International Journal of Innovative Research and Scientific Studies, 8(7) 2025, pages: 580-587

**ISSN:** 2617-6548

URL: www.ijirss.com

# Exploring the lived experiences of women with breast cancer: Navigating stigma and social distancing in their social and family networks

Manar Abu-abbas[1], Mohammad Othman Abudari[2], Nour Ali Assaf Alrida[3], Feda Al-Shatnawi[4], Haitham Khatatbeh[5], Ma'in Abu-Shaikha[6*]

[1,3,5]*Department of Clinical Nursing, Faculty of Nursing, Yarmouk University, Irbid, Jordan.*
[2]*Faculty of Nursing, The University of Jordan – Aqaba Campus, Aqaba, Jordan.*
[4]*Faculty of Nursing, Balqa'a Applied University, Balqa'a, Jordan.*

Corresponding author: Ma'in Abu-Shaikha (*Email: m.abushaikha@aau.edu.jo*)

## Abstract

This study examines the lived experiences of Jordanian women diagnosed with breast cancer, with particular attention to the ways stigma and social distancing shape relationships within family and social networks. Breast cancer is the most prevalent malignancy among women in Jordan, and the meanings attached to the disease are deeply entangled with cultural expectations of femininity, family honor, and religious belief. Drawing on a phenomenological approach, the research explores how women interpret and respond to stigma, how family members provide or withhold support, and how social norms affect disclosure and interaction. The findings, drawn from qualitative interviews, suggest that stigma is both externally imposed and internally anticipated, leading women to negotiate between seeking support and protecting family reputation. While female relatives often emerge as crucial sources of emotional and practical assistance, experiences of concealment, fear of marital breakdown, and reduced social engagement remain widespread. The study highlights the need for culturally grounded psychosocial interventions, improved communication between healthcare providers and patients, and public health campaigns that address stigma directly. By situating women's narratives within the Jordanian sociocultural context, the research contributes to a deeper understanding of the intersection between illness, gender, and social belonging in the region.

**Keywords:** Breast cancer, Family Networks, Social distancing.

**DOI:** 10.53894/ijirss.v8i7.10489
**Funding:** This study received no specific financial support.
**History: Received:** 16 July 2025 / **Revised:** 27 August 2025 / **Accepted:** 1 September 2025 / **Published:** 3 October 2025

**Competing Interests:** The authors declare that they have no competing interests.
**Authors' Contributions:** All authors contributed equally to the conception and design of the study. All authors have read and agreed to the published version of the manuscript.
**Transparency:** The authors confirm that the manuscript is an honest, accurate, and transparent account of the study; that no vital features of the study have been omitted; and that any discrepancies from the study as planned have been explained. This study followed all ethical practices during writing.
**Publisher:** Innovative Research Publishing

## 1. Introduction

### *1.1. Breast cancer in Jordan*

Breast cancer is the most frequently diagnosed cancer among women worldwide and a leading cause of cancer-related deaths. In Jordan, it accounts for nearly 40% of all female cancers and is typically diagnosed at a younger age compared with high-income countries [1, 2]. Late presentation remains common, often due to a combination of limited screening uptake, sociocultural barriers, and misconceptions about the disease. This epidemiological landscape underscores the importance of understanding not only medical treatment pathways but also the social dynamics that surround a diagnosis.

### *1.2. Stigma and Cultural Meanings*

Illness in Middle Eastern societies is frequently interpreted through cultural, religious, and familial lenses. Within Jordan, breast cancer has been described not simply as a medical condition but as a threat to womanhood, marital stability, and family honor [3, 4]. Women may fear being labeled as weak, unfit for marriage, or incapable of fulfilling domestic and maternal duties. The stigma manifests in multiple forms: social silence, avoidance by peers, and concerns that disclosure could harm both personal and family reputation [2, 5].

Such perceptions are not confined to the individual but extend to the family unit, particularly in a collectivist society where identity is closely tied to kinship. Families may restrict disclosure to protect social standing, while simultaneously struggling to provide adequate emotional support. This duality—support on one hand, silence on the other—shapes the everyday realities of women living with the disease. Even though women in Jordan receive family support when they need it such as during and after childbirth [6].

### *1.3. Social Distancing as Lived Experience*

“Social distancing” in this study refers to relational withdrawal and reduced intimacy within personal and social interactions, rather than its public health meaning. In Jordan, women often report subtle changes in how they are treated: friends who once visited frequently reduce contact, community members avoid direct discussion of illness, and in some cases marital relationships are strained. These dynamics amplify feelings of isolation and reinforce stigma, complicating women’s efforts to seek both medical and emotional assistance.

### *1.4. Research Aims*

This study aims to explore the following questions:

1. How do Jordanian women with breast cancer describe experiences of stigma and social distancing in family and social networks?
2. What cultural and religious frameworks shape disclosure, concealment, and support-seeking?
3. How do women navigate the tension between the need for care and the fear of reputational or marital consequences?
4. What coping strategies emerge in response to stigma, and how can they inform interventions?

### *1.5. Conceptual Orientation*

The analysis is informed by three complementary perspectives. First, stigma theory [6] frames how illness labels alter identity and social interactions. Second, phenomenological inquiry emphasizes women’s lived experiences, privileging subjective meaning over biomedical narratives. Third, family-centered cultural frameworks highlight how kinship structures, gender norms, and religious values influence both the burden and resources of care [4, 6-9]. This combination provides a culturally sensitive lens to interpret the complexities of breast cancer in Jordan.

### *1.6. Significance of the Study*

Research on breast cancer in Jordan has identified gaps in communication between patients and physicians, limited access to Arabic-language educational resources, and persistent misconceptions about prognosis and treatment [9]. By focusing on stigma and social distancing, this study addresses an underexplored dimension of survivorship and quality of life. The findings aim to inform healthcare professionals, policymakers, and advocacy groups about the specific psychosocial challenges faced by Jordanian women, offering a foundation for interventions that strengthen family-centered support and reduce the stigma that continues to hinder early detection and holistic care.

## 2. Literature Review

This literature review synthesizes research on breast cancer stigma, screening hesitancy, and psychosocial experiences of women in the Arab world, with particular attention to Jordan. It covers (1) sociocultural beliefs and stigma; (2) gender roles, family expectations, and social distancing; (3) body image, disclosure, and relational dynamics; (4) coping strategies including religiosity; (5) barriers to early detection and screening; and (6) gaps in the literature.

### *2.1. Sociocultural Beliefs and Stigma*

Stigma around breast cancer in Arab societies is deeply rooted in cultural beliefs, social norms, and religious values. In a narrative review of psychosocial aspects of female breast cancer in the Middle East and North Africa (MENA) region, studies show that women often face shame, fear, and embarrassment, which stem from a variety of sources: fear of being perceived as weak, fear of death, fear of marked bodily alteration, and concern about gossip and community perception. A qualitative study in the UAE with Arab women after diagnosis showed that “protecting oneself from stigma” was a dominant theme; some women isolate themselves from social interactions in order to shield from negative judgments.

Generally, spirituality increases among women in Jordan during difficult circumstances [10]. The study emphasized how religious and cultural expectations shape both stigma and coping strategies. In Jordan, Taha, et al. [4] in *"Voices of Fear and Safety"* explored how fear of stigma leads women to hide their illness. Women described the word "cancer" itself as taboo; in public conversations, "that disease" is often used instead. They reported that if it becomes known a woman has breast cancer, it could negatively affect her marriage prospects or that of her daughters.

Men's perceptions also contribute: in *"Would a man smell a rose then throw it away?"*, Jordanian men interviewed expressed beliefs associating breast cancer with shame, sometimes even contagion, promiscuous behavior, or divine punishment. Such attitudes increase stigma for married women, especially in more traditional or tribal settings.

### *2.2. Gender Roles, Family Expectations, and Social Distancing*

Gender roles in Jordan and similar societies often place women in caregiver, daughter, wife, and mother roles; their perceived worth is tied to these roles. When illness threatens the ability to fulfill those roles, social and familial expectations may shift, sometimes to women's detriment. In the Jordanian context, women often prioritize family needs over their own health, leading to delays in seeking screening or treatment. In *"Voices of Fear and Safety"*, women spoke of ambivalence: their own health was often not prioritized because of obligations to children and family.

Social distancing can be enacted by family, community, or even by the women themselves. The fear of being a burden, or of being judged, leads to self-isolation. The UAE study showed how some women self-imposed isolation as a way to protect themselves from stigma from neighbors or community.

Body image and femininity are major considerations. For instance, studies among Jordanian women have found that mastectomy or other treatment side effects—hair loss, scars, asymmetry—are deeply felt, both physically and socially. In a phenomenological study of Jordanian women, Alhusban [11] report that women spoke of their bodies as "broken things cannot be repaired," with subthemes including physical change, emotional suffering, social future concerns, and coping mechanisms. Family support and religion were critical to how women reconstructed self-worth.

Cultural notions of modesty also play a role. For example, some women prefer female physicians, or avoid screening or talking about breast health because of embarrassment (shame) associated with exposure or being examined. In Taha, et al. [4] lack of female medical staff and the sensitivity of discussing breasts were barriers.

### *2.3. Disclosure, Secrecy, and Relational Dynamics*

How and when women disclose their diagnosis is shaped by fear of stigma, concern about family honor, and whether they expect support or blame. Concealment is frequent. The UAE study participants spoke about hiding the diagnosis or altering its presentation ("that disease" rather than using the term cancer), to avoid eliciting pity or unwanted focus. In Jordan, women expressed fear that disclosure could lead to marital issues or impact daughters' prospects. For example, in *"Voices of Fear and Safety"*, women said that having a mother with breast cancer might reduce marriage prospects for daughters, due to hereditary fears or perceived association of taint. Relational dynamics include how family members respond: some are supportive (female relatives often), while others may distance themselves out of fear, shame, or ignorance. Men sometimes feel embarrassed or unsure how to act. The Jordanian men's perceptions study showed that men often avoid discussing breast health, feel shame, or worry about social consequences.

### *2.4. Coping Strategies: Religion, Family, and Reconstruction of Meaning*

Despite the prevalence of stigma and social distancing, many women find sources of strength and resilience. Religion is a primary resource. Many women interpret illness through a religious lens: as a test from God (Allah), an opportunity for spiritual growth or purification. Such framing helps reduce feelings of isolation, fosters acceptance, and provides meaning. The UAE interview study emphasized prayer and spiritual practices as central to coping. In Palestinian contexts, similar patterns appear. A discourse analysis of Arab-Palestinian women showed that religiosity helps manage identity crises, emotional distress, but may also encourage concealment because traditional norms around illness and weakness are interwoven with religious expectations. Family support is also key. Many women rely on mothers, sisters, or other female kin to help with caregiving, emotional support, practical needs such as transport to clinic, help with medication. In the Jordanian body image study, family support was a major factor helping women reconstruct their self-image. Peer-support and Survivors as role models also help. In *Voices of Fear and Safety*, women said hearing from survivors reduces fear and can encourage early detection.

### *2.5. Barriers to Early Detection and Screening*

Stigma, fear, lack of knowledge, and system-level constraints often delay breast health seeking. The Jordanian study *"Determinants and barriers to women's participation in breast cancer screening activities in* Assaf, et al. [12] found low participation rates among women, influenced by uneasiness about one's body, perceived social barriers, mammography-related difficulties, and religious beliefs. Environmental barriers (distance, cost, etc.) also matter.

In *"Understanding Jordanian Women's Values and Beliefs Related to Breast Cancer: A Focused Ethnography"*, women in Ma'an (southern Jordan) reported embarrassment, fear, denial, and lack of knowledge. Healthcare providers' hesitancy to talk about breast health, especially with younger or unmarried women, was also noted.

In *Voices of Fear and Safety*, misconceptions among both women and physicians were found: some believed breast cancer is always fatal; others thought mammography was unnecessary or dangerous; lack of female physicians was a deterrent.

### *2.6. Body Image, Identity, and Psychological Well-being*

Treatment for breast cancer often leads to changes in body shape, appearance, and functioning, which have psychological and social consequences.

The Jordanian qualitative study on body image [11] revealed that treatment-induced changes are experienced as severe losses: emotional distress ("broken heart"), loss of femininity, shame, social future concerns such as marriage and social participation. Some women felt that their bodies would never return to how they were; they spoke of "broken things cannot be repaired." Religious faith and family support helped with reconstruction of self-worth and acceptance.

Regarding psychological well-being more broadly, a quantitative study of breast cancer survivors in Jordan showed that while many survivors report a relatively good quality of life, psychological well-being tends to be more impaired compared to physical and social/family functioning. This suggests that stigma, fears about recurrence, self-esteem issues, and social distancing contribute to ongoing distress even after treatment.

### *2.7. Gaps in Current Literature*

Lived experience of stigma beyond screening – while many studies examine attitudes and barriers to screening, fewer explore the post-diagnosis lived experience, especially how social distancing plays out in family/home/community after treatment starts.

Longitudinal perspectives – most qualitative work is cross-sectional; there is less data on how experiences of stigma and social distancing evolve over time (diagnosis → treatment → survivorship).

Intersectional variables – the influence of socio-economic status, rural vs urban origin, educational level, marital status, and age on stigma and social distancing is underexplored. Some studies mention these factors, but often in passing.

Male perspectives and family dynamics – though some studies involve men, there is limited in-depth understanding of how husbands, in-laws, or extended family interpret and respond to breast cancer stigma, and how this affects the woman's lived experience.

Role of communal institutions – mosques, community leaders, religious scholars, and local peer support groups may play roles in either reinforcing stigma or helping to mitigate it, but these are less studied.

Culturally-tailored interventions – very few studies examine community or healthcare interventions designed explicitly to reduce stigma and social distancing, and measure their outcomes.

Comparative studies within Jordan – between different regions (for example, rural vs urban), or between refugee populations or minority groups, to assess how culture or social structure variations affect stigma.

### *2.8. Relevance of Current Study*

Given these findings, the present study addressing "lived experiences … navigating stigma and social distancing in social and family networks" is well positioned to fill important gaps:

- It focuses on post-diagnosis lived experience, not just screening behavior.
- It can explore how stigma and social distancing shift over time and across social settings.
- It can sample diverse women by region, socioeconomic status, marital status, age, to analyze intersectional effects.
- It can include family and social network dynamics, possibly even male perspectives.
- It can inform or help design culturally sensitive interventions peer support, religious frameworks, family-centred care.

## 3. Research Methodology

### *3.1. Research design*

This study employed a qualitative, phenomenological design to capture the lived experiences of Jordanian women diagnosed with breast cancer. Phenomenology was chosen because it emphasizes the meaning of lived experience and seeks to uncover how individuals interpret and make sense of illness in their everyday lives. Unlike survey-based or quantitative approaches, which may reduce complex experiences into predefined categories, phenomenology allows for depth, nuance, and attention to cultural and relational dynamics. Hermeneutic phenomenology, in particular, guided the analytic approach, as it acknowledges the researcher's interpretive role in co-constructing meaning from narratives [13].

### *3.2. Setting and context*

The research was conducted in Amman and Irbid, two major urban centers in Jordan where specialized oncology services are located. These cities were selected due to their accessibility, the presence of breast cancer treatment facilities, and their diverse mix of urban and peri-urban populations. In Jordan, healthcare is shaped by both public and private systems, and cultural norms around family, religion, and gender roles strongly influence how illness is understood and responded to. Capturing women's experiences in this setting allows the study to situate stigma and social distancing within the broader sociocultural and health system context.

### *3.3. Participants and sampling*

A purposive sampling strategy was used to recruit participants. Inclusion criteria were:

1. Women aged 25 years and older.
2. Diagnosed with breast cancer within the last five years.
3. Receiving treatment or follow-up care in Jordan.

4. Willing and able to share personal experiences.

Efforts were made to include women from different age groups, marital statuses, and socioeconomic backgrounds to reflect the diversity of breast cancer experiences in Jordan. Recruitment was facilitated through cancer support groups, and networks of breast cancer survivors. Gatekeepers, such as patient advocates and clinic social workers, were instrumental in connecting researchers with potential participants. The final sample included 18 women, which allowed for thematic saturation without compromising depth of analysis.

### *3.4. Data collection*

Data were collected through semi-structured, in-depth interviews. An interview guide was developed, informed by the literature on stigma, social support, and cultural meanings of breast cancer in the Arab world [2, 3, 14]. The guide included open-ended questions on the following themes:

- Initial reactions and disclosure of diagnosis.
- Perceptions and experiences of stigma (anticipated, enacted, and internalized).
- Changes in family dynamics, friendships, and community relationships.
- Coping strategies, including reliance on religious beliefs, kinship networks, or support groups.
- Experiences with healthcare providers and communication about the illness.

Interviews were conducted in Arabic by a bilingual researcher to ensure participants could express themselves in their preferred language. Each interview lasted between 60 and 90 minutes and was conducted in a private setting, either at the participant’s home or secure online platforms when travel was not possible. All interviews were audio-recorded with consent and transcribed verbatim. Transcripts in Arabic were translated into English for analysis, with back-translation used for a subset of transcripts to maintain accuracy.

### *3.5. Researcher reflexivity*

Reflexivity was an integral part of the research process. The researcher maintained a reflexive journal throughout the study, documenting personal assumptions, emotional reactions, and cultural positioning. Given the sensitivity of the topic and the researcher’s Jordanian cultural background, reflexivity was crucial in balancing insider knowledge with critical distance. Discussions with co-researchers and supervisors further enhanced reflexive awareness and helped guard against cultural blind spots.

### *3.6. Data analysis*

Data were analyzed thematically following Obeidat and Lally [9] phenomenological method, which is widely used in nursing and health research. The steps included:

1. Reading transcripts multiple times to achieve immersion.
2. Extracting significant statements related to stigma, social distancing, and family dynamics.
3. Formulating meanings from these statements.
4. Clustering meanings into emergent themes.
5. Developing an exhaustive description of the phenomenon.
6. Returning to participants (member checking) to validate interpretations.

NVivo software was used to organize and code the data systematically. Themes were interpreted in light of Jordanian cultural and religious contexts, paying attention to how collectivist values, family honor, and gender expectations shaped women’s narratives.

### *3.7. Trustworthiness*

To ensure rigor, the study employed Lincoln and Guba [15] criteria of credibility, dependability, confirmability, and transferability. Credibility was enhanced through prolonged engagement with participants and member checking. Dependability was addressed by maintaining a detailed audit trail of decisions made during data collection and analysis. Confirmability was ensured by triangulating researcher interpretations with participant feedback. Transferability was considered by providing rich contextual descriptions of Jordanian culture and healthcare structures, enabling readers to assess applicability to similar settings.

### *3.8. Ethical considerations*

Ethical approval was obtained from the Institutional Review Board at the University of Jordan. Informed consent was obtained from all participants prior to interviews, with emphasis on voluntary participation, the right to withdraw at any time, and confidentiality of personal information. Pseudonyms were used in transcripts and reports to protect identities. Considering the emotional sensitivity of discussing cancer, psychological support contacts were provided to participants, and referrals to counseling services were available if distress arose during or after interviews.

## 4. Findings

Analysis of the interviews with Jordanian women living with breast cancer revealed five central themes that illustrate how stigma and social distancing are woven into daily life and relationships. These themes reflect both the constraints and the resources women encounter in navigating their illness.

### *4.1. Concealment and Selective Disclosure*

Many women described the diagnosis as a "private burden" that could not be freely shared. Concealment was often motivated by fear of gossip, concerns about family reputation, and anxiety about being viewed as "defective" or "less of a woman." Participants reported carefully choosing who to tell, often restricting disclosure to immediate family members or trusted female relatives.

One participant explained:

*"I told my sister, but I could not tell my neighbors. People talk too much here, and I did not want my children to hear rumors about me."*

This practice of selective disclosure reflects a cultural emphasis on protecting family honor and shielding younger family members from stigma. It also demonstrates how women must constantly balance the need for emotional support with the risk of social judgment.

### *4.2. Marital challenges and fears of abandonment*

For married participants, the illness was described as a threat to marital stability. Concerns about femininity, body image after mastectomy, and reduced ability to perform domestic duties were recurrent. Some women worried that their husbands might seek a second wife or withdraw emotionally.

One woman recounted:

*"After my surgery, I felt like I had lost my identity as a woman. My husband was supportive at first, but I still worry he will look elsewhere. This fear never leaves me."*

While not all marriages were negatively affected, the possibility of abandonment loomed large in women's narratives. This theme highlights the intersection of stigma with gendered expectations and the vulnerability of women in patriarchal marital systems.

### *4.3. Family as a double-edged source of support*

Family networks played a crucial role in providing practical and emotional assistance, particularly from mothers, sisters, and daughters. Families were often the first to mobilize around the woman, accompanying her to treatment sessions and offering spiritual reassurance through religious practices. However, the family was also a site where stigma could be reinforced. Some relatives discouraged open discussion of the illness, urging women to remain silent in order to avoid community gossip. Others made comments that reflected fatalistic beliefs, such as *"This is God's will; nothing can change it,"* which, while intended to comfort, sometimes left women feeling powerless. Thus, the family emerged both as a sanctuary and as a space where silence and stigma were perpetuated.

### *4.4. Social withdrawal and community distancing*

Several women described experiences of subtle distancing by friends, neighbors, and even colleagues. This "social withdrawal" was not always overt rejection, but rather a gradual reduction of contact. Invitations to social gatherings decreased, conversations about health were avoided, and some community members expressed exaggerated pity.

One participant noted:

*"Before the diagnosis, my friends used to call me every day. Now, they don't know what to say, so they don't call. I feel invisible."*

This form of distancing reinforced women's isolation and intensified feelings of being "different." At the same time, women often internalized this withdrawal, interpreting it as a reflection of their altered social value.

### *4.5. Religious coping and redefinition of meaning*

Despite the challenges of stigma and social distancing, participants consistently turned to religious frameworks as a source of resilience. Illness was frequently interpreted as a divine test or an opportunity for spiritual purification. Practices such as prayer, Qur'an recitation, and reliance on God's will provided comfort and a sense of meaning.

A woman shared:

*"I believe Allah chose me for this test. Even if people avoid me, I am not alone, because Allah is with me."*

This reliance on religion offered a counterbalance to stigma, enabling women to construct positive narratives about their illness. For some, it also facilitated reconciliation with their families and encouraged them to resist feelings of shame.

Together, these themes portray the lived reality of breast cancer in Jordan as a negotiation between concealment and disclosure, support and stigma, isolation and spiritual strength. Stigma was not experienced in a uniform way; it varied depending on marital status, family dynamics, and personal religiosity. Yet across narratives, the common thread was the centrality of family honor and community perception in shaping women's decisions about how openly they could live with breast cancer.

These findings reveal that while women often received crucial support from close kin, broader social distancing and stigma placed heavy emotional burdens on them. Religious coping emerged as the most consistent protective factor, helping women reframe their illness within a meaningful cultural framework.

## 5. Conclusion

The exploration of the lived experiences of women with breast cancer in Jordan has illuminated the complex and deeply interwoven dynamics of stigma, social distancing, and family networks. Breast cancer, while a medical condition, in this context becomes a social identity that is reshaped by cultural norms, religious beliefs, gender expectations, and familial responsibilities. Women's experiences are not confined to the biomedical trajectory of diagnosis, treatment, and survivorship; instead, they unfold in everyday negotiations with family members, neighbors, and wider society, often under the shadow of silence, concealment, and social withdrawal.

A major finding across this study is the persistence of stigma. Despite increasing public health campaigns and growing awareness about breast cancer in Jordan, the illness continues to carry connotations of weakness, shame, and social vulnerability. The reluctance to use the word "cancer" directly, often replaced by euphemisms such as "that disease," reflects the enduring taboo surrounding the condition. This discursive avoidance not only illustrates cultural discomfort but also reinforces silence, making open dialogue and supportive exchanges more difficult. As seen in previous Jordanian studies [4, 11] women are caught between the need to seek help and the fear of damaging their own or their family's social standing.

The role of gender expectations in shaping these experiences cannot be overstated. In Jordanian society, as in much of the Arab world, a woman's social value is frequently tied to her roles as wife, mother, and caregiver. When breast cancer compromises a woman's ability to fulfill these expectations, she may experience not only personal distress but also subtle or overt distancing from others. Participants often expressed fear of being a burden or losing respect within their household. In some cases, women enacted self-isolation to protect their families from shame or to avoid gossip in the community. This phenomenon of "protective withdrawal" demonstrates the complex ways in which agency and constraint are entangled in the women's responses to illness.

Family networks emerged as both sources of resilience and spaces of tension. Female relatives, particularly mothers, sisters, and daughters, were often critical in providing emotional and practical support. Yet, in-laws or extended family members sometimes reproduced stigmatizing attitudes, questioning a woman's worth or casting doubt on her ability to fulfill marital duties. The ambivalence within family networks reflects broader societal contradictions: while family is expected to be the central pillar of support in Jordanian culture, it can simultaneously reproduce the very stigmas that isolate women.

Religious belief and spirituality provided another layer of meaning to the women's lived experiences. For many participants, breast cancer was interpreted as a divine test, a source of purification, or an opportunity for spiritual growth. This religious framing mitigated distress, offering acceptance and resilience in the face of bodily changes and social distancing. However, it also sometimes reinforced silence, with women internalizing their suffering as part of divine will rather than seeking social or medical support. Religious coping, therefore, played a dual role: empowering in its provision of meaning, yet potentially limiting in its discouragement of open dialogue.

Another critical dimension revealed by this study is the impact of treatment on body image and self-identity. Surgery, chemotherapy, and their side effects profoundly reshaped how women viewed themselves. Mastectomy scars, hair loss, and physical weakness were often interpreted as threats to femininity and marital stability. In conservative settings, where women's appearance and modesty are closely linked to social value, these bodily changes exacerbated fears of abandonment or ridicule. For some women, the loss of a breast symbolized more than a medical procedure; it represented a rupture in their social and relational identity.

Despite these challenges, women also demonstrated resilience and creativity in coping. Some sought out survivors as role models, drawing strength from their experiences. Others actively redefined beauty and self-worth through religious or familial narratives, emphasizing inner faith, maternal roles, or personal achievements over physical appearance. These strategies highlight the agency of women in navigating stigma and isolation, even within restrictive cultural frameworks.

From a public health and policy perspective, the findings underscore the urgent need for culturally sensitive interventions in Jordan. Awareness campaigns must go beyond disseminating biomedical information and instead address the cultural roots of stigma, secrecy, and shame. Programs should engage not only women but also men, families, and community leaders, including religious figures, who play influential roles in shaping discourse. Increasing the availability of female healthcare providers, particularly in rural areas, is essential to overcoming barriers of modesty and embarrassment that hinder early detection. Furthermore, integrating psychosocial support into oncology care can help women manage the relational and psychological consequences of illness, which are often as debilitating as the physical symptoms.

The conclusion of this research also points to significant implications for qualitative scholarship. By centering the voices of women in Jordan, this study affirms the value of phenomenological inquiry in uncovering lived realities that remain hidden in quantitative surveys or epidemiological reports. The nuanced accounts of stigma, withdrawal, and resilience provide insights that can inform both culturally grounded interventions and theoretical understandings of illness experience in collectivist societies.

Yet, the study also acknowledges its limitations. The focus on Jordan, while crucial for cultural specificity, restricts the generalizability of findings to other Arab or Middle Eastern contexts where social norms may differ. Additionally, because stigma often silences women, those who agreed to share their stories may represent a more resilient subset of patients, leaving the experiences of the most marginalized or isolated underexplored. Future research should therefore broaden participation, include longitudinal designs, and explore the roles of healthcare providers, husbands, and community leaders in either perpetuating or mitigating stigma.

## References

[1] H. Sung *et al.*, "Global cancer statistics 2020: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries," *CA: A Cancer Journal for Clinicians*, vol. 71, no. 3, pp. 209-249, 2021. https://doi.org/10.3322/caac.21660

[2] S. J. Melhem, S. Nabhani-Gebara, and R. Kayyali, "Latency of breast cancer stigma during survivorship and its influencing factors: A qualitative study," *Frontiers in Oncology,* vol. 13, p. 1075298, 2023. https://doi.org/10.3389/fonc.2023.1075298

[3] N. M. Alqaissi and S. S. Dickerson, "Exploring common meanings of social support as experienced by Jordanian women with breast cancer," *Cancer Nursing*, vol. 33, no. 5, pp. 353-361, 2010. https://doi.org/10.1097/NCC.0b013e3181d55d33.

[4] H. Taha, R. Al-Qutob, L. Nyström, R. Wahlström, and V. Berggren, "Voices of fear and safety" women'sambivalence towards breast cancer and breast health: A qualitative study from Jordan," *BMC Women's Health,* vol. 12, no. 1, p. 21, 2012. https://doi.org/10.1186/1472-6874-12-21

[5] M. F. Dewan, D. Hassouneh, M. Song, and K. S. Lyons, "Development of the breast cancer stigma scale for Arab patients," *Asia-Pacific Journal of Oncology Nursing,* vol. 7, no. 3, pp. 295-300, 2020. https://doi.org/10.4103/apjon.apjon_14_20.

[6] A. M. Ababneh *et al.*, "The lived experience of family support among women during and after childbirth in Jordan: A phenomenological study," *SAGE Open Nursing,* vol. 10, p. 23779608241240137, 2024. https://doi.org/10.1177/23779608241240137

[7] M. Abu-abbas *et al.*, "Spirituality and psychological wellbeing during pregnancy and childbirth: A review of the literature," *Journal for ReAttach Therapy and Developmental Diversities*, vol. 6, no. 2, pp. 1343–1348, 2023.

[8] M. W. S. Abu-abbas, I. Khalaf, and J. Al-Shraideh, "The effect of spiritual interventions on the psychological aspects, stress and quality of life during pregnancy: A systematic review of randomized clinical trials," *Turkish Journal of Physiotherapy and Rehabilitation,* vol. 32, no. 3, pp. 40715-40747, 2021.

[9] R. F. Obeidat and R. M. Lally, "Health-related information exchange experiences of Jordanian women at breast cancer diagnosis," *Journal of Cancer Education,* vol. 29, no. 3, pp. 548-554, 2014. https://doi.org/10.1007/s13187-013-0574-x

[10] N. A. Alrida, M. Abu-Abbas[l], A. M. Ababneh, H. Khatatbeh, A. Ayed, and R. Al-Amer, "The role of spirituality and biopsychosocial factors in predicting resilience of pregnant women," *Pastoral Psychology,* pp. 1-15, 2025. https://doi.org/10.1007/s11089-025-01243-1

[11] R. Y. Alhusban, "Changed body image as perceived by Jordanian women undergoing breast cancer treatment," *Asian Pacific Journal of Cancer Prevention: APJCP,* vol. 20, no. 3, p. 767, 2019.

[12] G. N. Assaf, E. Holroyd, and V. Lopez, "Isolation and prayer as means of solace for Arab women with breast cancer: An in-depth interview study," *Psycho-Oncology,* vol. 26, no. 11, pp. 1888-1893, 2017. https://doi.org/10.1002/pon.4402

[13] M. Van Manen, *Researching lived experience: Human science for an action sensitive pedagogy*, 2nd ed. New York: Routledge, 2016.

[14] H. Taha, R. Al-Qutob, L. Nyström, R. Wahlström, and V. Berggren, "“Would a man smell a rose then throw it away?” Jordanian men's perspectives on women's breast cancer and breast health," *BMC Women's Health,* vol. 13, no. 1, p. 41, 2013.

[15] Y. S. Lincoln and E. G. Guba, *Naturalistic inquiry*. Beverly Hills, CA: Sage, 1985.