidarity, and faith-based coping mechanisms of eastern culture emerged as key resources supporting emotional adjustment and well-being.

Keywords: Cancer, Cultural context, Phenomenology, Psychosocial experiences, Psychiatric nursing

ÖZ

Bu araştırmanın amacı, Türkiye'nin doğu bölgesine özgü sosyokültürel bağlam içerisinde kanser hastalarının tedavi sürecinde yaşadıkları psikososyal deneyimleri derinlemesine incelemektir. Araştırmada nitel bir fenomenolojik desen kullanılmıştır. Şubat–Eylül 2025 tarihleri arasında Muş Devlet Hastanesi'nde kemoterapi tedavisi alan 15 katılımcı ile çalışılmıştır. Veriler yarı yapılandırılmış görüşmeler yoluyla toplanmış, Colaizzi'nin yedi aşamalı analiz yöntemi kullanılarak çözümlenmiş ve bulgular COREQ kontrol listesine uygun biçimde raporlanmıştır. Analiz sonucunda, katılımcıların yaşantılarının özünü yansıtan dört birbiriyle ilişkili tema ortaya çıkmıştır. Tanı Şoku: Ölümle İlk Karşılaşma teması, tanı sonrası yaşanan varoluşsal sarsıntı ile bilişsel ve duygusal donukluğu ifade etmektedir. Görünmez Yük: Beden–Zaman–Mekân Kısıracı teması, tedavi sürecinde karşılaşılan fiziksel, ekonomik ve mekânsal zorlukların birbirine geçmiş doğasını ortaya koymaktadır. Sosyal Sarkaç: Geri Çekilme mi, Destek mi? teması, bireylerin izolasyon eğilimi ile sosyal destek arayışı arasında yaşadığı gelgitleri yansıtmaktadır. Umudun Yeniden İnşası: Anlam Yoluyla Yeniden Doğuş teması ise manevi yönelim, küçük hedefler belirleme ve öz-terapi stratejileri aracılığıyla yeniden kazanılan psikolojik dayanıklılığı göstermektedir. Kanser, yalnızca biyolojik bir hastalık değil; aynı zamanda varoluşsal, sosyal ve manevi boyutlarıyla bütüncül bir insan deneyimi olarak yaşanmaktadır. Doğu kültürünün karakteristik özellikleri olan güçlü aile bağları, toplumsal dayanışma ve inanca dayalı baş etme mekanizmaları, duygusal uyum ve psikolojik iyi oluşun temel kaynakları olarak belirlenmiştir.

Anahtar Kelimeler: Kanser, Kültürel bağlam, Fenomenoloji, Psikososyal deneyimler, Psikiyatri hemşireliği.

Highlights

- *This study provides an in-depth exploration of the psychosocial experiences of cancer patients in eastern Türkiye within their unique cultural context.
- *Findings highlight spirituality and family support as fundamental resources in coping with illness.
- *The study underscores the importance of culturally sensitive and meaning-centered psychosocial care in psychiatric nursing practice.

The study was approved by the Muş Alparslan University Ethics Committee (No: 2024/82, dated: 08.01.2025) and conducted in accordance with the Declaration of Helsinki. Institutional permission was also obtained.

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INTRODUCTION

Cancer is a major public health problem that affects all societies and profoundly impacts individuals physically, psychologically, and socially (1). According to the World Health Organization, cancer is among the leading causes of morbidity and mortality worldwide, with approximately 19.3 million new cases and nearly 10 million deaths reported globally in 2020, and this burden is expected to increase significantly in the coming decades. In Türkiye, cancer is the second leading cause of death after cardiovascular diseases (1). Beyond its high morbidity and mortality rates, cancer constitutes a biopsychosocial crisis that disrupts an individual's overall life balance (2). The uncertainty extending from diagnosis to the terminal stage, the fear of recurrence, and the challenges associated with treatment often lead to intense psychological distress among patients (3).

Studies have shown that a significant proportion of cancer patients experience anxiety, depression, and adjustment disorders during the diagnosis and treatment process. Symptoms of anxiety are observed in 10–40% of patients, depressive symptoms in 5–30%, and clinical-level psychiatric disorders develop in approximately 20–30% (4). Hinz et al. (2010) reported that the prevalence of anxiety and depression among cancer patients is nearly twice as high as in the general population. These psychological difficulties significantly reduce quality of life and hinder treatment adherence (5-6).

In the field of oncology, psychosocial care needs are reported to be high; however, these needs are often insufficiently addressed (7). Lack of information, inadequate emotional support, and social isolation are key factors that hinder patients' adherence to the treatment process (8). Morrison et al. (2012) emphasized that cancer patients primarily require information and social support throughout their care. Therefore, cancer care should not be limited to medical interventions alone but should be planned through a holistic approach that encompasses patients'

psychological and social needs (2).

Cultural and geographical contexts are known to influence how cancer experiences are perceived and lived. Individuals construct meaning around their illness and develop coping strategies in line with the values and beliefs of their society (9-10). In Türkiye, particularly in the eastern and southeastern regions, traditional family structures, strong kinship ties, and the prominent role of religious beliefs are distinctive features.⁽¹¹⁾ Within Turkish culture, religious coping strategies such as prayer, surrender to God, and trust in divine will are commonly practiced (10,11,12). Consequently, patients in rural areas often draw strength from spiritual beliefs and family support. Family members typically play an active role in the patient's care and decision-making processes, which can provide a supportive network but may also lead to paternalistic approaches at times (13). Harmonious family relationships facilitate patients' psychosocial adjustment, whereas conflictual dynamics may hinder this process (14). Moreover, in socioeconomically disadvantaged regions of Türkiye, geographical, financial, and linguistic barriers to accessing healthcare services further increase the psychological burden of cancer patients (15,16). These challenges directly shape how illness is interpreted and how psychosocial needs are expressed. However, qualitative studies focusing on the psychosocial experiences of cancer patients in the eastern and southeastern regions of Türkiye remain limited particularly those adopting a phenomenological perspective (17). Therefore, exploring how cultural and regional factors influence illness experiences is crucial for developing culturally sensitive psychosocial care models.

Psychiatric nursing plays a fundamental role in helping cancer patients cope with psychosocial challenges such as anxiety, hopelessness, body image concerns, and changes in social roles. In this context, the present study aims to explore in depth the psychosocial experiences of cancer patients living in Muş, Türkiye, during their treatment

process through a phenomenological approach. The findings of this study are expected to contribute to the existing literature and provide a foundation for the development

of culturally sensitive nursing practices that address the psychosocial dimensions of cancer care.

MATERIAL AND METHOD

Type of Research

This study was conducted using a phenomenological qualitative research design. In reporting the study, the COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist was followed, and all stages were standardized in accordance with these guidelines (Table 1). The phenomenological method allows for an in-depth understanding of the psychosocial experiences of cancer patients during their treatment process from their own subjective perspectives (18).

Study Population and Sample

The population of the study consisted of individuals undergoing cancer treatment at Muş State Hospital. The sample included those who met the inclusion criteria established for the study. Among purposive sampling techniques, criterion sampling was employed. This method involves selecting individuals who possess specific characteristics relevant to the research purpose based on predetermined criteria. Participants were selected from among those who were willing to share their treatment experiences and met the qualifications required for the study. The use of this sampling method enhanced the credibility of the research and supported the validity of the findings.

Inclusion Criteria

Participants were included in the study if they met the following criteria:

1. Aged 18 years or older,
2. Receiving outpatient chemotherapy treatment,
3. Able to express their psychosocial experiences and the challenges they encountered,
4. Willing to voluntarily participate in the study.

5. Having received a confirmed cancer diagnosis and currently undergoing active treatment,
6. Having sufficient cognitive capacity to participate in an in-depth interview.

Exclusion Criteria

Participants were excluded from the study if they met any of the following conditions:

1. Having severe cognitive impairment or communication difficulties that could hinder participation,
2. Having a diagnosed severe psychiatric disorder that could affect the reliability of the data,
3. Being unwilling to continue or withdraw from the interview process at any stage,
4. Being in a critical clinical condition that prevents participation in an interview.

The primary aim of phenomenological research is to obtain rich and in-depth data. In qualitative studies, data saturation is typically achieved with approximately 12 participants, and saturation occurs when similar codes begin to recur (19,20). Therefore, the number of participants in this study was determined once data saturation had been reached. Data saturation was achieved after interviews with 15 participants, and the sample size was finalized accordingly.

Data Collection Tools

Personal Information Form

This form was prepared by the researchers based on the relevant literature to identify the participants' basic sociodemographic characteristics, including age, gender, educational status, marital status, place of residence, and duration of treatment. The development of this form was informed by previous studies examining the sociodemographic and clinical characteristics of cancer patients in similar research contexts (12-14).

Semi-Structured Interview Form

The semi-structured interview form was developed in line with the literature to explore the psychosocial experiences of participants during the treatment process (10,18-21). The form was reviewed and finalized in consultation with three experts in psychiatric nursing who have extensive experience in qualitative research. It consisted of nine open-ended main questions. The questions included in the semi-structured interview form were as follows:

1. How did you experience the day you received your diagnosis?
2. What does the treatment process mean to you?
3. What were the most significant challenges and gains you experienced during this period?
4. Were there any individuals who supported you? How did you experience this support?
5. How would you describe your hopes and expectations for the future?

Data Collection Process

The study was conducted in Muş, Türkiye, between February and September 2025. Participants were selected on a voluntary basis and were informed in detail about the purpose and process of the study prior to participation. Written informed consent was obtained from all participants. Interviews were conducted face-to-face in private settings that ensured confidentiality and were audio-recorded with participants permission. Before each main interview, a 10–15-minute preliminary conversation was held to establish rapport; this segment was not included in the analysis. Each interview lasted approximately 30–60 minutes. All data were used solely for research purposes and stored in accordance with confidentiality and data protection principles. All interviews were conducted by the first author, while data analysis and interpretation of the findings were collaboratively performed by the research team. Throughout the process, the principles of therapeutic communication were observed, and participants were granted the right to

terminate the interview at any time.

Research Team and Reflexivity

This study was conducted by a team of three psychiatric/mental health nurses. The researchers' expertise in psychosocial experiences and qualitative research methods contributed to conducting the interviews with empathy, sensitivity, and adherence to ethical principles. Throughout data collection and analysis, the researchers maintained an active reflexive stance, continuously examining how their professional backgrounds and personal perspectives might influence the study to minimize potential bias. The first author guided the interviews, providing a supportive environment that encouraged participants to share their stories freely. The findings were derived directly from the data, independent of preconceptions, and substantiated by participants' quotations. This reflexive approach strengthened the ethical rigor and trustworthiness of the study.

Internal and External Validity

Several strategies were employed throughout the data analysis process to ensure the trustworthiness and credibility of the findings.

Credibility

Data were collaboratively analyzed by the research team. The transcripts were first read and coded independently, followed by blind reading and comparison of coding results. Through team discussions, themes and subthemes were developed, interpreted, and substantiated with participants' quotations to enhance the authenticity of the results.

Transferability

Interviews were conducted in quiet, comfortable settings that allowed participants to express themselves freely. Detailed descriptions of participant profiles, sociodemographic characteristics, and the research context were provided to strengthen the transferability of the findings to similar settings.

Dependability

To maintain methodological consistency,

all interviews were conducted by a single researcher, thereby minimizing procedural variations that might arise from multiple interviewers.

Confirmability

Interviews were digitally recorded, and all related materials were securely stored. Interpretations during analysis were derived directly from the data, with ongoing reflexivity used to minimize researcher bias. In addition, the identified themes and subthemes were reviewed by three experts in the field to ensure methodological rigor.

These strategies collectively enhanced the study's reliability within its context and supported its potential transferability to similar populations and circumstances.

Data Analysis

During the analysis process, the audio recordings obtained with participants' prior consent were manually transcribed and analyzed. Colaizzi's (1978) seven-step phenomenological analysis approach, widely used in qualitative research, was applied (22).

1. All interview transcripts were read multiple times to gain a holistic understanding of the psychosocial experiences of cancer patients during treatment.
2. Significant statements directly reflecting the phenomenon were identified and extracted as units of analysis.
3. The meanings underlying these statements were formulated clearly and concisely through collaborative comparison and consensus among the researchers.

4. Formulated meanings were then clustered according to similarities in content to generate themes and subthemes.
5. Based on these thematic clusters, a detailed descriptive narrative supported by participant quotations was developed, illustrating the psychosocial experience in its full complexity.
6. The comprehensive description was distilled into a succinct formulation representing the essential structure of the phenomenon.
7. The resulting themes and essential structure were shared with selected participants for feedback, and necessary refinements were made in light of their comments to reinforce the validity of the findings.

This systematic procedure ensured phenomenological rigor and enhanced the credibility and dependability of the study findings (22,23).

Ethical Procedures

This study was conducted in accordance with the principles of the Declaration of Helsinki. All procedures involving human participants were approved by the Muş Alparslan University Scientific Research and Publication Ethics Committee (Approval No: 2024/82). Institutional permission was also obtained from Muş State Hospital (Document No: 51732808-605.001.001-E.176705, dated January 8, 2025). Written informed consent was obtained from all participants prior to data collection.

RESULTS

The sample of this study consisted of 15 participants, whose ages ranged from 32 to 74 years, with a median age of 49 and a mean age of approximately 50.9 years. Gender distribution was relatively balanced, with eight women and seven men. In terms of educational attainment, six participants had completed primary school, three secondary school, four high school, one associate degree,

and one bachelor's degree. Regarding marital status, twelve participants were married and three were single. Most participants resided in urban areas; ten lived in the city center, three in villages, and two in district or town settings. The duration of treatment ranged from less than one year to over three years, with a median of two years and an average of approximately 3.4 years. Four participants

had been in treatment for one year or less, eight for one to three years, and three for more than three years. Overall, the sample predominantly represented middle-aged and older adults who were married, resided in central urban areas, and had an educational

background between primary and high school levels. The inclusion of participants with longer treatment histories added notable temporal depth to the study's findings (Table 2).

Table 2. Sociodemographic Characteristics of the Participants

Participant	Age	Gender	Educational Status	Marital Status	Place of Residence	Treatment Year
P01	61	Male	Primary school graduate	Married	City	2 year
P02	49	Female	Primary school graduate	Married	City	7 year
P03	74	Male	Primary school graduate	Married	City	15 year
P04	48	Male	High school graduate	Married	City	2 year
P05	61	Male	Primary school graduate	Married	City	1 year
P06	32	Female	Associate degree	Married	City	1 year
P07	40	Female	Secondary school	Married	City	3 year
P08	40	Female	Secondary school	Married	City	3 year
P09	52	Male	High school graduate	Married	village	1 year
P10	55	Female	Secondary school	Married	village	2 year
P11	39	Male	High school graduate	Bekar	City	3 year
P12	67	Female	Primary school graduate	Single	village	5 year
P13	35	Male	Associate degree	Single	City	1 year
P14	63	Female	High school graduate	Married	village	3 year
P15	47	Female	Primary school graduate	Married	village	1,5 year

Theme 1. Shock of Diagnosis – First Encounter with Death

This category encapsulates the existential rupture experienced at the moment of diagnosis. For participants, receiving a cancer diagnosis marked a definitive turning point that divided their lives into “before” and “after.” The recurring question “*Why me?*” signified a profound crisis in their sense of

justice and fate. Cognitive and emotional freezing was common—participants described narrowed perception, bodily numbness, and an inability to make decisions. The shock of diagnosis suspended not only the present but also future plans and self-narratives, compelling individuals to confront mortality and reconstruct the meaning of life (Table 3).

Table 3. Themes and Subthemes

Main Theme	Subtheme
1. Shock of Diagnosis · First Encounter with Death	1.1. Existential disruption 1.2. Cognitive–emotional paralysis 1.3. Collapse of the future narrative
2. The Invisible Burden · The Grip of Body–Time–Space	2.1. Negotiating side effects 2.2. Disruption of identity and productivity 2.3. Logistical and access burden
3. The Social Pendulum · Withdrawal or Support?	3.1. Faces of isolation 3.2. Domestic caregiving labor 3.3. Mediation through health literacy
4. Reconstruction of Hope · Rebuilding Through Meaning	4.1. Spiritual grounding and micro-goals 4.2. Self-therapy strategies 4.3. Re-tailoring of the self

“When the doctor said ‘cancer,’ I thought my life was over... the question ‘Why me?’ echoed in my mind.” (P11)

“I had career and travel plans—suddenly it felt like they were all taken away.” (P09)
“When I first heard the diagnosis, I was

terrified... my ears rang, I couldn't hear anything." (P05)

"They told me, 'You have cancer'... I cried for fifteen days." (P07)

"My world collapsed; my first thought was my children—they were so young." (P03)

"When the doctor said 'cancer,' I felt as if boiling water was poured over me." (P02)

Theme 2. The Invisible Burden – The Grip of Body, Time, and Space

This category illustrates the multifaceted impact of treatment on patients' daily lives. Participants struggled to balance "good days and bad days" while coping with fatigue, nausea, pain, hair loss, and changes in sleep and appetite. These side effects disrupted their identity and productivity, delaying their return to family and professional roles and evoking feelings of incompleteness and fluctuating self-efficacy. Hospital appointments, transportation barriers, and financial strain further distorted the rhythm of daily life, reshaping the spatial order between home, hospital, and travel. To maintain functionality, participants adopted coping strategies such as resting between tasks, dividing activities into smaller parts, and seeking help from social networks (Table 3).

"The first four or five days after chemotherapy are extremely hard—nausea, weakness, and fatigue overwhelm me." (P03)

"I can't maintain my old routines; housework is difficult, and I feel incomplete." (P03)

"My body is exhausted; there were days I couldn't eat even a bite." (P08)

"Fatigue, weakness... my hair became coarse, but I tell myself, 'continue your normal life.'" (P08)

"Financial hardship was very difficult. I had no insurance or income and feared being a burden to my family." (P07)

Theme 3. The Social Pendulum – Withdrawal or Support?

This category captures the dynamic nature of relational experiences oscillating between isolation and support. Participants described loneliness and withdrawal from social life due to fear of infection, fatigue, and stigma.

Simultaneously, family and neighborhood networks alleviated their burden by offering care, transportation, meals, and emotional comfort. Health literacy—enhanced through physicians' explanations, the shared experiences of other patients, and the "translator" role of family members—reduced uncertainty and facilitated treatment adherence. The "social pendulum" thus reflects a relational sphere continuously rebalanced between distance and closeness according to individuals' physical and emotional capacity (Table 3).

"I felt alone during treatment; sometimes I thought it was just me and God." (P09)

"I had to keep my distance even from my children; that was emotionally draining." (P07)

"Because I'm single, I was alone at home—but it taught me to stand on my own feet." (P11)

"My husband keeps saying, 'You'll get better'; those words give me strength." (P15)

"A friend told me about others who had recovered—it gave me relief." (P03)

"Those small gestures of support made me feel I wasn't alone; even a little care gave me strength." (P02)

Theme 4. Reconstruction of Hope – Rebuilding Through Meaning

This category conceptualizes the reconstruction of self and meaning. Participants gradually rebuilt their sense of hope and resilience through spiritual grounding, prayer, and setting micro-goals focused on "getting through today." Self-therapy strategies—such as listening to music, writing, gardening, or engaging in creative activities—helped them preserve emotional balance and enhance self-efficacy. Over time, a "re-tailoring of the self" unfolded: life priorities were redefined, small relational joys gained greater value, and existence was reframed through gratitude and patience. Hope thus evolved from an abstract belief into a lived, embodied practice, enabling individuals to reconstruct their narratives as agents living with, yet beyond, illness (Table 3).

"Still, I believe that with God's will I will

regain my health.” (P01)
“At first, I didn’t dare to hope, because this illness made me feel I was confronting death.” (P02)
“To cope, I prayed constantly and spent time in the garden; touching the soil felt like therapy.” (P02)
“My brother often took me for walks, and my children never left me alone.” (P07)
“I learned patience and began to value every

breath God grants.” (P01)
“A person cannot live without hope—the belief that ‘I will regain my health’ gives me strength.” (P14)
“Every morning I think, ‘I’ve gained another day; I will recover,’ and set small goals for myself.” (P11)
“This process taught me patience and gratitude for small things; loneliness showed me my own strength.” (P03, P13)

DISCUSSION

Shock of Diagnosis: First Encounter with Death

In this study, the cancer diagnosis was experienced by participants as a profound existential rupture that sharply divided their life trajectory into “before” and “after.” Analysis of the data revealed four main themes and their subthemes: “*Shock of Diagnosis: First Encounter with Death*,” “*The Invisible Burden: The Grip of Body–Time–Space*,” “*The Social Pendulum: Withdrawal or Support?*” and “*Reconstruction of Hope: Rebuilding Through Meaning*.” These themes are discussed below in light of the relevant literature.

In the present research, the moment of diagnosis represented not merely a piece of medical information but an event that destabilized the meaning of life and made death an immediate and tangible reality. Participants described emotional reactions such as shock, numbness, death anxiety, and the recurrent questioning of “*Why me?*” This finding aligns with previous studies reporting that cancer diagnosis is closely associated with high levels of anxiety and depression. For instance, Singer et al. (2010) found that approximately 23-53% of cancer patients experience clinically significant psychological distress (24). Similarly, Mitchell et al. (2011) described the post-diagnostic state of cognitive-behavioral paralysis as an *acute stress reaction* that severely tests psychological resilience (25).

Another key theme observed among participants was the collapse of the personal narrative about the future. Following

diagnosis, goals and roles related to work, education, and parenting were often suspended, leading individuals to experience a sense of being “trapped in the present.” This corresponds with findings in the literature linking post-diagnosis uncertainty and the cancellation of life plans to an increased risk of depressive symptoms (26).

Moreover, most participants evaluated the diagnostic process through disruptions in their sense of justice and destiny. In this respect, the study is consistent with research indicating that a cancer diagnosis can trigger spiritual questioning and the search for meaning (27).

In summary, the moment of diagnosis represents not merely the onset of disease but a multidimensional crisis encompassing psychological, existential, and social dimensions. Consistent with the literature, this phase appears to be one of the most emotionally demanding periods for patients, underscoring the critical importance of providing early psychosocial support (24,25,26).

The Invisible Burden: The Grip of Body, Time, and Space

The participants’ experiences revealed that cancer treatment is not only a biological process but also a multidimensional one encompassing physical, economic, and spatial burdens. Side effects of treatment—such as fatigue, nausea, and hair loss—limited daily functioning, leading to role losses and reduced self-efficacy.

These findings are consistent with previous studies in the literature. Lawrence et al. (2004) reported that treatment-related side effects

significantly decrease quality of life (28), while Pereira et al. (2012) found that loss of roles contributes to heightened anxiety and depression (29). The economic difficulties highlighted in participants' narratives also intensified the psychosocial burden. This aligns with studies showing that in low- and middle-income countries, cancer patients often allocate a substantial portion of their income to out-of-pocket expenditures, which increases their stress levels (30,31).

In conclusion, our findings indicate that cancer treatment extends beyond a biological struggle—it represents a multilayered transformation in which the body, time, and living spaces are continuously restructured. Within this context, effective management of side effects, compensation for role losses, and the strengthening of economic support mechanisms are crucial for enhancing the psychosocial resilience of cancer patients (28-31).

The Social Pendulum: Withdrawal or Support?

The findings of this study revealed that cancer patients oscillate between two opposing poles in their social relationships: social isolation and social support. Participants often withdrew from their surroundings due to the risk of infection, fatigue, and fear of stigmatization; however, the emotional, practical, and informational support provided by spouses, children, relatives, and healthcare professionals facilitated their coping process.

This finding is consistent with previous research indicating that social isolation increases the risk of depression and anxiety (26-32), while social support serves as one of the most powerful protective factors (33). Social support not only provided moral strength but also enhanced adherence to treatment (34). Moreover, access to information and health literacy emerged as crucial resources for coping with uncertainty during treatment (35).

In conclusion, the “social pendulum” observed in this study represents a delicate balance between withdrawal and receiving

support. Consistent with the literature, strengthening social support mechanisms and implementing interventions that improve health literacy may facilitate psychosocial adjustment among cancer patients (26,32,33).

Reconstruction of Hope: Rebuilding Through Meaning

Although participants initially experienced intense hopelessness, over time they began to generate new meanings and gradually reconstructed their sense of hope through spiritual beliefs and daily micro-goals. Prayer, worship, connection with nature, and engaging in productive activities emerged as central elements of this process.

These findings are consistent with previous studies indicating that spirituality and active coping strategies enhance psychological resilience (36,37). Over time, participants demonstrated cognitive restructuring characterized by increased patience, gratitude, and awareness of life's value—reflecting what Park (2010) defines as the “reconstruction of meaning.”

In conclusion, cancer patients in this study rebuilt their sense of hope through spiritual coping, self-therapy strategies, and meaning-making processes (38). This highlights the importance of incorporating spirituality and cultural sensitivity into psychiatric nursing practice. The present research demonstrates that the experiences of individuals diagnosed with cancer transcend physiological boundaries, encompassing existential, social, economic, and spiritual dimensions. The strong family ties, community solidarity, and religious practices characteristic of eastern culture serve as key resources supporting patients' resilience.

These findings emphasize the necessity of adopting a holistic nursing care model that integrates cultural sensitivity, spiritual orientation, and the active utilization of social support networks in psychiatric nursing. Such an approach is particularly vital for enhancing psychological recovery and treatment adherence among patients living within the eastern cultural context of Türkiye.

CONCLUSION AND RECOMMENDATIONS

This study demonstrated that receiving a cancer diagnosis creates a profound and multidimensional rupture in individuals' lives. Participants experienced intense shock, death anxiety, cognitive-emotional paralysis, and existential questioning such as "*Why me?*" at the moment of diagnosis, which led to the suspension of future plans. During the subsequent treatment process, side effects, loss of identity and productivity, and economic and logistical challenges deeply affected their daily functioning.

At the same time, participants described a fluctuating balance between social isolation and support, where assistance from family members, peers, and healthcare professionals played a crucial role in coping with uncertainty. Furthermore, spiritual anchoring, small achievable goals, and personal coping strategies enabled participants to reconstruct their sense of hope.

In conclusion, the findings reveal that the cancer experience represents a transformative journey—from the initial shock of diagnosis to the reconstruction of hope—where psychosocial, economic, and spiritual factors are deeply intertwined.

The findings of this study highlight the need for a holistic approach to cancer care in psychiatric nursing—one that addresses not only biological aspects but also emotional, social, and spiritual dimensions. During the diagnostic phase, nurses need to accompany individuals experiencing existential shock and death anxiety through therapeutic communication techniques. Throughout the treatment process, nurses should implement empowering interventions to help patients cope with side effects, role losses, and economic challenges.

The strong family bonds and spiritual values inherent in eastern culture should be recognized and utilized by nurses as supportive resources in care delivery. In this context, nurses are encouraged to assess and integrate patients' spiritual coping mechanisms—such as prayer, patience, and

reliance on divine will—into individualized care plans with cultural sensitivity and without judgment.

Furthermore, establishing support groups to reduce social isolation, improving health literacy, and implementing family-based psychosocial interventions can enhance patients' psychological resilience and treatment adherence. Based on these findings, psychiatric nurses are advised to incorporate culturally attuned, meaning-centered, and hope-oriented approaches into their clinical practice to promote comprehensive psychosocial well-being among cancer patients.

Strengths and Limitations

Strengths

This study employed a rigorous phenomenological design guided by the COREQ framework and Colaizzi's seven-step method, ensuring methodological credibility and transparency. The semi-structured interview guide was literature-based and validated by three experts, supporting content validity. Data saturation was reached at 15 participants through criterion-based purposive sampling, reinforced by multi-coder consensus and participant validation. Reflexivity was maintained throughout, with all interviews conducted by a single researcher to ensure consistency. Importantly, the study offers culturally grounded insights into the interconnection of spirituality, family cohesion, and socioeconomic context within eastern Türkiye.

Limitations

The single-center, context-specific design limits generalizability, emphasizing transferability over statistical inference. Voluntary participation may have introduced selection bias, while the cross-sectional and self-report nature raises potential recall or desirability bias. Clinical heterogeneity restricted subgroup analysis, and triangulation was limited by the absence of observational or caregiver data. Finally, variations in literacy

and the lack of objective assessment of financial burden (financial toxicity) may have influenced data depth.

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Author Contributions

Concept, design, data collection, ethics, and literature review – Fatih ŞAHİN; materials and methods – Eda ALBARAK GÜNDAY; data analysis – Kübra GÜLİRMAL GÜLER; critical review – all authors.

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Conflict of Interest

The authors declare that there is no conflict of interest regarding the publication of this paper.

Data Availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Ethical Approval and Participant Consent

This study was conducted in accordance with the principles of the Declaration of Helsinki. All procedures involving research participants were approved by the Muş Alparslan University Scientific Research and Publication Ethics Committee (Approval No: 2024/82). Institutional permission was also obtained from Muş State Hospital (Document No: 51732808-605.001.001-E.176705). Written informed consent was obtained from all participants, and confidentiality was ensured throughout the study.

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