

From a Death Sentence to a Disrupted Life: Palestinian Women's Experiences and Coping With Breast Cancer

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Abstract

This study explores women's experiences of breast cancer in the occupied Palestinian territory. We use an inductive qualitative design with a thematic analytical approach for conducting and analyzing 35 semi-structured interviews with breast cancer patients. The interviews focused on diagnosis, experiences and coping with breast cancer, social support and care needs, and the impact of illness on their families and social relationships. Three themes emerged: (a) the transition from initial shock to the daily struggles with disruptions caused by illness, (b) the role of social support in helping women cope with the burden of disease, and the importance of (c) faith and reliance on God (tawakkul). In the Palestinian context, women's narratives highlighted the disruptive nature of breast cancer. Our findings underline the importance of social support provided by extended family members. Finally, faith is an important overarching theme that influences how women make sense of and cope with breast cancer.

Keywords

adaptation; coping; enduring; breast cancer; cancer; caregivers; caretaking; lived experience, health; chronic, illness and disease; qualitative; thematic analysis; Palestine; Palestinians; Arab World; Middle East

In the occupied Palestinian territory (oPt), breast cancer is the most common type of cancer among women and the leading cause of cancer-related mortality (Husseini et al., 2009). Many cases are diagnosed at later stages (Khleif & Imam, 2013) and there is some evidence of higher than average mortality among cancer patients in the oPt (Shawawra & Khleif, 2011). The health infrastructure in the oPt faces various challenges resulting from military occupation, restrictions on radiation treatment within the oPt, as well as structural problems in the nascent health system (Mataria et al., 2009; Giacaman et al, 2009). Although great strides have been made in primary health care (namely maternal and child health care), the treatment and management of chronic diseases, including cancer and palliative care, are limited (Husseini et al., 2009; Shawawra & Khleif, 2011) and often require referral to hospitals outside of the Palestinian health care system for more advanced care. Furthermore, psychosocial care for cancer patients, as with other diseases, is not available at most hospitals; in fact, cancer treatment at government hospitals is primarily restricted to chemotherapy, with little capacity for a wider range of treatment options (Shawawra & Khleif, 2011).

Despite considerable research on the impact of breast cancer on various dimensions of women's lives, little is known about how Palestinian women experience and

cope with breast cancer. This article addresses this research gap through an exploratory study of Palestinian women's experiences of breast cancer in the oPt. In this article, we focus on women's reactions to and the ways in which they make sense of their breast cancer diagnosis, their experiences with illness and treatment, the services and support available to them, and the impact of breast cancer on their lives more broadly.

Some salient features of Palestinian society are important to understanding the context in which women experience and make sense of cancer diagnosis. While in many societies the family means the nuclear family, the Palestinian family broadly refers to the extended family, including grandparents, grandchildren, aunts, and uncles. Various members of the extended family may be relied upon, to provide physical, material, and psychosocial support for an individual family member in crisis (Johnson, 2006). The extended family is central to the formation of identity, and decisions made by individuals

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and couples, including decisions made when family members are sick. Similar to other places in the Middle East (Kangas, 2001), diagnosis, treatment, and follow-up of patients are usually handled collectively by the extended family (Johnson, 2006).

A distinguishing feature of the life of Palestinian women are the fundamental difficulties at the core of Israeli military occupation—restricted mobility and Israeli army security checkpoints are common both within the oPt and between the West Bank, the Gaza Strip, and Israel. Health care facilities in East Jerusalem, previously at the center of medical care for Palestinian women, are now, for most women, off limits or accessible only after a long application process for travel permits to enter from the West Bank to East Jerusalem (B'tselem, 2010).

There is vast literature on the psychosocial effects of breast cancer on women's lives, whereby the process through which women understand, come to terms with, and cope with their disease has been characterized as complex, and oftentimes contradictory (Al-Azri, Al-Awisi, & Al-Moundhri, 2009; Arman & Rehnsfeldt, 2002; Carpenter, Brockopp, & Andrykowski, 2001; Ching, Martinson, & Wong, 2012; Doumit, El Saghir, Abu-Saad Huijjer, Kelley, & Nassar, 2010; Kernan & Lepore, 2009; Liamputtong & Suwankhong, 2015; Nelson, 1996). The positive role of social support in coping with breast cancer has been highlighted extensively (Al-Azri et al., 2009; Ching et al., 2012; Doumit, El Saghir, et al., 2010; Kagawa-Singer & Wellisch, 2003; Taleghani, Yekta, & Nasrabadi, 2006; Tam Ashing, Padilla, Tejero, & Kagawa-Singer, 2003). The role of family, friends, support groups, and other social relations are fundamental to the way women deal with and come to terms with cancer. Various studies also highlight the important role faith and religion play in defining the understanding and experience of cancer for women; studies have shown that spirituality facilitates coping and can be a source of strength for women (Al-Azri et al., 2009; Gurm et al., 2008; Harandy et al., 2009; Liamputtong & Suwankhong, 2015; Lynn Gall & Cornblat, 2002; Taleghani et al., 2006).

While research shows a high incidence and prevalence of breast cancer in the Middle East as well as younger ages at diagnosis (Najjar & Easson, 2010), little is known about its ramifications on women's quality of life and wellbeing, and the effects of this disease on family life. We situate this article within this scant but growing literature on the experiences of Middle Eastern women with breast cancer. We also draw on the literature on spirituality and illness more broadly (Al-Azri, Al-Awisi, Al-Rasbi, & Al-Moundhri, 2014; Hamdy, 2009; Harandy et al., 2009; Taleghani et al., 2006). Furthermore, we also draw on the Liamputtong and Suwankhong's (2015) extension

of the notion of "biographical disruption" where chronic illness, and cancer specifically, is viewed as an experience that disrupts the structure and meanings of daily life.

A few recent studies have begun to address these issues (Al-Azri et al., 2014; Doumit, El Saghir, et al., 2010; Doumit, Huijjer, Kelley, El Saghir, & Nassar, 2010; Harandy et al., 2009). Doumit, El Saghir, et al. (2010) and Doumit, Huijjer, et al. (2010) highlight the importance of the psychosocial context of women with breast cancer in shaping how Lebanese women experience this disease. The authors also underline the main difficulties that women go through, including feelings of loss and guilt, living with fear and uncertainty, and living with the need to gain information and share their knowledge with others. Other studies highlight the importance of religion and spirituality in the way women cope with and understand breast cancer, and its importance in overcoming negative thinking (Al-Azri et al., 2014; Taleghani et al., 2006). These studies highlight that although religion and spirituality are important in coming to terms with illness whereby women often view illness as the Will of God, this is not a passive acceptance of disease (Al-Azri et al., 2014) and does not prevent women from seeking out medical treatment. Here it is important to point out the distinction between dependence (*ittikal*) and reliance (*tawakkul*) in Islamic thought. Contrary to *ittikal* (dependence), which is not encouraged in Islam, *tawakkul*, or reliance on God, does not exclude some level of agency (Hamdy, 2009). Furthermore, in many interpretations of *tawakkul*, it becomes the patients' responsibility to seek treatment and then trust her/his faith in God, ultimately, for a cure.

Methodology

In this study, we utilize a qualitative inductive approach to explore women's experiences of breast cancer in the oPt. Given the scarcity of research conducted on women's experiences with breast cancer in the oPt, and our interest in understanding women's lived experiences of breast cancer, its psychosocial impacts, the various ways in which women coped with their disease, and the support and resources available to them, a qualitative approach seemed most appropriate. Furthermore, a qualitative inductive approach allows for a deeper understanding of individuals' lives and experiences (Liamputtong, 2013). We employ a thematic analysis in this study (Braun & Clarke, 2006; Vaismoradi, Turunen, & Bondas, 2013). As we discuss further in the analysis portion of this section, this approach provides us with the flexibility we require given the exploratory nature of this study. Furthermore, our approach to this study since its inception was shaped by the interdisciplinary background of the research team, as well as the Reproductive Health Working Group,

which played an important role in the development of this study, especially as similar studies were being implemented in other settings in the Arab world and Turkey.

Description of Research Setting

Prior to beginning fieldwork for this study, the researchers based in the West Bank, and living within Palestinian society, consulted various stakeholders and researchers, both within the oPt as well as in the Arab region more broadly. We also consulted with health providers living and working in the oPt. Stakeholders and other researchers made note of the sensitive nature of research on cancer in the local setting, often noting that people rarely referred to cancer by name, but rather as the “bad disease.” This was also consistent with our own observations. We decided to begin planning and designing the study by visiting the only three Palestinian hospitals offering cancer treatment in the West Bank (including East Jerusalem), at the time, two governmental hospitals in the north and south of the West Bank, and one non-governmental (NGO) hospital in East Jerusalem. Due to mobility restrictions, we did not have physical access to any hospitals based in the Gaza Strip. Given the cultural sensitivity around cancer generally and the importance of reaching women from various backgrounds and experiences, we thought that hospital-based interviews would offer us more access to women with breast cancer, compared with snowballing techniques.

Furthermore, between the three hospitals, we had access to women from various parts of the West Bank, and even access to women from the Gaza Strip through the East Jerusalem hospital, which would have otherwise been nearly impossible given mobility restrictions. These women resided in the Gaza Strip and were able to secure permits issued by the Israeli military so that they can receive treatment in East Jerusalem. The government hospital in the North catered to women undergoing chemotherapy who resided in different towns, villages, and camps in the North West Bank, whereas the hospital in the South catered primarily to women undergoing chemotherapy who resided in different localities throughout the South West Bank, and occasionally to women in the Central West Bank who were not able to secure permits for entry into East Jerusalem. The East Jerusalem hospital catered primarily to women from the Central West Bank and East Jerusalem. It was also the only Palestinian hospital that had access to radiotherapy technology, and was consequently the main referral hospital for women requiring radiotherapy, regardless of where they resided in the West Bank and Gaza Strip. These women were required to obtain a travel permit to East Jerusalem from the Israeli military administration to access East Jerusalem.

Permissions and Ethical Review

Ethical review of the study was obtained from the Ethical Review Committee at the Palestinian university two of the co-authors are affiliated with. The Palestinian Ministry of Health (MoH) and NGO hospital then reviewed the project and granted the research team access to the cancer treatment facilities and to interview patients. As noted previously, the research team conducted field visits to the three hospitals to familiarize themselves with the field as well as to meet with hospital staff to seek their input on how best to approach the fieldwork in each setting. Most of the planning for fieldwork took place following these visits, but was re-evaluated during the course of fieldwork.

Through our meetings with staff prior to beginning fieldwork, we learned that typically family members are informed of the diagnosis and decide whether to inform the patient or not. This is similar to Kangas's (2001) experience conducting fieldwork in Yemen. In a few cases we witnessed, patients were not told that they have cancer but rather that they had a severe infection and needed strong antibiotics. The inclusion criteria for this study required that women be diagnosed with breast cancer (regardless of stage) and that they began treatment at least 3 months prior to the interview date; finally, they must have been aware of their diagnosis (Ching et al., 2012). Most married women we spoke to were told their diagnosis directly by the health provider, after they had consulted with their spouse. Some other women, however, were told their diagnosis by their spouse or other family members (mainly siblings in the case of unmarried women), and then went on to discuss their diagnosis and treatment with an oncologist.

We began the study with semi-structured interviewing and then used focus group discussions after completing preliminary coding on the interview transcripts. The purpose of using the focus groups was to triangulate the interviews and to validate our interpretations of what women had said in the interviews. It also allowed women with breast cancer to respond to our initial analysis. In this article, we only present data from the semi-structured interviews with women. It is important to note, however, that our final interpretation and analysis of the interviews was shaped in part by the focus group discussions.

The Interview

We began developing the interview guide with a review of the literature. The proposed semi-structured interview guide was sent to researchers who were members of the Reproductive Health Working Group and conducting research on breast cancer among women in Egypt, Turkey, Oman, and Lebanon at the time. We also sent the

interview guide to clinicians at the NGO hospital in East Jerusalem and to officials and clinicians at the Palestinian Ministry of Health in the West Bank for their insights. We sent the interview guide to other researchers and clinicians to ensure the instrument was as comprehensive as possible and was also culturally sensitive in its approach to questions about women's experiences. Some researchers and clinicians suggested adding questions pertaining to various aspects of care, whereas others advised us on the language we used to assure sensitivity.

Interviews were arranged in consultation with hospital staff at the three sites. At the NGO hospital, the Psychosocial Unit prearranged interviews. At the government hospitals, the nurse(s) directed the researchers to breast cancer patients. Because patients at the government hospitals were not required by hospital regulations to be fully aware of their diagnosis, researchers asked hospital staff to direct us to breast cancer patients who were aware of their diagnosis. The researchers then approached these patients directly and secured informed consent orally before beginning the interview. Participants were assured anonymity and were guaranteed that participation in the study was voluntary and had no bearing on their treatment. Only two women declined to be interviewed. The research team had a target of at least 10 interviews per hospital to assure as many perspectives as possible and likely to reach data saturation. The research team conducted 35 interviews at the three hospitals (13 in the East Jerusalem hospital, 12 in the North West Bank hospital, and 10 in the South West Bank hospital), when data saturation had been reached, with women aged 25 to 71.

Interviews were conducted in colloquial Palestinian Arabic by the first author of this article and another fieldworker between April 20, 2010 and May 17, 2010. Interviews typically lasted for an hour on average (ranging from 45 minutes to 3 hours). Because the interviewers are Palestinians, reside in the oPt, and are familiar with the culture, they were able to pick up on cues and assure social proximity between interviewer and interviewee (Bourdieu, 1996). The fieldwork process was reflective and flexible enough to allow for adjustments based on experiences in the field as well as to assure cultural appropriateness and sensitivity. Where it was apparent that women were uneasy with a question that was asked, an attempt to reword the question was made, and at times dropped all together if the respondent was clearly upset. In addition, at the end of each interview, the interviewers probed women on their reactions to the content of the questions asked. This type of feedback was very important to the continuous re-evaluation of the interviewing process, where, given the sensitivity of the topic, adjustments were made as necessary (Liamputtong, 2007). Based on women's feedback, questions about the impact of breast cancer diagnosis on women's families were

added. Many women told us that their experience with cancer was also profoundly impacted by the effect it had on their families. Another question about whether women feared that their health condition would worsen was removed. Some women we interviewed objected to this question because they felt it was insensitive, particularly to patients still undergoing treatment. Topics included in the interview were as follows:

1. Socio-demographic characteristics: education, employment (before and after diagnosis/treatment), marital status, and children.
2. How were respondents diagnosed? How did they react to the diagnosis?
3. How did family and loved ones react to the diagnosis?
4. What type of treatment did respondents receive?
5. The impact of diagnosis on respondents' lives.
6. Support respondents received and their needs.
7. Respondents' ability to cope with illness and factors they felt necessary for coping.
8. Women's satisfaction with services and support they received.
9. Factors important to respondents' quality of life and how this can be improved.

During the interviews, one interviewer posed questions, while another took notes. Interview and field notes were then checked and discussed by the two interviewers to assure completeness of the transcripts. Names and any other identifiers were not included in the transcripts. Transcripts were only accessible to researchers working on this project.

Analysis

We utilize a thematic analysis approach (Braun & Clarke, 2006; Vaismoradi et al., 2013) in this study. We chose a thematic analysis approach because of the flexibility it provides. While we do hope to build on this study in the future in the direction of theory development, which would benefit from a grounded theory approach, we opted for a thematic analysis approach in this study because of the exploratory nature of the study and the scarcity of other studies in the Palestinian context. Thematic analysis provides us that flexibility while also providing a systematic framework for the analysis of the data based on study objectives (Braun & Clarke, 2006; Vaismoradi et al., 2013).

Data were closely analyzed through repeated readings and discussion for the purpose of familiarization. Line by line data coding was then conducted (independently by two team members) systematically in thematic tables, assisting in the clustering of responses. Transcripts were

kept in the original Arabic for coding purposes, where specific quotes were translated into English for writing purposes. Codes were compared and discussed to arrive at a consensus in cases of difference. In cases where there was some disagreement, the research team discussed the differences in interpretation. In all cases, disagreements were resolved after extended discussion and some alterations of the classification of codes after consensus had been reached. Codes were then organized again into themes and subthemes in line with the consensus. The process of coding and organizing codes into subthemes and themes occurred inductively. Themes and subthemes represent patterns that cut across codes. We initially grouped similar codes together in thematic tables and diagrams. We then reviewed the thematic tables and diagrams to assess whether there were links between groups of codes. Similar groups of codes (subthemes) were then placed under a larger overarching theme. Groups of codes that did not fit with others groups/patterns of codes were considered their own themes. The research team worked on the thematic tables again by re-interpreting the results and explaining them based on the original research objective and the themes that emerged from the data (Braun & Clarke, 2006).

Findings

In total, 35 women were interviewed. Women were at various stages of disease and came from throughout the West Bank, with a few also from the Gaza Strip. Table 1 provides the characteristics of the study participants.

Three main themes emerged from the women's narratives in relation to their response to and methods of coping with breast cancer. The women discussed: (a) the transition from initial shock to the daily struggles and disruption caused by the disease; (b) the role of social and family support in helping them cope with the burden of disease and treatment; (c) faith and reliance on God (*tawakkul*) which formed an important overarching theme. This was inherent to the women's understanding of the disease and crucial to the meaning-making process that accompanied acceptance and coping.

From a Death Sentence to a Daily Burden

Initial shock. Most women reported shock, sadness, and disbelief when they found out they had the disease. The idea itself, the word "cancer," was a source of distress as cancer was usually seen as a confrontation with death in the local context. "Its name is scary," pointed out one woman. Another broke down emotionally when she heard it was the "bad disease" (a common term used in reference to cancer locally as the word is not uttered because of the fear of death). These quotes showed the

Table 1. Total Sample Characteristics of Interviewed Women (N = 35).

Age	
20–29	1
30–39	5
40–49	12
50–59	11
60+	6
Education	
Primary or below	15
Preparatory	5
Secondary	5
Post-secondary	10
Marital status	
Married	23
Divorced	1
Widowed	6
Never married	5
Number of children	
0	3
1–2	3
3–4	12
5–7	11
8+	3
Region	
South West Bank	9
Center West Bank (including Jerusalem)	11
Northern West Bank	12
Gaza Strip	3
Type of locality	
Urban	13
Rural	16
Refugee camp	6
Employed	8
Age at diagnosis	
20–29	2
30–39	6
40–49	14
50–59	8
60+	5
Time since diagnosis	
<1 year	13
1–2 years	10
3 years+	12
Late stage	7
Types of treatment received	
Chemotherapy only	1
Mastectomy and chemotherapy	10
Mastectomy, chemotherapy, and radiotherapy	14
Women with other chronic conditions	15

uttering of the word "cancer" (or local equivalents) invoked supernatural properties, oftentimes associated with death. The utterance of the word "cancer" itself was

very dramatic, and was avoided by most of the women we spoke to. Aside from the name being scary, others did not want to deal with the pity or prying that came from people in their social networks.

When I went to the doctor I went walking (literally “on my feet”), but when the doctor told me that you have the “bad disease,” at that moment, I was no longer able to go to the house, except in the car. I had a nervous episode and I felt the “bad disease.” (35-year-old woman from a village near Nablus)

Another woman noted, “When the doctor told me you need surgery, I felt like I was going to die, I started to cry and cry as if there were ten dead people in front of me” (55-year-old woman from a Jericho Refugee camp). This woman’s metaphor gives a clear idea of the intensity of the shock and underlines the common articulation of cancer with death. Given the common association of cancer (or the *bad disease*) with death, for many women, cancer diagnosis served as a reminder of one’s own mortality.

In their discussions of death, women were vocal about the possible consequences their death would have on others, especially young children. Most women also worried about the consequences of their physical weakness on their children. As reported by a woman from the Nablus region, “At first I was sad, I was sad about my children because my husband is sick and in prison (he has to go through kidney dialysis), and now their mother and father are (both) sick” (46-year-old woman from Nablus). Given cultural expectations defining the role of women as selfless caretakers (Johnson, 2006; Johnson & Kuttub, 2001; Moghadam, 2004), feelings of guilt stemming from their inability to fulfill this role were common.

Living a disrupted life: The daily struggle of coping with the disruption of breast cancer. The dramatic intensity of the initial shock subsided quickly and gave way to concerns with the daily burdens of disease. As more time went by in women’s lives since diagnosis, distress was no longer linked to the emotional reaction to a scary diagnosis, but rather to the daily realities of living with the consequences of treatment. Rather than a death sentence, the disease, primarily through its treatment, became part of a disrupted life.

The availability of treatment played an important role in this transition from viewing cancer as a death sentence to seeing it as a manageable disease. However, while treatment itself was seen as a source of temporary comfort, the side effects of treatment reduced women’s abilities to function physically and carry out their roles and responsibilities: “I would be sitting and I would get tired. I stopped working as I would like. I can’t carry anything and the heat affects me and if I got cold, my chest would start to hurt” (48-year-old woman from a village near Jerusalem). This reduced ability to function was a major source of distress for women. It transformed women, in

many ways, from caregivers to care receivers, rendering them unable to perform their expected social roles.

Changes to physical appearance resulting from treatment were also an important emotional and psychological concern. In this study, women were especially vocal about their reactions to hair loss. Many women noted that they would cover their hair at home with a scarf or wig, and some even while they slept. Women expressed joy when their hair began to grow back, and to some, the doctor or health provider’s assurances that their hair would grow back normally were very comforting. One woman noted, “My mother, when I cut my hair, she went crazy and when my hair began to fall off when I was brushing it she went crazy” (36-year-old woman from refugee camp near Nablus). This woman explained that she had cut her hair short, because it would make it easier for her to deal with it falling, especially since she had always had long thick hair. After her mother’s reaction, she decided to shave it completely, because it would upset her every time she would see thick strands of hair in her brush. It was easier for her to deal with the loss all at once, rather than deal with that loss gradually. When we interviewed her, she had been enduring treatment for over 2 years, and was in a wheelchair because she was weak from treatment (her cancer had metastasized to other parts of her body). She told us that she used to spend a lot of time taking care of her physical appearance in the past, and didn’t recognize herself anymore. At the end of the interview, she asked her husband (who had been waiting outside) in to show us a picture of her he had kept in his wallet. She wanted us to see what she looked like before, so that we understood what she lost due to her illness.

Reactions to breast loss were typically expressed in relation to women’s abilities to cover the lost breast. In the public space, this was not a major problem, because women usually wore loose-fitting clothing and were able to disguise the absence of the breast by stuffing their bras. At home, women were forced to face the physical loss of the breast, which could no longer be disguised. Women had trouble looking at themselves in the mirror. During sexual intercourse, most women said their husbands were sensitive and supportive; however, women expressed their own insecurities and feelings of being incomplete:

When I am with my husband, even though he is understanding, the sight of it [the missing breast] is upsetting and I start crying. And he would tell me: “Even if they removed both of your breasts I would still love you.”

Reducing the Burden: Family and Social Support

The daily struggles depicted in the narratives of these women are intimately linked with life in the extended family. Husbands were expected to provide emotional

support, mainly through comforting words and their acceptance of their wives' physical condition.

It didn't affect it (relationship) at all at all, even sexually he has accepted the situation and that is the most important thing. I would feel like there is something missing from me but he has accepted. Especially since the two breasts complete the female (feminine body). When your husband stands by you and accepts the situation, of course, the patient's *nafsiyeh* (psychological status) will be beautiful.

Female relatives were mainly expected to provide practical assistance with household chores. Support was important to meeting the basic needs of the family and continuation of day-to-day life. But it was often difficult for women to come to terms with being care recipients rather than caretakers. Women expressed a deep sense of guilt when their young children had to take on responsibilities the women were no longer able to fulfill.

... I don't like to fall short of my children's needs, but for example the girls, all the housework is on them. Sometimes they don't know how to do something and I would be unable to do it and I would start crying.

Here the tension between the gendered norms of nurturing and care and the necessities imposed by disease appeared to cause much distress. The need for support was a reminder of the disruption caused by illness and the strains placed on women's self-reliance in the process, thereby placing women in the category of "ill" where healthiness is embodied through being a self-sufficient caretaker. Therefore, it was important for women to find ways to be self-reliant and to reclaim their own agency. "The household responsibilities and house chores, I do all of it. It is true that I have this disease, but I want to live my life normally, and my spirits are high" (47-year-old woman from Deir Al-Balah [Gaza]). By gradually becoming self-reliant, women were in a way reclaiming their roles and identities as caretakers and moving past the temporary incapacitation and disruption imposed by disease. Their identities were deeply rooted in their family, and by stressing the impact their diagnosis had on their families, they reaffirmed their identity as caretakers and thus cemented an identity that is primarily relational.

In rare cases, families were unsupportive. In these cases, the emotional destructiveness of unsupportive or absent ones cannot be overstated. For example, a widow with limited means, living alone in a refugee camp, complained about the lack of financial and emotional support from her children: "Sometimes, even if jokingly, they (her sons) start saying 'that's it, well you are going to go anyways [die]' (she cries)." Later on, she added: "Nothing has poisoned my body/being, except my children, my family is poisoning my body/being."

Acceptance and Beyond: Faith and Tawakkul

Regardless of the intensity of the initial shock or the pervasiveness of the cancer in their daily lives, almost all women eventually came to terms with their disease. This is not to say that women's feelings did not oscillate from time to time, particularly when they were more drained physically and emotionally from both disease and treatment. Religion and faith played fundamental roles in women's acceptance of cancer as part of their destiny, among both Christian and Muslim women interviewed. References to God were omnipresent in all the interviews. Their illness was seen as the will of God and their daily struggles as a test of faith that would be rewarded in the afterlife:

What can I do, La Hawla Wala [there is no power greater than the power of God]. I was surprised and sad. No one is not sad because of this disease. But this is the will of Rab al-'Alamin [The God of the world/universe].

Another woman added,

The most important thing is that I have accepted the disease itself. And, I have put my situation in God's hands. I am bothered from the things I am in pain from. But God willing all of this will be on my balance of good deeds.

Although understanding disease as part of one's destiny was important in coming to terms with cancer, on rare occasions women questioned their fate:

In the beginning I was strong. The first week after the surgery, naturally my husband, my daughter and my sisters-in-law helped me. But after that I began to do everything on my own, when I improved and when my health came back. Now I went back to work and I laugh and joke but sometimes, at some moments, I begin to think and say "Why me?"

This woman went to tell us that when she got to the point where she was asking (God) "why me?," she quickly tried to push herself out of that mind-set and focus on moving forward. Even in these instances women pushed themselves to find solace in faith. Reliance on God was fundamental to the women's coping; where God was ultimately the source of cure from disease. Although God was seen as the ultimate source of cure, women adhered to the prescribed treatment. As one woman puts it, "Of course the cure is from God because He (God) created the illness/disease and the medicine."

As disease was perceived to be part of divine will, women similarly relied (*tawakkul*) on God for treatment. Women perceived treatment as their responsibility; where the doctor and medical treatment were a means (at times referred to God's tools on earth) to a cure that ultimately

depended on God. "I came here to the hospital knowing that God is the one that cures, God created the treatment and God created the medicine (cure)."

Discussion

The results presented in this article provide insights into how Palestinian women react to, cope with, and make sense of breast cancer. There are clear parallels between their experiences and the experiences of women in other settings, particularly in the importance of faith and social support (Doumit, El Saghir, et al., 2010; Kagawa-Singer & Wellisch, 2003; Tam Ashing et al., 2003). At the same time, there are differences that can only be understood within the larger socio-cultural context that shapes the way in which women perceive and cope with their disease.

After women discussed their initial shock upon receiving their diagnosis, most women focused on the disruption disease and treatment caused to their lives. This disruption parallels the "biographical disruption" discussed by Liamputtong and Suwankhong (2015) in relation to breast cancer. Liamputtong and Suwankhong draw on the notion of biographical disruption of illness theorized by Bury and extended by Williams (cited in Liamputtong & Suwankhong, 2015), where chronic illness, and namely cancer, disrupts the structures of everyday life. Similarly to Liamputtong and Suwankhong's study, women in our study also drew on cultural and religious beliefs to manage the disruption caused by cancer, in addition to medical treatment which mitigated the physical threat of cancer. In the Palestinian setting, cancer and chemotherapy were considered "life-changing" and disruptive in the sense that they prevented the women from fulfilling their social roles as mothers or as wives and caretakers. Similar to the work of Joseph (1993) among Arab families in Lebanon, the women participating in this study did not expect, value, or express a desire for autonomy and separateness. Selfhood and identity therefore remained social, understood through relationships and connections with others, especially as a wife and mother.

Social support played an integral role in the way women coped with breast cancer (Doumit, El Saghir, et al., 2010; Kagawa-Singer & Wellisch, 2003; Tam Ashing et al., 2003), where female relatives were the main providers of support. Women also emphasized the importance of receiving emotional support from their husbands. Although most women had access to social support, not all women who participated in this study reported the same degree of support from their social networks. Women mobilized the social support they received as well as their own (emotional and physical) resources to cope with the disruption breast cancer caused (Ching et al., 2012; Liamputtong & Suwankhong, 2015).

Although the extended family social support network plays a critical role in women's abilities to cope with breast cancer in the Palestinian setting, this support system has its limitations and should not be taken for granted. This is especially true with the increasing urbanization of the oPt, the increasing nuclearization of families, and the loss of daily access to extended families due to the delocalization of couples in search of livelihood in urban areas (Giacaman, 2010).

These life changes vis-à-vis the family are compounded by the presence of a multitude of access restrictions that are gradually undermining the social support system available to Palestinian women, including Israeli army checkpoints which restrict or sometimes prohibit movement from one part of the West Bank to the other; the Separation Wall which separates family from family, from the land that they till and from their sources of livelihoods; and the geopolitical separation of the West Bank and Gaza Strip (Giacaman, 2010). Some of the women seeking treatment in the East Jerusalem hospital discussed how many members of their family could not get permits to accompany them for treatment, and how this made the journey more difficult for these women. Some women were also separated from family members and spouses because these family members were incarcerated by the Israeli military. Others faced longer travel times due to checkpoints, thereby making the journey more exhausting, both physically and emotionally. Our data suggest that a deeper analysis of the effects of these problems on breast cancer patients' access to care in the oPt is warranted.

In cases where family social support was deficient, the health care system was ill-equipped to cope with the non-medical needs of women. Further investments in these more formal sources of support are essential for women whose families do not or cannot provide necessary support. Psychosocial care, which was consistently available in only one hospital, may also be of benefit to women struggling with breast cancer at all hospitals (Al-Azri et al., 2009; Doumit, El Saghir, et al., 2010; Goodwin et al., 2001; Helgeson, Cohen, Schulz, & Yasko, 2000).

Faith and the acceptance of Divine Will was a clear and important characteristic of the way women made sense of what was happening to them. This didn't mean that the patients were passive subjects, accepting their disease without acting, without thinking about or debating it (Al-Azri et al., 2014). Similar to what Hamdy (2009, p. 176) found in her study on kidney transplantation patients in Egypt, "the disposition of submission to God's utter will (*al-tawakkul*) is not a passive form of fatalism that negates human agency . . ." In other words, this study points to faith as an important way of coping rather than submission, and warns against alternative interpretations fixating on the issue of fatalism as part of Muslim and Arab culture.

Finally, breast cancer is increasingly important to women's health and is the leading cause of cancer-related death among women (Husseini et al., 2009), requiring policy and operational changes in the nascent Palestinian health system. The health system suffers from fragmentation and focuses primarily on the biomedical aspects of patient management, without due regard to the psychosocial aspects of care (Mataria et al., 2009). The results of this study reiterate the need to expand the notion of care to bridge the increasing social and psychological support gaps (Hammoudeh, Mataria, Wick, & Giacaman, 2009). Considerable health policy attention should therefore be directed toward the provision of more holistic care that takes women's medical and non-medical needs into account.

Limitations

Our study has several limitations. Given limitations on access to cancer patients due to cultural taboos, we opted for a hospital-based design. This limited us to women who were seeking treatment as well as some women coming in for check-ups. Furthermore, we were not able to access women who did not receive any treatment or upper- or middle-class women who opt to seek treatment in Jordanian or Israeli hospitals, or women who were in remission. Furthermore, some interviews took place in more crowded areas and it was more difficult to establish rapport with the woman. This undoubtedly impacted the quality of some interviews. Despite these limitations, we believe that the study provides important information and insights into the experiences of women with breast cancer in the oPt, which will help pave the way for future research, policy development, and interventions.

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