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Cultural Beliefs and Psychosocial Responses among Cervical Cancer Patients

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Abstract

Background: Cervical cancer patients frequently experience psychosocial challenges that are influenced by sociocultural beliefs regarding illness and treatment.
Aims: This study examined the association between cultural beliefs and psychosocial responses among cervical cancer patients.
Methods: An observational cross-sectional study was conducted from January to April 2024 among 61 cervical cancer patients receiving treatment at Dr. Hasan Sadikin Hospital, Bandung, Indonesia. Participants were recruited using convenience sampling. Data collection was conducted using structured questionnaires designed to obtain participants' demographic characteristics, cultural beliefs, and psychosocial responses. Descriptive statistics and Spearman rank correlation analysis were performed to examine the relationship between cultural beliefs and psychosocial responses.
Results: The mean cultural beliefs score was 1.11 (SD = 0.18), while the mean psychosocial response score was 1.39 (SD = 0.32). Spearman's rank correlation analysis identified a moderate, statistically significant positive association between cultural beliefs and psychosocial responses ($r = 0.525$, $p < .001$).
Conclusion: Cultural beliefs were significantly associated with psychosocial responses among cervical cancer patients. Sociocultural considerations should be integrated into culturally responsive psychosocial support, nursing care, and community-based cervical cancer support initiatives.

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INTRODUCTION

Despite advances in prevention and treatment, cervical cancer continues to impose a substantial public health burden and remains among the leading cancers affecting women globally, particularly in low- and middle-income countries (Shah et al., 2019; Wilailak et al., 2025; World Health Organization, 2020). Global epidemiological evidence indicates that cervical cancer continues to contribute substantially to the global cancer burden (Sung et al., 2021). According to the WHO, cervical cancer accounts for substantial morbidity and mortality among women, with delayed diagnosis, limited screening coverage, and inadequate access to treatment contributing to poor outcomes (World Health Organization, 2025).

Several factors contribute to the continued burden of cervical cancer, including low screening participation, limited awareness of human papillomavirus (HPV) infection, sociocultural stigma related to reproductive health examinations, delayed healthcare-seeking behavior, and unequal access to preventive services. If these issues remain unaddressed, women may present at more advanced disease stages, experience increased psychosocial distress, reduced treatment adherence,

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lower quality of life, and higher mortality risk. Consequently, psychosocial adaptation has become an important component of comprehensive cervical cancer management.

In addition to its clinical burden, cervical cancer imposes substantial economic and social challenges on patients, families, and healthcare systems. Prolonged treatment, decreased household income, decreased productivity, and greater caregiving dependency are common outcomes for women with cervical cancer. Family members frequently assume caregiving responsibilities that may contribute to emotional strain and financial hardship. In Indonesia, the National Health Insurance (JKN) program, which is run by BPJS Kesehatan, reflects the growing economic burden of cancer care. Delayed diagnosis and advanced-stage presentation further increase treatment complexity and healthcare costs, emphasizing the importance of comprehensive prevention and supportive care strategies.

In Indonesia, cervical cancer continues to rank among the top causes of cancer-related death in women, with approximately 36,000 new cases and 21,000 deaths reported annually despite ongoing national prevention initiatives (Sung et al., 2021). Many Indonesian women are diagnosed at advanced stages, resulting in poorer prognosis and increased physical, emotional, and psychosocial burden (Sung et al., 2021). Beyond physical suffering, women with cervical cancer frequently experience psychosocial challenges, including anxiety, depression, hopelessness, social withdrawal, fear of stigma, spiritual distress, and financial difficulties (Smith, 2015; Zhang et al., 2025). These psychosocial responses substantially influence treatment adherence, general well-being, quality of life, and emotional adjustment (Afiyanti et al., 2019; Zhang et al., 2025). A recent systematic review further confirmed that cervical cancer substantially affects physical, psychological, sexual, and social dimensions of quality of life, emphasizing the need for comprehensive supportive care alongside medical treatment (Soares & Dantas, 2024). Psychosocial interventions have also been shown to reduce anxiety and depression among cervical cancer patients while improving coping capacity and quality of life.

Psychosocial responses to illness are strongly associated with sociocultural contexts. Cultural beliefs shape how individuals interpret illness causation, perceive treatment options, and respond emotionally to health conditions. Recent evidence indicates that cultural barriers, stigma, and misconceptions regarding cervical cancer continue to influence healthcare-seeking behavior and participation in cervical cancer prevention programs across diverse populations (Bando et al., 2025). Moreover, recent evidence suggests that stigma remains one of the most important yet underrecognized barriers to cervical cancer prevention and elimination worldwide because it negatively affects HPV vaccination, screening participation, treatment uptake, and psychosocial well-being (Bae & Temkin, 2025). Consistent with these findings, Bennett and Astari (2026) reported that cervical cancer stigma in Indonesia is deeply embedded within sociocultural norms and healthcare interactions, influencing women's willingness to disclose their diagnosis, seek treatment, and engage with health services. In many Asian communities, including Indonesia, cancer is often associated with stigma, supernatural beliefs, hereditary perceptions, or spiritual punishment, potentially influencing health-seeking behavior and coping mechanisms (Oystacher, 2018; Shah et al., 2019). Cultural values may therefore contribute to delayed treatment, psychological distress, and maladaptive psychosocial responses.

Recent evidence has increasingly demonstrated that cultural beliefs surrounding cervical cancer extend beyond illness perceptions and substantially influence psychosocial adaptation, treatment-seeking behavior, and quality of life. Studies conducted in Zambia, Morocco, Turkey, Rwanda, Ghana, Nepal, and Kenya consistently report that stigma, misconceptions regarding disease causation, spiritual beliefs, and reliance on traditional medicine contribute to anxiety, depression, social isolation, delayed treatment initiation, and reduced social support among those who have cervical cancer (Jacobs et al., 2026; Khalfi et al., 2025; Ayşin et al., 2026; Rugengamanzi et al., 2026; Asakitogum et al., 2026; Ginjupalli et al., 2022; Paneru et al., 2023).

From a transcultural nursing perspective, Leininger's Transcultural Nursing Theory emphasizes that culturally congruent care is essential for improving health outcomes and psychosocial adaptation. Nurses and midwives play an important role in recognizing patients' sociocultural perceptions and integrating cultural sensitivity into healthcare delivery. Understanding cultural beliefs among cervical cancer patients is therefore essential to improve communication, patient-centered care, and psychosocial support.

In Indonesia, traditional healing practices and cultural beliefs remain highly influential in healthcare decision-making. Studies indicate that women may delay screening or treatment due to shame, stigma surrounding reproductive health examinations, family influences, or sociocultural barriers influencing healthcare utilization (Marlow et al., 2015; Maryati et al., 2021; Oystacher, 2018; Shah et al., 2019). Sociocultural norms surrounding women's health may therefore shape psychosocial experiences throughout the cancer trajectory.

Although previous studies have examined the psychological and social consequences experienced by women with cervical cancer, most have focused on quality of life, depression, anxiety, or clinical interventions (Afiyanti et al., 2019; Smith, 2015). Limited evidence specifically examines how patients' sociocultural beliefs influence illness perceptions, cope with treatment, and respond psychologically throughout the course of cervical cancer. Furthermore, cultural perceptions related to spiritual causation, fatalistic beliefs, traditional healing practices, and illness stigma remain underexplored within Indonesian oncology settings, limiting the development of culturally responsive psychosocial interventions.

Dr. Hasan Sadikin Hospital is one of the largest tertiary referral hospitals in West Java and serves as a major oncology referral center. The hospital receives a substantial number of cervical cancer cases annually, making it an appropriate setting for examining psychosocial and sociocultural aspects among women undergoing cancer treatment. Furthermore, the diversity of patients referred from different districts and cities across West Java provides an opportunity to explore cultural beliefs within a heterogeneous sociocultural population.

To our knowledge, this study is among the first to simultaneously examine culturally contextual beliefs, including spiritual causation, fatalistic perceptions, traditional healing beliefs, and psychosocial responses among Indonesian women with cervical cancer. Few studies in Southeast Asia have simultaneously evaluated culturally contextual beliefs and psychosocial adaptation among cervical cancer patients. This study may therefore contribute locally relevant evidence supporting culturally responsive community psychosocial education and empowerment strategies for cervical cancer care**.** Therefore, the purpose of this study was to investigate how cultural beliefs and psychosocial responses relate to cervical cancer patients at Dr. Hasan Sadikin Hospital, Bandung, Indonesia.

METHOD

This study used a cross-sectional, quantitative observational design to investigate the connection between cultural beliefs and psychosocial responses in patients with cervical cancer. To evaluate the relationship between variables at a particular point in time without changing study settings, a cross-sectional design was chosen. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guideline for observational research was followed in the reporting of the study.

Participants were women diagnosed with cervical cancer who were receiving treatment at Dr. Hasan Sadikin Hospital, Bandung, Indonesia. Eligibility criteria included: (1) women aged ≥18 years; (2) found to have cervical cancer; (3) able to communicate verbally; and (4) willing to participate by providing informed consent. Patients who could not complete the questionnaire due to significant clinical deterioration or cognitive impairment were not included. A total of 61 participants met the eligibility criteria and were included in the study.

The target population comprised women receiving treatment for cervical cancer at Dr. Hasan Sadikin Hospital. Patients with cervical cancer who received oncology services between January and April of 2024 were included in the accessible population. Participants were recruited through convenience sampling based on clinical accessibility and participant availability. Although convenience sampling increased feasibility in clinical settings, it may reduce representativeness and limit generalizability.

Sample size estimation was performed using a correlation analysis formula assuming an expected correlation coefficient of 0.35, statistical power of 80%, and significance level of 0.05. The minimum required sample size was calculated to be 62 participants. In the end, the analysis contained 61 qualified subjects. Although the achieved sample size was slightly below the minimum estimation, recruitment concluded because of limited participant availability during the study period.

This study employed a survey approach using structured questionnaires consisting of three main components: respondent demographic characteristics, cultural beliefs assessment, and psychosocial response assessment. Demographic variables included age, educational level, marital status, occupation, cancer stage, and duration since diagnosis.

Cultural beliefs were operationally defined as patients' sociocultural perceptions regarding illness causation, traditional healing practices, fatalistic beliefs, and illness-related stigma associated with cervical cancer. A standardized questionnaire with ten items assessed on a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree) was used to gauge cultural beliefs. Higher scores indicated a stronger endorsement of cultural beliefs impacting the perception of sickness. The raw scores ranged from 10 to 50. For analysis purposes, raw scores were subsequently transformed into standardized mean scores by dividing total scores by the number of questionnaire items, resulting in a final score range of 1.00–5.00. Therefore, reported values represent averaged item scores rather than raw total scores.

Psychosocial responses were operationally defined as emotional, social, spiritual, and psychological reactions experienced by cervical cancer patients during illness adaptation. Psychosocial responses were assessed using a 49-item questionnaire rated on a Likert scale of five points, from 1 (never) to 5 (always). Greater psychosocial stress was indicated by higher scores, which ranged from 49 to 245. Similar to cultural belief scores, total psychosocial response scores were transformed into standardized mean scores to facilitate comparability across study variables, producing final scores ranging from 1.00–5.00.

Experts in psychological health and oncology nursing reviewed the instruments to determine their content validity. Exploratory factor analysis (EFA) was used to assess the cultural beliefs instrument's construct validity. Cronbach's alpha coefficient was used to evaluate the reliability of internal consistency. Excellent internal consistency reliability was shown by the psychosocial response tool ($\alpha = .947$). The reliability of the cultural beliefs instrument's internal consistency was modest ($\alpha = .586$). Although Cronbach's alpha was below conventional thresholds, exploratory research involving culturally contextual constructs may demonstrate lower internal consistency because of multidimensional cultural representations. Therefore, findings involving cultural belief measures should be interpreted cautiously.

Participants completed self-administered paper-based questionnaires in designated clinical areas. Questionnaire completion required approximately 20–30 minutes. Data collection was conducted from January to April 2024 at Dr. Hasan Sadikin Hospital, Bandung, Indonesia. Eligible participants were identified through oncology services. Following explanation of study objectives and procedures, participants who consented to take part gave written, informed consent prior to the distribution of the questionnaire. Research assistants provided clarification when necessary while minimizing interviewer influence. Data completeness was evaluated before statistical analysis. Cases with missing responses exceeding 10% of questionnaire items were excluded. For questionnaires with less than 10% missing responses, mean substitution within the same instrument domain was performed. Because overall missing data were minimal (<5%), complete-case analysis was ultimately applied.

Statistical software was used to analyze the data. The study variables and participant characteristics were summarised using descriptive statistics. Categorical variables were shown as

frequencies and percentages, whereas continuous variables were shown as means and standard deviations or, depending on distributional assumptions, medians and interquartile ranges. The Shapiro-Wilk test was used to evaluate the normality of the data. Spearman rank correlation analysis was chosen to investigate the relationship between cultural beliefs and psychosocial responses because the study variables showed a non-normal distribution. At $p < .05$, statistical significance was determined.

The Dr. Hasan Sadikin Hospital Bandung's Health Research Ethics Committee granted ethical approval (Approval Number: LB.02.01/X.6.5/123/2024). Before beginning the trial, each participant provided written informed consent. Throughout the study, participant anonymity and confidentiality were upheld.

When interpreting study results, a number of limitations should be taken into account. First, because exposure and outcome variables were collected concurrently, the cross-sectional design restricts the ability to draw conclusions about causality. Convenience sampling has the potential to decrease external validity and induce selection bias. Third, the study's limited generalizability to larger cervical cancer populations stems from its single tertiary referral hospital setting. Fourth, recollection bias and social desirability bias may be exacerbated by self-reported questionnaires. Lastly, the actual sample size was smaller than anticipated, which could lower statistical power and raise the risk of Type II error. As a result, results should be carefully interpreted and confirmed by more extensive multicenter research.

RESULTS AND DISCUSSION

Results

A total of 67 cervical cancer patients were screened for eligibility during the study period. Six participants were excluded, including three patients who declined participation and three patients with incomplete questionnaire responses. Consequently, the final analysis included 61 eligible participants who met the inclusion criteria.

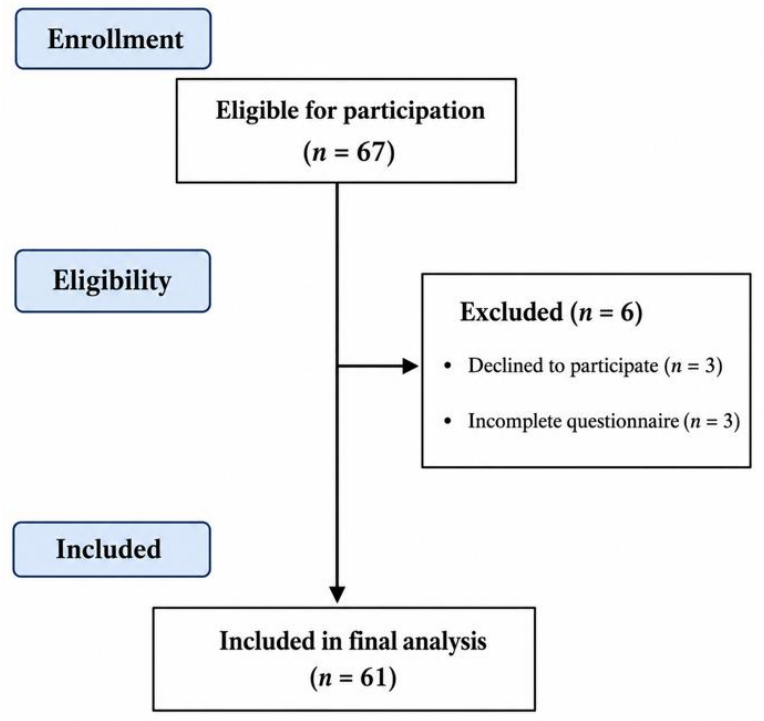

Figure 1. Participant Flow

Figure 1 presents the participant flow throughout the study recruitment process. During the study period, using predetermined inclusion and exclusion criteria, 67 patients with cervical cancer were screened for eligibility. Six participants were excluded from the study, comprising three individuals who declined participation and three individuals with incomplete questionnaire responses. Ultimately, the final analysis included 61 participants who met the eligibility requirements. This recruitment process was conducted to ensure participant eligibility, data completeness, and adherence to study procedures.

Respondent Characteristics

Table 1. Characteristics of Respondents (n=61)

Variable	Frequency	Percentage (%)
Education		
Elementary school	7	11.5
Junior high school	10	16.4
Senior high school	32	52.5
College/University	12	19.6
Occupation		
Housewife	38	62.3
Private employee	9	14.8
Entrepreneur	6	9.8
Farmer/Laborer	5	8.2
Others	3	4.9
Income		
< IDR 2,000,000	35	57.4
IDR 2,000,000–5,000,000	19	31.1
> IDR 5,000,000	7	11.5
Marital status		
Married	48	78.7
Widow/Divorced	9	14.8
Single	4	6.5
Ethnicity		
Sundanese	44	72.1
Javanese	10	16.4
Others	7	11.5
Religion		
Islam	56	91.8
Christian/Catholic	5	8.2
Cancer stage		
Stage I–II	18	29.5
Stage III–IV	43	70.5

Most participants were middle-aged women (mean age 45.45 ± 10.25 years). More than half of the participants had completed senior high school education (52.5%), suggesting that educational attainment was predominantly concentrated at the secondary education level. A similar pattern was observed in socioeconomic status, where a substantial proportion of respondents had a monthly household income below IDR 2,000,000 (57.4%) and were predominantly homemakers (62.3%).

From a clinical perspective, most patients were diagnosed at advanced stages of cervical cancer (stage III–IV; 70.5%), whereas only a small proportion were identified at earlier stages. This pattern may reflect potential barriers related to healthcare utilization or earlier detection

pathways; however, causal interpretation cannot be established within the present study design. Furthermore, the predominance of married respondents (78.7%), individuals of Sundanese ethnicity (72.1%), and those practicing Islam (91.8%) reflects the relatively homogeneous sociocultural characteristics of the study population.

Overall, the respondent profile indicates that participants predominantly had secondary education, monthly household incomes below IDR 2,000,000, and advanced-stage cervical cancer at diagnosis. These characteristics provide contextual information regarding the demographic and clinical profile of the study population.

Descriptive Analysis of Main Variables

Table 2. Descriptive Analysis of Main Variables

Variable	Median	Minimum	Maximum
Cultural beliefs	1.00	1.00	1.69
Psychosocial responses	1.29	1.00	2.24

Scores represent standardized mean item scores (range 1–5)

Because the data were not normally distributed, descriptive statistics were presented using median, minimum, and maximum values. The median cultural beliefs score was 1.00, with scores ranging from 1.00 to 1.69, indicating generally low endorsement of cultural beliefs related to illness causation, traditional healing practices, and fatalistic perceptions. The median psychosocial response score was 1.29, with scores ranging from 1.00 to 2.24, suggesting variability in psychosocial experiences among cervical cancer patients.

Relationship between Cultural Beliefs and Psychosocial Responses

Table 3. Spearman Rank Correlation Analysis

Variables	r	p-value
Cultural beliefs and psychosocial responses	0.525	<0.001

Spearman correlation analysis demonstrated a moderate positive association between cultural beliefs and psychosocial responses ($r = .525$, $p < .001$), indicating that higher endorsement of sociocultural beliefs tended to accompany greater psychosocial burden.

Discussion

The purpose of this study was to investigate the connection between cervical cancer patients' cultural beliefs and psychosocial responses. The findings showed a significant positive association between cultural beliefs and psychosocial responses, indicating that sociocultural perceptions may be crucial in shaping psychological adaptation and social experiences among women living with cervical cancer. Although the overall level of cultural belief endorsement was relatively low, variations in cultural belief scores remained significantly associated with psychosocial responses. This finding suggests that even modest differences in sociocultural perceptions may influence emotional adaptation and psychosocial experiences among women living with cervical cancer (Zhang et al., 2025).

These findings are consistent with previous evidence indicating that psychosocial well-being is closely linked to quality of life among women living with cervical cancer. Recent evidence from Zambia further demonstrated that greater cancer-related stigma was significantly associated with lower perceived social support and poorer quality of life among women receiving treatment for cervical cancer, highlighting the interconnected nature of psychosocial experiences and overall well-being (Jacobs et al., 2026).

The descriptive findings further strengthen this interpretation. Participants demonstrated relatively low endorsement of cultural beliefs, as reflected by the standardized mean cultural belief

score (mean = 1.11; SD = 0.18), indicating that respondents generally reported limited agreement with beliefs related to supernatural illness causation, fatalistic perceptions, traditional healing reliance, and illness-related stigma. The relatively narrow variability further suggests homogeneity in cultural belief patterns across participants. Although overall endorsement remained low, variability in responses remained sufficient to demonstrate statistically significant associations. This finding suggests that even relatively modest differences in sociocultural perceptions may remain relevant to psychosocial adaptation among women living with cervical cancer (Pitman et al., 2018). Several cultural dimensions identified in the current study including beliefs related to spiritual causes of illness, traditional healing practices, and fatalistic perceptions may contribute to emotional responses such as anxiety, uncertainty, hopelessness, or social withdrawal (Smith, 2015; Zhang et al., 2025).

Fatalistic beliefs may reduce perceived personal control over illness, potentially increasing helplessness and psychological burden (Smith, 2015). Similarly, reliance on traditional healing practices may influence healthcare decision-making processes and contribute to uncertainty regarding treatment experiences. These mechanisms may partially explain how sociocultural beliefs relate to psychosocial experiences among women living with cervical cancer. Traditional medicine continues to influence health-seeking behavior among those who have cervical cancer, particularly in low- and middle-income countries. Women frequently attribute cervical cancer to spiritual causes, witchcraft, or supernatural punishment, leading them to seek traditional healers before accessing biomedical services (Mwaka et al., 2015). Similar results have been documented in Ghana, where cultural beliefs strongly shaped perceptions regarding the causes, prevention, and treatment of cervical cancer. More recently, Asakitogum et al. (2026) demonstrated that traditional medicine remained an important component of treatment decisions despite concurrent biomedical care.

Consistent with previous studies, sociocultural stigma may also discourage cervical cancer screening. Women frequently avoid screening because of embarrassment, fear of discrimination, and misconceptions regarding HPV infection (William et al., 2014; Paneru et al., 2023). Şanli et al. (2025) additionally demonstrated that HPV-positive women experienced stigmatization and social isolation, which further reduced willingness to disclose their condition or seek healthcare

Another notable finding was that most participants were diagnosed at advanced cancer stages. This pattern may partially reflect sociocultural barriers influencing health-seeking behavior. Previous evidence suggests that stigma, embarrassment, cultural beliefs, and social norms surrounding reproductive health contribute to delayed cervical cancer screening participation and treatment initiation (Bando et al., 2025; Maryati et al., 2021). Women may postpone seeking healthcare because symptoms are normalized, interpreted through traditional explanatory models, or associated with social stigma. Consequently, advanced-stage diagnosis may coincide with greater psychosocial challenges following diagnosis (World Health Organization, 2025).

The observed relationship between cultural beliefs and psychosocial responses is consistent with previous literature demonstrating that sociocultural context substantially influences psychological experiences among cervical cancer patients. Afiyanti et al. (2021) reported that unmet psychosocial needs among gynecologic cancer survivors were associated with quality-of-life outcomes, highlighting the importance of psychosocial adaptation during survivorship. Similarly, qualitative evidence further indicates that spirituality, cultural values, and family beliefs shape coping responses and emotional adjustment during treatment. Cultural beliefs may therefore function as both protective resources and barriers. Spiritual beliefs may facilitate resilience and acceptance, whereas fatalistic perceptions and stigma-related beliefs may increase emotional vulnerability and hinder adaptive coping mechanisms.

The current findings are consistent with recent international evidence demonstrating that cancer-related stigma remains one of the strongest psychosocial determinants among women living with cervical cancer. Cancer-related stigma has also been documented across several low- and middle-income countries, where it contributes to delayed healthcare-seeking behavior, reduced disclosure, and social isolation among women affected by cervical and breast cancer (Nyblade et al., 2017). In Zambia, Jacobs et al. (2026) reported that stigma was significantly associated with lower perceived social support and poorer quality of life among women undergoing cervical cancer treatment, highlighting the detrimental effects of social discrimination on psychosocial well-being. Similarly, Coleman et al. (2024) found that stigma, inadequate social support, and limited spiritual coping were associated with greater symptom burden among Black, Latina, and Chinese American cervical cancer survivors, emphasizing the interconnected roles of psychosocial resources and cultural context in symptom management. In Turkey, Ayşin et al. (2026) further described how stigmatization negatively affected women's spiritual coping, emotional adjustment, and social relationships throughout the disease trajectory. Comparable findings were also reported in Rwanda, where community misconceptions and persistent social stigma contributed to isolation, reduced communication, and delayed engagement with cervical cancer care (Rugengamanzi et al., 2026). Furthermore, qualitative evidence among women with HPV infection demonstrated that stigmatization frequently resulted in shame, fear of disclosure, and social isolation, further exacerbating psychological distress and limiting help-seeking behavior (Şanli et al., 2025). Collectively, these studies reinforce the present findings by demonstrating that stigma extends beyond emotional distress and substantially influences social support, coping capacity, quality of life, and healthcare engagement among women living with cervical cancer.

Beyond stigma, social support has emerged as one of the most important protective factors influencing psychosocial adaptation among women living with cervical cancer. Although the present study did not directly measure social support, the observed relationship between cultural beliefs and psychosocial responses may be partially explained by differences in the availability and perception of supportive social environments. Recent evidence from Zambia demonstrated that women experiencing higher levels of cervical cancer-related stigma reported significantly lower social support and poorer quality of life, suggesting that stigma may weaken interpersonal relationships and reduce access to emotional and practical support during treatment (Jacobs et al., 2026). Likewise, Coleman et al. (2024) reported that greater symptom burden among cervical cancer survivors was associated with higher stigma, limited social support, and lower levels of spiritual coping, indicating that psychosocial outcomes are influenced by the interaction between adverse sociocultural experiences and protective psychosocial resources. Furthermore, Wang et al. (2024) reported that among Chinese women with abnormal cervical cancer screening findings, stronger resilience and hope were linked to better perceived social support and lower anxiety levels, while higher psychological stress was linked to higher anxiety. These findings suggest that social support may strengthen adaptive coping, enhance resilience, and reduce the negative psychological consequences of culturally embedded stigma. Collectively, the current evidence indicates that culturally responsive psychosocial interventions should not only address stigma and misconceptions surrounding cervical cancer but also reinforce family involvement, peer support, and community-based support systems to promote resilience, the general quality of life and emotional health of women with cervical cancer.

The quality of life for women with cervical cancer will also be significantly impacted by the current findings. Although quality of life was not directly assessed in the current study, the observed association between cultural beliefs and psychosocial responses suggests that sociocultural perceptions may indirectly influence multiple dimensions of patients' well-being. These results are in line with other research showing that women with cervical cancer often have

reduced health-related quality of life in the social, emotional, and physical spheres (Dos Santos et al., 2019). Similarly, qualitative evidence from Ghana revealed that cervical cancer survivors commonly experience persistent physical symptoms, including pain, fatigue, urinary problems, and sexual dysfunction, which may further compromise emotional well-being and social functioning (Hobenu & Naab, 2020). Recent evidence from Zambia further demonstrated that greater stigma associated with cancer was significantly linked to a decreased sense of social support and poorer quality of life among women receiving treatment for cervical cancer, highlighting the interconnected nature of psychosocial experiences and overall well-being (Jacobs et al., 2026). Likewise, Punithavathi et al. (2025) reported that women treated for cervical cancer frequently experienced sexual health challenges, psychiatric morbidity, and reduced quality of life, emphasizing that psychosocial consequences extend beyond emotional distress to affect intimate relationships, daily functioning, and social participation. Furthermore, Coleman et al. (2024) found that stigma, limited social support, and inadequate spiritual coping were associated with greater symptom burden among cervical cancer survivors, suggesting that psychosocial resources play a crucial role in maintaining quality of life despite the challenges of cancer treatment. Collectively, these findings indicate that cultural beliefs and psychosocial responses should be recognized as integral components of holistic cervical cancer care. Addressing stigma, strengthening social support, and providing culturally sensitive psychosocial interventions may contribute not only to improved emotional adjustment but also to improve the general quality of life for women who have cervical cancer.

Psychological adaptation among women living with cervical cancer is also influenced by resilience, hope, perceived stress, and social support. Recent evidence suggests that these psychosocial resources may buffer the negative emotional consequences associated with cancer diagnosis and treatment. Wang et al. (2024) reported that greater resilience and hope were associated with lower anxiety among Chinese women with abnormal cervical cancer screening results. These findings suggest that positive psychological resources may facilitate adaptive coping and reduce emotional vulnerability during the cancer trajectory. Similarly, Khalfi et al. (2025) observed substantial psychosocial distress immediately following cervical cancer diagnosis, with many women experiencing anxiety, fear, uncertainty, and emotional disruption related to the diagnosis and anticipated treatment. Similar findings were reported by Maree et al. (2025), who described that women living with cervical cancer in sub-Saharan Africa frequently experienced anxiety, emotional distress, altered family relationships, concerns regarding body image and sexuality, and uncertainty about the future, highlighting the broad psychosocial impact of the disease across different cultural settings. These findings support the present study by suggesting that cultural beliefs may interact with psychological factors to influence patients' emotional responses. Therefore, early psychosocial assessment, culturally sensitive counseling, and interventions that strengthen resilience, hope, and social support should be incorporated into comprehensive cervical cancer care to improve psychological adaptation and overall well-being.

The present findings are further supported by recent evidence indicating that routine psychosocial screening has become an essential component of comprehensive oncology care. A recent scoping review identified several validated psychosocial screening instruments that enable healthcare providers to detect psychological distress early and implement timely supportive interventions, thereby facilitating emotional adaptation, treatment adherence, and improved quality of life among cancer patients (Maryati et al., 2026). Integrating psychosocial screening into routine cervical cancer services may therefore strengthen culturally responsive, patient-centered supportive care.

The results have consequences for health policy and nursing practice as well. Community-based psychoeducational programs involving family support systems, community health workers,

religious leaders, and culturally tailored educational approaches may improve psychosocial adaptation and reduce stigma (Dhakal et al., 2024; Tuffaha et al., 2019). Strengthening family involvement should also be considered an integral component of psychosocial care because family-centered discharge planning has been shown to improve continuity of care, facilitate communication between healthcare providers and families, and support patients' adaptation throughout the transition from hospital to home (Maryati et al., 2026). Healthcare providers should develop communication strategies that acknowledge cultural beliefs while strengthening evidence-based understanding regarding cervical cancer prevention and treatment (World Health Organization, 2020).

When evaluating these results, a number of restrictions should be taken into account. Convenience sampling may limit generalizability, and the cross-sectional approach restricts causal interpretation. Additionally, reporting bias may be introduced by self-reported questionnaires. The moderate internal consistency reliability of the cultural belief instrument ($\alpha = .586$) should also be considered when interpreting findings because it may reduce measurement precision. Nevertheless, this study contributes important evidence regarding the role of cultural beliefs in psychosocial experiences among cervical cancer patients within the Indonesian sociocultural context.

Overall, the findings suggest that cultural beliefs appear to be factors associated with psychosocial responses among cervical cancer patients. Integrating sociocultural perspectives into psychosocial oncology care may facilitate more comprehensive, culturally responsive, and patient-centered approaches to improving psychological well-being among women living with cervical cancer.

Implications

The findings of this study have several important implications for clinical practice, nursing education, health promotion, health policy, and community empowerment. In clinical practice, healthcare professionals, particularly oncology nurses, should routinely assess patients' cultural beliefs as part of psychosocial assessments to identify beliefs that may influence emotional adaptation, treatment adherence, and healthcare-seeking behavior. In nursing education, curricula and continuing professional development programs should strengthen competencies in culturally responsive and transcultural nursing care to enhance communication and the delivery of patient-centered care for women with cervical cancer from diverse cultural backgrounds. From a health promotion perspective, community-based educational programs involving family members, religious leaders, and community health workers are essential to address misconceptions, stigma, and fatalistic beliefs surrounding cervical cancer while promoting evidence-based prevention, early detection, and treatment. At the policy level, healthcare policymakers should integrate culturally sensitive psychosocial interventions into comprehensive cervical cancer control programs, including screening initiatives, survivorship care, and community support services. Furthermore, community empowerment strategies that incorporate local cultural values can improve public acceptance of cervical cancer screening, strengthen psychosocial support networks, and ultimately contribute to better health outcomes and quality of life for women living with cervical cancer.

Research contribution

This study contributes to the existing body of literature in several important ways. First, it provides empirical evidence on the association between cultural beliefs and psychosocial responses among Indonesian women with cervical cancer, addressing a gap in the current literature on psychosocial oncology in the Indonesian context. Second, it extends previous research by incorporating sociocultural dimensions, including spiritual beliefs, fatalistic perceptions, traditional

healing practices, and illness-related stigma, as key factors influencing patients' psychosocial experiences. Third, the study enriches the application of transcultural nursing theory in cervical cancer care by demonstrating its relevance within Southeast Asian healthcare settings. Furthermore, the findings support the development of culturally tailored psychosocial interventions and patient-centered nursing care that are responsive to patients' cultural values and beliefs. Finally, this study provides locally relevant evidence that may serve as a foundation for future psychosocial oncology research in Indonesia and other multicultural low- and middle-income countries, thereby contributing to the advancement of culturally informed cancer care and nursing practice.

Limitations

Several limitations should be considered when interpreting the findings of this study. First, the cross-sectional design does not allow for the establishment of causal relationships between cultural beliefs and psychosocial responses. Second, the use of convenience sampling may have introduced selection bias and reduced the external validity of the findings. Third, because the study was conducted in a single tertiary referral hospital, the results may not be generalizable to other healthcare settings or populations. In addition, the relatively small sample size may have limited the statistical power to detect certain associations. Furthermore, psychosocial responses and cultural beliefs were assessed using self-reported questionnaires, making the data susceptible to social desirability and recall bias. Finally, the cultural beliefs instrument demonstrated only moderate internal consistency (Cronbach's $\alpha = .586$), indicating that further refinement and validation of culturally specific measurement tools are needed to improve the reliability and accuracy of future research.

Suggestions

Based on the findings of this study, several recommendations are proposed for future research. First, multicenter longitudinal or prospective cohort studies are recommended to clarify the causal relationships between cultural beliefs and psychosocial adaptation among women with cervical cancer. Future studies should also include larger and more representative samples from diverse cultural and geographical regions to enhance the generalizability of the findings. In addition, researchers are encouraged to evaluate the effectiveness of culturally tailored psychosocial interventions, such as psychoeducation, family-centered counseling, and community empowerment programs, in addressing the psychosocial needs of patients. Mixed-methods and qualitative research designs are also recommended to provide a deeper understanding of patients' cultural experiences, beliefs, and coping mechanisms throughout the cancer journey. Furthermore, future intervention studies should investigate whether culturally responsive nursing care can improve treatment adherence, psychological well-being, and quality of life among individuals living with cervical cancer.

CONCLUSION

This study demonstrated a significant association between cultural beliefs and psychosocial responses among women with cervical cancer receiving treatment at Dr. Hasan Sadikin Hospital, Bandung, Indonesia. The findings suggest that sociocultural factors, including spiritual beliefs, fatalistic perceptions, and traditional healing practices, may influence psychosocial adaptation and should therefore be considered in comprehensive cancer care. These results highlight the importance of integrating culturally sensitive approaches into oncology nursing practice to improve psychosocial support and patient-centered care. Furthermore, this study contributes to the growing evidence on the role of culture in cancer experiences within the Indonesian context and supports

the development of culturally tailored psychosocial interventions. Although the findings should be interpreted in light of the study's methodological limitations, they provide a valuable foundation for future research aimed at strengthening culturally responsive nursing practice and improving psychosocial outcomes for women with cervical cancer.

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AUTHOR CONTRIBUTION STATEMENT

IM, WF, SY: Conceptualization, methodology, investigation, and project design. IM, WF, TH: Data collection and formal analysis. SSR, TP: Data validation, visualization, and investigation. IM, WF, SY, TH: Writing original draft preparation. SSR, TP, SH: Writing review and editing. IM: Supervision and project administration. All authors have read and approved the final manuscript.

AI DISCLOSURE STATEMENT

During the creation of this work, the authors used ChatGPT to help with drafting, content organization, and language improvement. Following the use of the tool, the authors carefully examined the material, made any necessary edits, and accepted full responsibility for the publication's content. AI was not used for statistical analysis or interpretation of the study findings.

CONFLICTS OF INTEREST

The authors confirm that they have no financial, institutional, or personal conflicts of interest that might have affected how this study was conducted, how the data were analyzed, how the paper was prepared, or whether it was published.

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