


Religiosity as a Cultural Resource for Arab-Palestinian Women's Coping with Cancer

SAGE Open
 January-March 2020: 1–7
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 DOI: 10.1177/2158244019898730
journals.sagepub.com/home/sgo


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Abstract

Drawing on the discourse analysis of 36 in-depth interviews, this qualitative study explores how Arab-Palestinian women cope with breast cancer and ascribe meaning to their illness within the local religious and traditional cultural context. In particular, the study shows that religious beliefs and practices help Arab-Palestinian women to handle emotional and psychological difficulties while perpetuating traditional cultural norms of concealment. Two main functions of religiosity as a coping resource are analyzed by (a) managing distress and identity crisis and (b) changing the meaning of the illness experience. In this sociocultural context, the practice of religious rituals provides cancer patients with an effective and culturally situated instrument for coping with a deep existential crisis. Practical implications of the study are discussed in the conclusions.

Keywords

breast cancer, religiosity, religion, coping resources, occupied Palestinian territories, Arab-Palestinian women

Introduction

Studies have analyzed the cancer patients' coping resources which mainly focuses on individualistic strategies such as positivity, fighting spirit, or personality traits, such as "sense of coherence" (Antonovsky, 1979; Sarenmalm et al., 2013; Silva et al., 2012).

Coping is found to be the major determinant in a process that starts with stressful events and then to adaptation outcomes, such as psychological symptoms and somatic illness. For example, coping strategies can influence treatment outcomes and survival rates of women who have breast cancer (Lazarus, 1993; Mehrabi et al., 2016).

Also, coping with cancer is affected by the kind of resources that members of a culture use to interpret life events. Religiosity has been explored as a potential adaptive resource for cancer patients and survivors in several cultural contexts (Gesselman et al., 2016; Thuné-Boyle et al., 2006, 2011). Drawing on Lazarus and Folkman's Transactional Model of Stress and Coping, Mukwato et al. (2010) found that the "reliance to God" was one of the four predominant coping strategies by patients and family caregivers (together with social support, positive attitude and acquisition of information and education). Fatalism as well as elements of the popular culture (e.g., the notion of adverse events as strengthening and the uselessness of despairing) can be powerful resources to give meaning to a recent cancer diagnosis and to

face the disease (Alby, 2018, 2019; Alby, Fatigante, et al., 2017; Alby & Zucchermaglio, 2019; Alby, Zucchermaglio, et al., 2017). The literature has shown also how cultural repertoires are in evolution including debates on the meanings of stigma, shame, and confidentiality, as well as repertoires that enhance both determination and willingness to survive (Ahmadi, Hussin, et al., 2018; Ahmadi, Khodayarifard, et al., 2018; Alby et al., 2015; Alby, Fatigante, et al., 2017; Fosket et al., 2000; Klawiter, 1999; Patterson, 1987; Sontag, 1978; Zucchermaglio & Alby, 2016; Zucchermaglio et al., 2016).

This work focuses on the sociocultural context of the occupied Palestinian territories (OPT). The Palestinian society is crossed by strong conservation trends of values and traditional lifestyles. This tendency is strengthened by the long Israeli–Palestinian conflict which promotes an appreciation of identities that are distinctive of a cultural tradition. It is traditionally a collectivist society that gives priority to the needs of the family compared with individual needs, in which women play a central role in preserving cultural norms and values through child care (Surbone, 2008). The increased levels of education

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and the entry into labor market have led to changes for Palestinian women, who nevertheless coexist with strong conservative tendencies sustained by the adherence to family values, customs, and by widespread religious beliefs (Azaiza, 2013). More than three quarters of the Palestinian population claim to be religious (Goldblatt et al., 2012).

Some studies have documented the cultural resources used by Arab women in Israel to interpret and cope with a disruptive life event such as a diagnosis of breast cancer. Goldblatt et al. (2012) described how the coping strategies of Arab women in Israel are affected by local cultural norms, beliefs, and perceptions. Findings stress a duality in participants' cancer coping experience: they comply with the traditional cultural norms of concealment, while encountering more open Western attitudes through interactions with health care providers and Jewish women receiving treatment alongside them. A recent study, conducted by Goldblatt et al. (2016) on Arab women in Israel, indicated, among the strategies mostly used to cope with the disease; praying, talking to God, reading the Quran or the New Testament, accepting the disease as "meant to be" and believing on God's healing powers. Research participants stated that their belief in God had increased their personal strength to confront the disease. Several other studies involving breast cancer patients (including Muslim and Christian Palestinian women) found that deeply rooted religious beliefs assisted patients in making decisions related to their health; even though most patients attributed their disease to the will of God, they were actively engaged in fighting it and strictly adhered to medical treatments (Doumit et al., 2010; Hammoudeh et al., 2017; Harandy et al., 2009; Taleghani et al., 2006). Somewhat different findings were found by Azaiza and Cohen (2008) following which Arab women in Israel defer to God, or predestination, the responsibility for their body and health, adopting a passive attitude toward self-care.

The importance of "Tawakkul" (reliance on the power of God) was found among both Palestinian caregivers and cancer patients (Hammoudeh et al., 2017). These findings show how religion and spirituality incorporate internal and external beliefs and values, and how these interwoven beliefs are deeply rooted in the Palestinian sociocultural system (see also Albarghouthi & Klempe, 2019).

Several studies showed that in the Arab and Palestinian society, a powerful social stigma is still attached to cancer (Hammoudeh et al., 2017 see also Hwang, 2013; Lamyian et al., 2007). Some studies showed that Arab breast cancer patients try to hide their illness to neighbors, friends, and colleagues refraining from socializing and attending gatherings and celebrations (Azaiza & Cohen, 2008; and see also Azaiza et al., 2011; Goldblatt et al., 2012).

Moreover, in Israel, Arab women rely more on cultural resources such as religiosity in the absence of any social support or in case of marriage problems, in their attempt to get through the tribulations of a challenging experience such as breast cancer (Azaiza et al., 2011).

Trust in religion as a resort and a coping strategy can also be explained by the difficulties experienced by patients in accessing cancer care in the OPT. Treatments available are limited (in particular there are restrictions on radiation therapy due to security reasons; treatment plans can be delayed due to lack of medications); moreover, patients face many challenges in accessing the health system due to the military occupation and the restrictions to mobility (Giacaman, 2018; Hammoudeh et al., 2017).

In the OPT, breast cancer is the most common type of cancer among women and the leading cause of cancer-related mortality (Husseini et al., 2009).

Objectives

To date, very few studies have focused on and gave a voice to Arab-Palestinian women diagnosed with breast cancer. We aim to study how they ascribe meaning to their illness and to examine their coping strategies within this religious and traditional cultural context. We focus on the particular role played by religiosity, broadly defined as a personal devotion and participation in religious practices.

Method

This article focuses on a subset of data gathered in a study conducted in the OPT. Data were collected through in-depth interviews with breast cancer patients of two medical centers: (a) the Oncology Department at Beit Jala Government Hospital in Bethlehem Governorate, which is the first hospital distinguished for providing a large part of diagnostic and therapeutic services for oncology patients in the OPT; (b) Dunya Women's Cancer Center in Ramallah Governorate, which is the first and only non-profit center that provides an early diagnostic service for breast cancer and gynecological cases in the Palestinian Territories.

The study was approved by the Palestinian Ministry of Health. Research participants were requested to sign an informed consent form. Data were collected by a researcher who was an Arab-Palestinian woman, which probably facilitated adherence to the research (there was no refusal to participate). Participants were also fully ensured about the anonymity and confidentiality of any information collected for the purpose of the study. The data collection ran from January 2015 to April 2015.

The participants recruited for the study are 36 women selected according to the following inclusion criteria: (a) living in the OPT; (b) been diagnosed with breast cancer between 1 month to 3 years prior to the interview; (c) having no previous history of mental disorders or other forms of cancer; (d) accepting to be interviewed without the presence of a third person to ensure the participant's freedom to express their feelings; (e) signing an informed consent form.

The interview guide had three sections. The first section explored how the illness was discovered, the second section

focused on the communication with doctors and the treatment decision-making process, and the third section explored changes and adjustments in life after the illness. This last section examined religiosity as a resource for coping by asking what changed in the interviewee's life after the diagnosis; if the interviewee defined herself religious, with which degree of observance; and if (and how) religion was a source of support in facing the illness. This article focuses on the answers given to questions within the third section.

The interview also covered sociodemographic characteristics (religion, degree of religiosity, age, place of residence, education, marital status, employment status, how many children) and medical information (date of diagnosis, stage, type of treatment).

The interviews were carried out in a private room at the hospital or in the cancer center by one of the authors (M.I.A.A.) who presented herself as a researcher in social psychology. The participants were informed about the study's objectives both orally and in writing. All the interviews were conducted in Arabic (Palestinian dialect) through audio recording, transcribed into standard Arabic and then finally translated into English. The actual names of the participants have been replaced for confidentiality. The time period of participants' interviews ranged from 1 to 2 hr.

Analytical procedures involved a discourse analysis of the interviews' transcripts (Alby & Fatigante, 2014; Edwards & Potter, 1992; Wilkinson & Kitzinger, 2000). In the discourse analysis, we considered the accounts produced in the interviews as modes through which interviewees reconstruct and make comprehensible their actions and their own selves while they narrate them (Edwards, 1998).

We coded as "negative" the instances in which the interviewees, when asked about changes in life following the illness, report of fear, distress, embarrassment. We coded as "non-negative" the instances that report either a positive effect or assert a non significant effect (e.g., "life continued as before"). We decided to focus on the analysis of these latter instances because they offered a good opportunity to explore the features of religion as a coping resource. We then developed an analytic focus on the specific functions that religiosity plays in the interviewees' perceptions of the illness experience. A quantitative analysis was performed to calculate the frequency of the interviewees' answers to yes/no questions.

Results

Participant Characteristics

The participants of this study consisted of 34 Muslim and two Christian women from the OPT. When asked about the degree of religiosity, 23 participants stated that they were moderately religious, whereas 13 stated that they were extremely religious. The participants' age ranged between 22 and 67 years. As for the participants' educational level, it

ranged from no formal schooling (i.e., illiteracy) to second university degree (i.e., graduate studies). Only one participant did not have any school education at all; two participants had completed 6 years of school. Six participants had completed 9 years of school, and two participants had completed 12 years. Eight participants had obtained a postschool diploma (i.e., community college). Eleven participants had completed high school, whereas five participants had completed their first degree university education. Finally, only one participant had a Master's degree. As for their social status and number of children, the majority of the participants ($N = 31$) were married and two thirds ($N = 24$) were housewives. Thirty had children and the number of children per participant ranged from one to nine. Seventeen participants reported that they did not know at which stage of the disease they were at when they were first diagnosed; five participants reported that they were diagnosed with breast cancer at Stage 1, nine participants at Stage 2, and three participants at Stage 3. Three participants stated that they were diagnosed with advanced breast cancer (Stage 4). Regarding the treatments, 22 participants were still receiving their treatment (i.e., chemotherapy), whereas 14 participants reported that they had completed it, but still had to undergo follow-up tests and diagnostic images regularly according to posttreatment follow-up guidelines.

Life Following the Cancer Illness: The Role of Religiosity

When asked about changes in life following their illness, most of the interviewees report negative effects on their mood, behaviors, and relationships; higher levels of distress; and tendency to isolation. We found 23 instances of this kind across 36 data extracts. We will briefly outline some of these. In the following extract, Maria is talking about her reactions to being told she has cancer:

My mood has become bad, my behavior at home has changed, and my view of life has also changed. Sometimes I prefer to sit alone and to be isolated from others, and I don't like to get out of my home. My relationship with my husband was completely affected. He treats me well but I can't deal with him after I had cancer, as I still can't accept that I have cancer until now! Maria (38 years old)

Next to answers that report of fear, regret, and embarrassment regarding the illness, some interviewees' answers depict a quite different experience, which suggest a better adjustment to the situation. These answers were less expected (given the meanings and beliefs associated with the disease and the disruptive impact on the patients' lives) and seem to offer an opportunity to deepen the possibilities of coping offered by religion. We therefore chose to focus in particular on these instances. Specifically, nine instances reported that life following the illness continued as before and that there

was neither positive nor negative significant effect, and four instances indicated that the illness had a positive effect on their life since this experience made them stronger by bringing them closer to God. The salience of religious customs in coping with the illness for Arab-Palestinian women is outlined in the words of Tamara:

Yes, illness alerts us to certain things such as how to be closer to God, this helps to deal with people in a better way. Tamara (42 years old)

Tamara frames the disease as a learning experience which allows her to review the order of priority of her life by putting the religious experience first, a change of perspective that also helps to better manage relationships.

Participants reported that religion was a source of support for them in coping with the disease, particularly by performing certain religious acts, worship, or rituals.

Our analysis revealed that religiosity has two main functions: (a) managing distress and the identity crisis involved in such a life-threatening situation; (b) changing the meaning of the illness experience into something else: a test, a learning path, the mean to a reward.

The features of the two main functions are further analyzed in the following sections.

a) Managing distress and identity crisis. The following quotes well illustrate the psychological and emotional support coming from faith. Some women became religious after the diagnosis and clearly acknowledge the faith in God as a way of dealing with the disease, as Safa says,

Feeling weak is not simple; I needed the support of some power. Honestly, I have never been religious but I am now trying to be religious . . . Believing in a (supreme) divine power helps a lot. Safa (56 years old)

Safa represents herself as a nonreligious person before the illness and as a religious person after the illness. According to Safa, faith provided her major help and emotional encouragement and the sense of a “borrowed” power of control throughout the illness. It is interesting to note that she makes it a psychological rather than a spiritual matter, which is linked to her ability to manage and overcome a difficult situation. Lama too considered God the only source of support:

My faith in God is what made me endure the situation. When I felt pain I used to say “God: be with me!” instead of calling on my father, mother or siblings for help or support. Lama (41 years old)

According to Lama, her faith strengthened and helped her to cope. She started to perform daily prayers and read the Quran as a strategy for her distress.

In Lama’s words, we can possibly retrace the need of some of these women to conceal their distress and not to be a burden to relatives. In this sense, faith can be seen as a women’s way for self-help, while respecting the wider cultural prescriptions. In this cultural context, the use of religiosity as a solitary coping strategy is in line with sociocultural expectations that favor traditional customs such as concealing the disease and opposing the sharing of negative emotions.

Dima became closer to God after being diagnosed with cancer. In the next extract, she said that her faith helped to manage anxiety by focusing on religious matters and by reassuring herself through the belief in God’s reward to sick people for withstanding all the suffering and pain:

If I wasn’t close to God, I would be wandering about like a crazy woman. In the beginning, when I found out I had breast cancer, I couldn’t sleep, and I would stand in front of the mirror and cry. Now, I sometimes I get up at night and read on the Internet about religious matters and God’s reward. Dima (36 years old)

Cancer is here described as something that makes the interviewee cry while alone with herself in front of a mirror, as something that challenges her body image and her identity, a disruptive event that could make her lose her mind. Faith mitigates the identity crisis, saves the interviewee from being split between mind and body (becoming a crazy woman), and calms her down by pulling her attention on something else (she reads during the sleepless nights instead of crying). There is a “beginning,” the moment of the initial diagnosis, in which Dima locates her identity crisis, and there is a “now” in which she presents herself as less hopeless, a self that has been shaped by her religious practices.

b) Changing the meaning of the illness experience. In thinking of a divine reward for her sufferings, Dima comforts herself and finds hope by framing this event within a more general class of events that God assesses and rewards or punishes. The disease is perceived as a God’s test, which may eventually grant good things in life (a renewed health) or in the afterlife. Such an existential shift relieves the interviewee from the emotional burden of an uncertain, life-threatening outcome.

For Tamara, the very meaning of the illness changes when seen as a faith experience:

One should thank God in sickness and in health; sickness is God’s test to the extent of our endurance and patience. Tamara (42 years old)

The illness is seen as a path through which one can develop competences such as patience and endurance, and learn a different attitude toward difficulties in life.

Also, Rana represents the illness as a learning experience that will lead to value life differently:

When I read verses from the Holy Quran or Sayings (Hadith) by Prophet Mohammed or stories that give hope of God's reward after all the suffering and pain, and the idea that after all this something pleasant would come my way, I don't believe that cancer is miserable but I hope that after my experience with it I can truly appreciate happiness, and can learn patience. Rana (22 years old)

Rana also explained the benefits received by her commitment to certain religious duties and rituals, such as reading the Holy Quran (other religious practices included fasting, praying, talking to God). Ruba also states in the next extract that she resorts to the recitation of the Quran when she feels troubled:

When I feel restless, I read the Quran and rise over everything; death is in God's hands, and—when He wills—the day will come and I will die. I'm certain that I will be cured from this illness. Ruba (56 years old)

The belief that “death rests in God's hands” turns death into something that is not caused by cancer but something that is controlled by God, and therefore something that can only be dealt with within a religious framework.

In this perspective, healing is provided by medical treatment, but through praying and appealing to God (cf. also Hussein, 1998). The spiritual inspiration which one feels by firmly believing that God will heal her is considered to be a type of treatment in itself, which can provide spiritual, if not a physical healing, as stated by Asma:

I used to read the Quran and based on my knowledge (of Islam), I was quite certain that I would be treated by the Quran. Asma (37 years old)

Following religious prescriptions of behavior not only mitigates the deep identity crisis of the interviewees but completely reformulates the meaning of the disease that is described as a spiritual experience, by moving it from the domain of medicine into the sacred or divine dimension. It is therefore an experience that can find a resolution only in that area: in this realm, the Quran is discursively represented as a more effective and suitable resource than medical treatments.

Discussion

This research is one of the few studies that analyzes the relation between Arab-Palestinian women's cancer coping and the religious sociocultural context of the OPT. The study also outlines the specific functions played by religious beliefs and practices as available cultural coping resources. In the OPT, Arab women with breast cancer experience a double difficulty: on one hand, they live an existential crisis because of the oncological illness, on the other hand, they find themselves in a sociocultural context that stigmatizes cancer,

invites to its concealment, and promotes adherence to traditional customs, of which religion is an important component. This cultural background sheds light on the results of our study that seems to outline religiosity as a relevant coping resource among the interviewees. In several instances, participants asserted that religion was one of the most important sources which helped them to adjust to the disease and boosted their determination to resist the disease.

Our study shows that the interviewees rely on the available cultural resources to handle emotional and psychological difficulties while respecting and perpetuating cultural norms that invite to hide the disease from the social environment.

This study also shows that religious beliefs and practices help the participants to change their outlook on the disease. They re-interpreted the disease as part of God's will and as a test of their endurance. In addition, their belief in God's healing power and in predestination (whether they have cancer or not) orient them to frame their current uncertain situation within a broader unpredictability in life shared by humankind while helping them to maintain hope for the future. By making a shift from a medical to a spiritual perspective, religious practice (together with medical treatments) is seen as life-saving devices.

The religious coping operates through a radical work of re-signification of the whole experience of illness. The accounts refer of an existential shift, marked by a “conversion,” a reading of the events in a religious key, which changed the way the interviewees feel and deal with the illness. After taking such a perspective, the sense of the disease is discursively transformed into a formative and spiritual experience and we encounter another version of the interviewees, better able to manage anxiety and disruptive events.

In terms of practical implication, this study is an initial step for a culturally situated practice that tailors psychosocial interventions to patients' unique cultural background. In particular, the present results support the previous literature on the efficacy of encouraging the practice of religious rituals for breast cancer patients in Arab communities (Doumit et al., 2010; Goldblatt et al., 2012, 2016; Taleghani et al., 2006). Our findings show that, at the stage of cancer diagnosis and treatment, religious practices and beliefs seem to be a useful resource for coping with the disease rather than an obstacle to seeking medical services, as found in other studies (cf. “Introduction”). In our data, there is no evidence of a passive attitude, but rather the respondents use the faith as a culturally situated instrument for self-help, a way to find comfort and construct meanings during a deep identity and existential crisis.

Further analyses on the data will be performed to better understand the relationship between the stage of the illness and religious practices and beliefs. Given the nature of qualitative research, we do not aim to generalize results, but to contribute to the situated understanding of coping within the local context of the OPT.

Acknowledgments

The authors, hereby, thank all of the patients who participated in this study and shared their experiences with us.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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