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Research Article

Psychological Capital and Flourishing in Women with Breast Cancer: Acceptance as a Mediator

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Abstract

Background: Cancer can be associated with positive consequences in addition to traumatic events. Emphasizing these consequences and the benefits of positive psychology can help patients better undergo medical treatment.

Objectives: The present study mainly aimed to examine the mediating role of acceptance in the relationship between psychological capital and the flourishing of women with breast cancer.

Methods: This study employs a descriptive-correlational design with partial structural equation modeling. A total of 233 breast cancer-suffering women in Isfahan, Iran, were selected using the convenience sampling method. Data were gathered by Flourishing Scale, Psychological Capital Questionnaire, and Acceptance and Action Questionnaire-II (AAQ-II).

Results: The results showed the coefficient for the direct path of psychological capital to acceptance and flourishing was positive and significant. Also, acceptance proved to play a mediating role between the psychological capital and the flourishing of women with breast cancer ($P < 0.001$). The partial mediation model showed good fit, with psychological capital retaining a direct effect on flourishing.

Conclusions: Our findings demonstrate that acceptance mediates the relationship between psychological capital and flourishing in women with breast cancer, highlighting its role as a key mechanism in the psychological flourishing process of women with cancer. This suggests that interventions targeting both psychological capital and acceptance could potentially enhance psychological well-being in this population.

Keywords: Breast Neoplasms, Acceptance and Commitment Therapy, Positive Psychology

1. Background

Breast cancer constitutes approximately 30% of all female cancers and is the most prevalent malignancy in women globally (1). Compared to other types of cancer, breast cancer often results in more severe psychological impacts, including depression, despair, and irrational beliefs that hinder coping and adaptation (2, 3). In Iran, breast cancer accounts for 25.4% of all female cancers (4). Breast cancer accounts for ~ 30% of all cancers among Iranian women, with an age-standardized incidence rate (ASR) of 35.6 per 100 000. Isfahan province reports incidence rates higher than the national average, attributed to urbanization and lifestyle changes (5).

1.1. Flourishing in Women with Breast Cancer

Despite its negative psychological effects, some breast cancer survivors report fewer mental health problems, which may be linked to flourishing. Flourishing is a multi-dimensional construct rooted in philosophy and positive psychology, defined as living a good and balanced life with satisfaction and resilience (6, 7). It is not a static trait but a dynamic process of growth involving emotional, psychological, and social well-being (8). Individuals who flourish tend to manage

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stress effectively, maintain relationships, pursue life goals, and exhibit higher energy, self-control, and recovery capacity (9).

1.2. Psychological Capital in Women with Breast Cancer

Psychological capital, comprising hope, self-efficacy, resilience, and optimism, enhances coping capacity and mental well-being (10). Psychological capital encompasses self-perception, goal-directed persistence, and resilience in adversity, collectively enhancing adaptive functioning. Hope, in particular, supports emotional health by promoting adaptive coping and reducing anxiety (11). Higher psychological capital has been associated with improved well-being, reduced depression and anxiety, and less reliance on medical treatment (12).

1.3. Acceptance in Women with Breast Cancer

Acceptance is crucial in how patients cope with disease-related stress. It involves acknowledging one's condition, emotions, and limitations with self-compassion (13). Higher acceptance is associated with reduced emotional distress and better psychological adaptation (14). For breast cancer patients, acceptance contributes to treatment adherence and improved mental health (15). Studies show that greater disease acceptance correlates with lower anxiety and depression and enhances perceived quality of life (16, 17).

1.4. Proposed Model

This study proposes a model, in which acceptance mediates the relationship between flourishing and psychological capital. Acceptance-based interventions have been shown to significantly enhance emotional well-being and reduce psychological distress in cancer patients (18). Psychological capital provides internal resources that promote acceptance, which in turn may lead to flourishing. Components such as resilience and optimism can be cultivated to improve coping and reduce depressive symptoms (19). Psychological interventions should be integrated into medical care to improve the quality of life (20).

1.5. The Present Study

While many studies have examined mental health in women with breast cancer, few have focused on factors influencing their optimal psychological functioning or flourishing. Positive psychology emphasizes strengths and virtues that enable individuals to thrive, offering a framework to explore flourishing in this population (21).

2. Objectives

The present study aimed to examine the roles of psychological capital and acceptance in fostering flourishing among women with breast cancer. We tested a partial mediation model, in which psychological capital was hypothesized to directly predict flourishing and indirectly through acceptance. Competing models (e.g., full mediation) were not tested as our theoretical framework supported partial mediation.

3. Methods

3.1. Study Design

This correlational study was conducted using structural equation modeling. A total of 233 women were recruited via convenience sampling from the Breast Cancer Council in Isfahan, Iran. This study was conducted in Isfahan, Iran, in collaboration with the Breast Cancer Council of Isfahan. Participants were recruited through convenience sampling from the Council's registry between March to September 2022 (6-month recruitment window). Data collection occurred during the same period, with all surveys completed by October 2022. The Council serves as a centralized hub for breast cancer patients in the region, providing access to a representative sample of women undergoing treatment or post-treatment follow-up. Eligibility criteria included a histologically confirmed breast cancer diagnosis (≥ 6 months post-diagnosis to ensure adjustment period) without active metastasis or terminal prognosis, age 25 to 75 years (capturing reproductive to post-menopausal cases), minimum elementary education (ensuring questionnaire comprehension), and Persian language fluency. Exclusion criteria comprised comorbid autoimmune/neurodegenerative disorders, current psychotropic medication use (e.g., antidepressants, anxiolytics), psychiatric hospitalization in the past year, and cognitive impairment (MMSE score < 24 if screened). From 287 initially screened participants, 233 met all criteria (81.2% inclusion rate), with primary exclusions being recent diagnosis (< 6 months; n = 32) and psychiatric medication use (n = 19). A power analysis using G*Power ($\alpha = 0.05$, power = 0.80, medium effect size) indicated a minimum sample of 200; our final sample (n = 233) met this target. In addition, the sample size was determined based on SEM requirements

of 5 to 10 participants per parameter, with our final n = 233 providing adequate power for mediation analysis.

To minimize confounding effects, we implemented a multi-tiered approach: We excluded participants with psychiatric comorbidities or using psychotropic medications (via screening questions), as these factors could independently influence both psychological capital and flourishing outcomes. The ≥ 6-month post-diagnosis criterion ensured participants had passed the initial acute stress phase. All scales demonstrated discriminant validity in prior studies [PCQ: R < 0.30 with depression scales; Acceptance and Action Questionnaire-II (AAQ-II): R = 0.12 - 0.42 with anxiety measures], reducing overlapping construct bias. Education level and Persian fluency requirements standardized comprehension capacity. In our structural equation model, we covaried for: Age (continuous) and time since diagnosis (months), as psychological adaptation processes vary temporally, cancer stage [early (1 - 2) vs. advanced (3 - 4)], given its known impact on well-being, treatment status (active vs. completed), as treatment side effects may transiently affect measures. These covariates were selected a priori based on established literature about breast cancer adjustment. Sensitivity analyses confirmed their inclusion did not substantially alter the primary mediation effects ($\Delta\beta < 0.05$ for pomological capital → flourishing paths).

3.2. Measures

3.2.1. Flourishing Scale

The 8-item Flourishing Scale evaluates key psychological functions such as meaningful relationships, self-worth, and purpose. Items are rated on a 7-point Likert scale (1 = completely disagree to 7 = completely agree), with scores ranging from 8 to 56 (8). Previous studies report Cronbach's alpha values between 0.73 and 0.83 and factor loadings between 0.60 and 0.70. In the current study, the scale's content validity was confirmed by 3 experts, its factor structure was verified, and Cronbach's alpha was 0.90.

3.2.2. Psychological Capital Questionnaire

This 24-item instrument assesses hope, resilience, optimism, and self-efficacy on a 6-point Likert scale. Subscale scores are summed to obtain a total score ranging from 24 to 144, with higher scores indicating stronger psychological capital. The scale's validity has been supported through confirmatory factor analysis (CFA) (10). For the Persian version, reported Cronbach's alpha range from .70 to .90 (22). In the present study, the alpha was 0.95.

3.2.3. Acceptance and Action Questionnaire-II

The AAQ-II is a 10-item scale measuring psychological flexibility on a 7-point Likert scale (23). Previous studies have shown acceptable reliability, with internal consistency ranging from 0.71 to 0.89 for the Persian version (24, 25). In this study, Cronbach's alpha was 0.91.

All measures were administered in Persian by trained research assistants at the Breast Cancer Council clinic. The AAQ-II was completed before clinical consultations to avoid treatment bias. The PCQ is administered in private consultation rooms. The Flourishing Scale was double-entered by 2 research assistants to ensure accuracy. All participants provided written informed consent. Medical records were reviewed by an oncologist to confirm diagnosis dates/stages, current treatment status, and absence of exclusionary comorbidities. To minimize bias, participants with psychiatric comorbidities or recent diagnoses (< 6 months) were excluded. Questionnaires were administered pre-consultation (AAQ-II) and in private (PCQ), and double-data entry was used for the Flourishing Scale to ensure accuracy.

3.3. Data Analysis

Pearson correlations and structural equation modeling were conducted using SPSS and AMOS version 16. The SEM was employed to test a partial mediation model, wherein psychological capital was modeled to have both a direct effect on flourishing and an indirect effect mediated by acceptance. First, CFA tested the measurement models for psychological capital, acceptance, and flourishing, with all latent variables showing adequate fit (CFI = 0.97, RMSEA = 0.06). Notably, higher pomological capital scores were observed in subscales of optimism [mean (M) = 23.55, standard deviation (SD) = 7.16] and resilience (M = 23.15, SD = 7.09), suggesting these traits may be pivotal for psychological adaptation in breast cancer patients. Missing data were imputed using participants' responses to other items in the same domain. Significance was set at $P < 0.05$. Assumptions for SEM were verified: Multicollinearity was assessed using variance inflation and tolerance tests; independence of errors via the Durbin-Watson test; and linearity through scatterplots. Bootstrapping was used to test indirect effects. All quantitative variables (psychological capital, acceptance, flourishing scores) were treated as continuous. Normality was

confirmed via skewness/kurtosis values (all < |1|). No transformations were needed. Covariates (age, time since diagnosis) were mean-centered for analysis.

4. Results

The participants' mean age was 43.39 years (SD = 12.25), with an average of 21.70 years (SD = 15.28) of married life and 2.56 children (SD = 2.02). In terms of education, 50.2% had formal schooling, 41.7% held undergraduate degrees, and 7.8% had postgraduate education. Regarding marital status, 61.8% were married, 23.8% single, and 14.6% divorced. Mean years since diagnosis was 1.96 (SD = 0.68), with 89% undergoing active treatment. Table 1 presents means, standard deviations, and correlations among psychological capital, acceptance, and flourishing.

Participants reported moderate levels of flourishing (M = 35.18, SD = 11.87; range: 10 = 54) and psychological capital (M = 91.65, SD = 27.11; range: 32 - 138). Acceptance scores (M = 44.12, SD = 12.34; range: 18 - 62) indicated room for targeted interventions. Notably, higher pomological capital scores were observed in subscales of optimism (M = 23.55, SD = 7.16) and resilience (M = 23.15, SD = 7.09), suggesting these traits may be pivotal for psychological adaptation in breast cancer patients. Psychological capital showed a significant positive correlation with both acceptance and flourishing ($P < 0.01$). Additionally, acceptance was positively correlated with flourishing. The strongest correlation emerged between total pomological capital and flourishing ($R = 0.41$, $P < 0.01$), underscoring the role of positive psychological resources in well-being. Acceptance showed comparable associations with both pomological capital ($R = 0.24$, $P < 0.01$) and flourishing ($R = 0.38$, $P < 0.01$).

Before model analysis, assumptions of structural equation modeling were met, including normality, absence of multicollinearity, and independence of errors. Figure 1 illustrates the tested model. Psychological capital had significant direct effects on both acceptance ($\beta = 0.25$) and flourishing ($\beta = 0.34$), while acceptance also significantly predicted flourishing ($\beta = 0.34$).

Model fit indices indicate good overall fit (Table 2). Although the chi-square was significant — as expected in large samples — the ratio of chi-square to degrees of freedom was acceptable (2.68). Other fit indices (GFI, NFI, RFI, IFI, CFI) exceeded .90, and RMSEA was .08, all supporting the model's adequacy.

Bootstrapping confirmed that acceptance mediated the relationship between psychological capital and flourishing (Table 3). The indirect effect coefficient was $\beta = 0.25$. Sobel's test also supported this mediation effect ($P < 0.01$, $Z = 2.76$).

5. Discussion

The findings indicate a direct effect of psychological capital on psychological acceptance, aligning with studies on patients with chronic illnesses, where both variables were linked to enhanced life satisfaction (26). Psychological capital equips individuals to cope more effectively with stress, enabling resilience and a constructive response to adversity (27). This study also supports previous findings showing a positive relationship between psychological capital and flourishing (28), as well as with resilience and cognitive flexibility (29).

Psychological capital, comprising hope, efficacy, resilience, and optimism (10), appears to foster flourishing by promoting positive attitudes and future outlooks. Teaching these components has been shown to reduce depression and improve coping in cancer patients (19). Such training can help women with breast cancer perceive challenges as opportunities rather than defeats, thereby enhancing self-efficacy.

Additionally, a direct relationship between acceptance and flourishing was observed. This echoes research suggesting that acceptance facilitates goal re-engagement and psychological growth (30, 31). Acceptance involves a realistic appraisal of one's strengths and weaknesses, which enhances adaptability and fosters well-being (32). Therapeutic approaches based on acceptance and commitment have also been shown to improve flourishing (33).

Furthermore, this study confirmed that acceptance mediates the relationship between psychological capital and flourishing. Prior research has demonstrated the beneficial effects of acceptance-based interventions, particularly among vulnerable populations (34, 35). Psychological capital helps individuals adjust to chronic illness, thereby improving psychological well-being and facilitating acceptance, which in turn supports flourishing (36). Patients with higher psychological capital are more likely to embrace challenges, pursue meaningful goals, and maintain a sense of purpose despite their illness.

5.1. Conclusions

Table 1. Mean, Standard Deviation, and Correlation Values for the Studied Variables

Variables	1	2	3	4	5	6	7	8	M ± SD
Psychological capital									
Self-efficacy	1	-	-	-	-	-	-	-	22.48 ± 8.36
Hope	0.77 [a]	1	-	-	-	-	-	-	22.47 ± 7.49
Resilience	0.74 [a]	0.78 [a]	1	-	-	-	-	-	23.15 ± 7.09
Optimism	0.75 [a]	0.70 [a]	0.74 [a]	1	-	-	-	-	23.55 ± 7.16
Total score	0.91 [a]	0.90 [a]	0.90 [a]	0.88 [a]	1	-	-	-	91.65 ± 27.11
Acceptance									
Experiential avoidance	0.21 [a]	0.22 [a]	0.23 [a]	0.27 [a]	0.26 [a]	1	-	-	30.35 ± 9.05
Life control	0.14 [a]	0.10	0.09	0.21 [a]	0.15 [a]	0.74 [a]	1	-	13.77 ± 4.06
Total score	0.20 [a]	0.19 [a]	0.20 [a]	0.27 [a]	0.24 [a]	0.97 [a]	0.88 [a]	1	44.12 ± 12.34
Flourishing									
Total score	0.41 [a]	0.33 [a]	0.31 [a]	0.41 [a]	0.41 [a]	0.36 [a]	0.37 [a]	0.38 [a]	35.18 ± 11.87

Abbreviations: M, mean; SD, standard deviation.

[a] $P < 0.01$

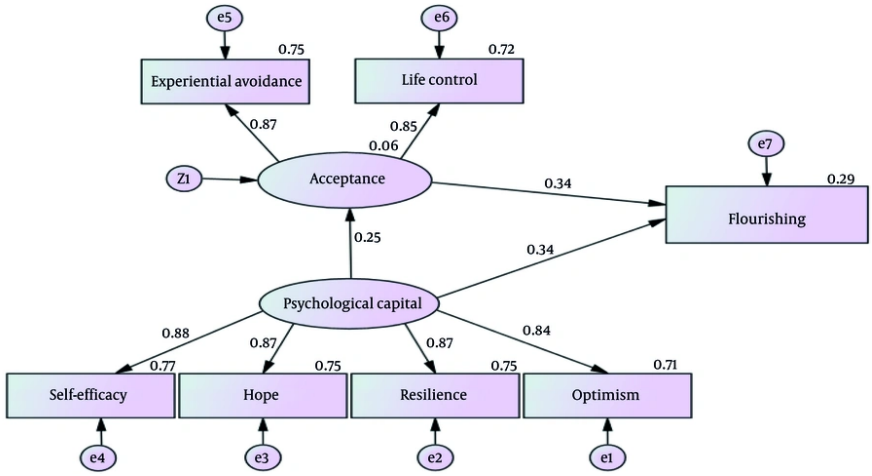

Figure 1. Structural model of the relationships between psychological capital, acceptance, and flourishing of women with breast cancer

Table 2. Indices for the Model Fitness

Index	CMIN	DF	CMIN/DF	GFI	NFI	IFI	TLI	CFI	RMSEA
Value	32.16	12	2.680	0.96	0.97	0.98	0.96	0.98	0.08

This study highlights the critical role of psychological capital in enhancing acceptance and flourishing among women with breast cancer. These components — rooted in positive psychology — are teachable and can complement medical interventions. By emphasizing personal strengths and positive growth, such interventions may help patients accept their condition and achieve psychological well-being.

Table 3. Assessment of the Direct and Indirect Effects of Independent and Mediating Variables on Flourishing

Independent Variables	Mediating Variables	Dependent Variables	Assessment					
			Direct		Indirect		Total	
			Value	P-Value	Value	P-Value	Value	P-Value
Psychological capital	-	Acceptance	0.25	0.039	-	-	0.25	0.039
-	-	Flourishing	0.34	0.001	-	-	0.42	0.001
-	Acceptance	Flourishing	-	-	0.08	0.009	0.42	0.001
Acceptance	-	Flourishing	0.34	0.001	-	-	0.34	0.001

Training programs that integrate psychological capital could, thus, be valuable in fostering resilience and improving overall quality of life.

5.2. Limitations

This study had several limitations. The limited prior research made contextualization of the findings challenging. Additionally, unmeasured variables such as socioeconomic status, disease severity, and social support may have influenced results. While convenience sampling ensured feasibility, it may limit the generalizability of findings to broader populations.

5.3. Recommendations

Future studies should employ stratified random sampling to enhance representativeness. Future studies should control for these factors and consider longitudinal or qualitative approaches to better understand acceptance in breast cancer patients. Given the model's confirmation, experimental studies are recommended to evaluate interventions aimed at enhancing psychological capital and acceptance, thereby promoting flourishing among this population.

Footnotes

Authors' Contribution: A. T. participated in data collection, data analysis, and prepare the manuscript. Y. R. M. participated in study design, drafting, and perspiring the manuscript. Z. A. and A. C. participated in revision of the manuscript. All authors read and approved the final manuscript.

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Informed Consent: Written informed consent was obtained from the participants. Before the research started, its objectives were explained to the participants, and the secrecy of their information was ensured.

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