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## The Lived Experiences of Middle Eastern Immigrant Women During Their Cancer Survivorship Journey: A Phenomenological Study

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## The Lived Experiences of Middle Eastern Immigrant Women During Their Cancer Survivorship Journey: A Phenomenological Study

### Abstract

The number of Middle Eastern immigrant women (MEIW) living in Canada has significantly increased. However, this group of women is underrepresented in health research and there is a gap in knowledge of their cancer survivorship experiences in Canada. This phenomenological qualitative approach was employed to uncover the meaning of the lived experiences of MEIW during their cancer survivorship journey (CSJ). Data were collected through unstructured interviews and one written description from three MEIW. The participants' perspectives of cancer risk factors were believed to be the cause of their cancer, and their CSJ was fear-inducing and anxiety-provoking. There appears to be similar and homogenous lived experiences among the participants. Participants showed that their own cancer survivorship experiences were shaped by mutual contributions from different factors and circumstances. Importantly, when they talked about their experiences, they related their personal, familial, cultural and immigrational, gender, economics, social support, self-image, and other associated factors that contributed to their illness and wellness. Healthcare professionals need to identify immigrant women's unmet needs of support and psychosocial responses during their CSJ. Language-specific and culturally competent cancer-care intervention programs need development within the Canadian healthcare system.

### Keywords

lived experience, Immigrant women, qualitative approach, cancer, Middle Eastern, phenomenology, women

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# The Lived Experiences of Middle Eastern Immigrant Women During Their Cancer Survivorship Journey: A Phenomenological Study

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The number of Middle Eastern immigrant women (MEIW) living in Canada has significantly increased. However, this group of women is underrepresented in health research and there is a gap in knowledge of their cancer survivorship experiences in Canada. This phenomenological qualitative approach was employed to uncover the meaning of the lived experiences of MEIW during their cancer survivorship journey (CSJ). Data were collected through unstructured interviews and one written description from three MEIW. The participants' perspectives of cancer risk factors were believed to be the cause of their cancer, and their CSJ was fear-inducing and anxiety-provoking. There appears to be similar and homogenous lived experiences among the participants. Participants showed that their own cancer survivorship experiences were shaped by mutual contributions from different factors and circumstances. Importantly, when they talked about their experiences, they related their personal, familial, cultural and immigrational, gender, economics, social support, self-image, and other associated factors that contributed to their illness and wellness. Healthcare professionals need to identify immigrant women's unmet needs of support and psychosocial responses during their CSJ. Language-specific and culturally competent cancer-care intervention programs need development within the Canadian healthcare system.

*Keywords:* lived experience, Immigrant women, qualitative approach, cancer, Middle Eastern, phenomenology, women

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## Background and Problem Statement

The cancer survivorship journey is very complicated and affects cancer patients physically, psychosocially, and emotionally due to associated feelings of fear, worry, sadness, distress, anxiety, and depression (Ashing-Giwa & Lim, 2011; Duffy & Aquino-Russell, 2007; Williams & Jeanetta, 2016; Williams et al., 2016). The cancer survivorship journey is influenced by various factors, including ethnicity, race, cultural beliefs, socioeconomic status, education, lifestyle, and access to health services (Ashing-Giwa & Lim, 2009, 2011; Holst-Hansson et al., 2018). For example, lower socioeconomic status and lower levels of education have been linked to diminished health outcomes in women diagnosed with cancer (Ashing-Giwa & Lim, 2011). Furthermore, women from ethnic minorities who are cancer survivors experience lower rates of emotional wellbeing, higher rates of fear of recurrence, and more symptoms of depression than non-minority women (Ashing-Giwa & Lim, 2011; Christensen et al., 2009).

Immigrant women's cultural identities and values influence various aspects of their survivorship experiences. These include their perception of illness, relationship with healthcare providers, ability to communicate their illness symptoms, preferred type of care and degree of compliance to the recommended care, ability to share their emotions, and responses to life-threatening diseases (Ashing-Giwa et al., 2004; Holst-Hansson et al., 2018). A healthcare system comprised of culturally sensitive healthcare professionals is essential in Canada to improve health outcomes and quality of care. It can also contribute to eliminating racial and ethnic health disparities to achieve health equity.

In the last sixty years, the ethnic and cultural makeup of immigrants in Canada has changed dramatically, resulting in a significant impact on the composition of Canadian society (Statistics Canada, 2016). For example, within the last 15 years, the most updated report found that the number of immigrant women from Asia and the Middle East has significantly increased to more than 50% of Canada's total female immigrant population (Hudon, 2015). Therefore, the frequency of healthcare providers interacting with immigrant women from the Middle East and Asia has increased and will continue to grow, along with the need for healthcare providers to have more knowledge about their cultures and experiences to provide culturally competent healthcare services.

Several Canadian studies have shown that immigrant women who are from South Asia, new immigrants to Canada, and in the family and refugee classes have the lowest cancer screening rates leading to delays in cancer diagnosis and poor cancer survivorship outcomes (Lofters et al., 2019; Lofters et al., 2017; Vahabi & Lofters, 2016). Immigrant women from the Middle East and Africa have higher breast cancer incident rates compared with counterpart immigrant women in Canada (Shuldiner et al., 2018). Furthermore, in general, immigrant women experience challenges understanding the Canadian culture, communicating the English/French language, integrating into Canadian society, and finding employment (Esses & Medianu, 2012). This leads to immigrant women having challenges navigating the Canadian healthcare system and available programs for cancer patients, accessing culturally sensitive education programs and female healthcare professionals (Vahabi & Lofters, 2016), and finding cancer support groups for immigrant women who can communicate in their own language in order to understand their individual cultural needs. All of these challenges will have a significant impact on their cancer survivorship journey and its outcomes.

Although there are some research reports in the literature focusing on the experiences of South-Asian and East-Asian immigrant women during their cancer care in Canada (Bedi & Devins, 2016; Gurm et al., 2008; Hulme et al., 2016), there is little known about the lived experiences of MEIW during their cancer survivorship journey in Canada. Therefore, this phenomenological study aims to understand the lived experiences of MEIW in Canada during their cancer survivorship journey. This study's results will enhance healthcare providers' understandings of MEIW's lived experiences, cultural beliefs, and attitudes towards health and illness during their cancer survivorship journey. Their voices, perceptions, and meaning of the experience for these women will help healthcare professionals to provide this cultural group of women with culturally appropriate and patient-centred care. Therefore, to capture the lived experiences of these women, the research question for this study was: what are the lived experiences of MEIW during their cancer survivorship journey? The findings were viewed through the lens of the population health theory.

From my (Dr. E. A) lived experience as a Middle Eastern immigrant woman in Canada, there are many factors related to the new culture and acculturation process that I believe may influence the health and wellbeing of immigrant women in Canada. I believe that when immigrant women are diagnosed with cancer in Canada, it would be a very distinct and distressing experience. As a Middle Eastern immigrant woman and an Applied Health Services Researcher, I questioned what Middle Eastern immigrant women were living and experiencing

during their cancer diagnosis and treatment and thus wanted to explore what might be the lived experiences of MEIW during their cancer survivorship journeys. To explore this research question, I was guided and supported during the research process by my coauthors, Dr. CA-R and Dr. KA, who have extensive experience in qualitative research, phenomenology, and exploring immigrants' health. I proposed and conducted the project with directions and recommendations from Dr. CA-R and Dr. KA. Dr. CA supported data analysis and oversaw the whole project as the supervisor of my master's thesis. Dr. CA-R has extensive qualitative phenomenological research expertise as well as having participated in the writing of my thesis and the final review of the manuscript. Dr. KA supported in providing insight on how to approach participants, interview them, and helped prepare the final manuscript for publication.

## **Method**

### **Design**

A qualitative descriptive phenomenological methodology developed by Giorgi (1970, 1985, 2009) was used to uncover the lived experiences of Middle Eastern immigrant women during their cancer survivorship journeys. Phenomenology as a research methodology is a rigorous, critical, systematic, investigative methodology to study human lived experiences (Cilesiz, 2011). This method helps in describing and understanding the meaning of the phenomenon as described by those who have lived the consciousness experience (Giorgi, 2012; Giorgi & Giorgi, 2008). Giorgi aimed to create a rigorous scientific phenomenological psychology that was inspired by Husserl's ideas of studying the essences of phenomena as they appeared in the person's consciousness (Giorgi, 1985). Researchers from any discipline can employ Giorgi's descriptive phenomenological method to view lived experiences from their own disciplinary lens (Giorgi 2012). This feature of Giorgi's method helps researchers to understand participants' lived experiences in a meaningful way from the researcher's own disciplinary perspective (Giorgi, 2012). In this research, the population health theory was used as a lens to view the participants' language to describe their lived experiences.

### **Ethical Considerations**

This project was ethically approved by the Ethical Review Committee in the Faculty of Nursing at the University of New Brunswick, as well as the main Research Ethics Board (REB) at the University of New Brunswick. This project was also ethically approved by the REB at Horizon Health Network-New Brunswick, Canada.

### **Recruitment**

The recruitment for this study was purposeful snowballing sampling. Social media support groups were the best method in this project to reach out to the highest number of Middle Eastern immigrant women in Canada. Facebook support groups for Middle Eastern communities living in Canada helped to reach out to two participants. WhatsApp support group for refugee women allowed us to reach out to one participant. The first author, Dr. EA, was a Middle Eastern immigrant and she could communicate in English, French, and Arabic languages proficiently. Therefore, she translated the research advertisement poster and information sheet to make sure they were available in all three languages.

The aim was to recruit up to eight women for this study to elucidate the richness of the individual experiences. However, recruiting immigrant women for this study was a challenge. This difficulty concurred with previous studies, which indicated that recruiting immigrant

women and women from ethnic minorities is very complicated because of the same barriers to health disparities amongst immigrant women (such as cultural beliefs, education, and language) (Renert et al., 2013).

We attempted to recruit participants through oncology clinics, various multicultural associations, and local cancer support groups and organizations (e.g., Canadian Cancer Society and Breast Cancer Network) in Atlantic Canada. We also tried to recruit participants by placing advertisements in public locations where MEIW and cancer survivors might frequent (e.g., mosque, library, etc.) through public service announcements and social media. Social media platforms helped me to reach out to two more participants.

## Participants

As mentioned, the sample for this study was a purposeful, snowballing sample of MEIW immigrant cancer survivors in Canada. This group of women were legitimate informants who have lived the reality of the research phenomenon and were able to describe what the experience was like for them in responding to the research question of this study. Participants were eligible to participate in this study if they met the following inclusion criteria: MEIW, diagnosed with cancer within the last five years, aged 20-65 years at the time of the interview, reside in Canada, and able to speak English or Arabic.

For this study, three women were interested in participating, and their average age was 44 years (age range of 41 to 47 years) at the time of the interview (Table 1):

**Table 1**

*Participants Demographics (n =3)*

Characteristics	Number
Age Range	41-47
Time lived in Canada	
Less than 5 years	2
Between 5 and 10 years	1
Between 10 and 20 years	0
More than 20 years	0
Education level	
No high school Diploma	1
High school Diploma	0
College	1
Bachelor's degree	0
Master's Degree	1
PhD	0
Employment	
Yes	1
No	2
Living area	
Urban	3
Rural	0
Have children	
Yes	2
No	1
Time diagnosed with Cancer	
	1 (3 years ago)
	2 (4 years ago)
Type of cancer	3 (breast cancer)

Cancer history in the family	
Yes	3
No	0

The three participants lived in urban cities across Canada (the names of the cities are not included to protect the participants' anonymity). Two of them have been living in Canada for less than five years, while one participant has been living in Canada for a period between five and ten years. One participant was employed, and two participants were not employed. The three participants' education levels differed; one had a university degree, one had a college education, and one had no high school education. All participants were affiliated with the Islam faith.

Furthermore, participants' demographic data (Table 1) shows that these women were diagnosed with breast cancer between the ages of 37 to 43, with an average age at diagnosis of 40 years. The women were diagnosed with breast cancer on average 3.7 years ago. They have a history of cancer in their families. As shown in Table 2, all underwent similar cancer treatment, including mastectomy, chemotherapy, radiotherapy, and hormonal therapy (except for one participant who did not undergo hormonal therapy). During the interviews, the participants described their treatment locations: two participants were treated at hospitals, and one woman was treated at a cancer care center.

**Table 2**

*Characteristics of the Middle Eastern immigrant women participants*

Pseudonym	Age	Cancer treatment	Relationship status	Immigration category
Marwa	47	Mastectomy Chemotherapy Radiotherapy	Married	Refugee category
Nora	41	Chemotherapy Mastectomy Hormonotherapy Radiotherapy	Divorced	Economic category
Eman	44	Chemotherapy Mastectomy Radiotherapy Hormonotherapy	Married	Family category

Table 2 presents the characteristics of each participant. Participants' characteristics were pulled from descriptive data to help better understand the lived experiences of the three women who participated in this study. Each participant chose a pseudonym to maintain anonymity and confidentiality. It can be noted that two participants were married, and one participant was divorced and a single mother. Further, the three women represent three different Canadian immigration categories: refugee, economic, and family.

### Data Collection

Data was collected from two unstructured interviews and one written description by email, as per participants' choosing, as well as demographic data sheets from each participant. Giorgi's phenomenological method allows the researcher to have an in-depth one-to-one interview with the participants and to ask one open-ended question to let the participants'

descriptions emerge in a natural setting with minimal interference from the researcher (Giorgi, 2009). In this study, the participants were asked to respond to the following open-ended statement: "*As a Middle Eastern immigrant woman in Canada, please describe your lived experiences during your cancer survivorship journey.*" Further, whenever the participant started to generalize about the experience, questions were asked, such as: "*can you talk more about---*?" and "*What was it like?*" These questions allowed the participants to express their experiences in their own ways and at their own pace.

In-depth one-on-one interviews are the most common data collection method in phenomenological studies (Creswell & Poth, 2017; Giorgi, 1997; Guerrero-Castañeda et al., 2017). In this study, unstructured, in-depth interviews were conducted with two participants at a location and time that was most convenient for each participant. The participant who lived near the primary investigator (PI) at the time of the interview preferred an in-person interview at her home. This is the most common data collection for qualitative research and is considered effective as the researcher interacts with the participant and facilitates openness and trust (Novick, 2008).

A phone interview was conducted with the other participant living far away from the PI at the time of the interview. Although phone interviews are less common in qualitative research, they can be a versatile data collection method. Previous studies had declared that when phone interviews were a data collection tool, the participants felt relaxed and willing to speak freely and disclose confidential information (Novick, 2008). The qualitative data have been prosperous, vivid, and detailed with high quality. Since Giorgi's method allow the participants to describe their lived experience at their pace with minimal direction from the researcher, a phone interview was an acceptable and effective option to collect data in this study.

With improving technology and growing media communication methods, researchers try to explore using various technologies in qualitative research (Branthwaite & Patterson, 2011). Email as a data collection method has been previously used by various researchers (Bowden & Galindo-Gonzalez, 2015; Gordon, 2009). One participant, who lived far away from the PI at the time of the interview, preferred to write down the description of her lived experience and send it to the researchers via email. In accordance with Giorgi's (1985) method of data collection and analysis, this participant was requested by email to respond to the research's integratory statement. The participant had the freedom to write as much information about her experiences as she wished. The participant was given a period of up to one month to send her description. It has been declared previously that a one-month time frame is sufficient when email as a data collection method is used (Aquino-Russell, 2003; Gordon, 2009). When the PI received the email, the story was written in Arabic. Therefore, the PI translated the transcript into English and sent an email to the participant asking her if she would like to add anything, but she did not add any extra comments.

In-depth interviews were conducted between December 2018 and May 2019. The length of the interviews was between 45-65 minutes. The three participants were Arabic-speaking women, with Arabic as their first language. Since the primary investigator is a Middle Eastern immigrant, she was able to communicate in English and Arabic. Therefore, each interview was conducted in the participant's preferred language. The participants preferred to conduct the interviews in Arabic as it was easier for them to express their feelings and experiences in Arabic rather than in English. The interviews were recorded on a digital recorder. Following the time with the participants, the PI transcribed and translated the interviews.

After the interviews, participants filled out a demographic data sheet that required less than five minutes to complete. The participant who emailed in her response also filled out this



document. The demographic data sheet collected information about the participants, such as age, time living in Canada, and cancer history.

### Data Analysis

The interviews that were conducted in Arabic were translated literally into English and transcribed verbatim. Once the interviews were transcribed and the text became ready to be analyzed, data analysis-synthesis was conducted using Giorgi's method to analyze-synthesize descriptive phenomenological studies as described in Table (3) (Giorgi, 1970, 1985, 1992, 1997, 2012; Giorgi et al., 2017).

Step	Name	Description
1	<b>Contemplative dwelling with the descriptions</b>	The participants' transcripts were read freely and openly many times to gain an overall sense of the descriptions of the whole statements.
2	<b>Assuming the attitude of the phenomenological scientific reduction</b>	It is assumed that the elements within the participant's transcript were the phenomenon that presented themselves to the consciousness of the participant.
3	<b>Identifying the meaning units (MUs)</b>	MUs are passages of text expressing the meaning in the participant's own words. It is done by breaking down the descriptions into smaller parts.
4	<b>Identifying the focal meanings (FMs)</b>	The participants' language (MUs) was transformed into scientific expressions (the researcher's/disciplinary language, which was the population health perspective, emphasizing the phenomenon being studied).
5	<b>Synthesizing the situated structural description (SSD)</b>	The FM was transformed into an SSD for each participant's specific situation/context. The SSD grasps the meaning from each participant's perspective. This step brings the population health lens to the forefront.
6	<b>Synthesizing the general structural descriptions (GSD)</b>	The GSD of the lived experiences of the research participants was synthesized from their SSDs. The GSD includes essences from all of the participants.

### Trustworthiness

In this study, the descriptions of data collection, data analysis-synthesis, and the findings were rigorous and trustworthy through different actions: Credibility and dependability were achieved through (1) engagement with participants by having in-depth interviews with each of two participants, (2) peer debriefing by consulting and meeting with the research team to evaluate and explore various aspects of the analysis, (3) presenting the participants' words in the discussion of the findings, and (4) the PI transcribing the interviews and translating into the English language. The transcript in Arabic and English was sent to participants by email as a pdf file. The PI asked them if they would like to add anything they could call her back. However, they were all satisfied with their individual transcripts. Credibility and dependability were also achieved through (5) journaling during the whole research process, describing the

changes that occurred, how these changes affected the way the research was approached, and (6) thick description. Steps 5 and 6, in addition to bracketing and inquiry audits (creating an audit trail including all the research documents such as interview transcripts and reflective notes), were applied to establish the confirmability of the data. Transferability is achieved by the thick descriptions to determine that the data have meaning to others in similar settings.

### Findings

In this study, the meaning of these women's lived experiences was affected and shaped by the social determinants of health. The findings suggested that the essences of the lived experiences of MEIW are interrelated with each other. The meaning of the experience of Middle Eastern women's cancer survivorship journey involves six major themes or essences:

1. Their perspectives on cancer risk factors were considered as being the cause of their cancer
2. Their cancer survivorship journey was fear-inducing and anxiety-provoking, which was persistent throughout the entire journey
3. They used various coping mechanisms to harmonize their lives
4. Social support was the key to persistence for participants
5. Their survivorship journey was combined with changes in their physical and social environments
6. As women, their self-image was impacted greatly

Each theme and combining subtheme is illustrated and supported by quotes (meaning units) from the participants that represent the participants' experience during their survivorship journey.

#### **1. Their Perspectives on Cancer Risk Factors were Considered as being the Cause of their Cancer**

The meaning of living the cancer survivorship journey for the immigrant women of this research involved perceptions that cancer was caused by risk factors. The participants of this study stated and understood that there were risk factors for developing cancer in their lifetime. Each participant identified a risk factor for developing breast cancer in their lifetime based on their experiences and knowledge of cancer.

The participant Eman (a pseudonym), who was an educated, family-class immigrant and diagnosed with breast cancer at the age of 40, described her family history of breast cancer: *"I have a family history of cancer, my aunt, my mother's cousin, and my aunt from my dad's side all had breast cancer."* She believed that biological factors and family history of cancer could have been the reason for developing breast cancer in her lifetime. For this reason, she started annual mammogram screening at an early age (36 years), as she described, *"So, I started doing mammogram four years before the diagnosis. I did it every year."* Since Eman is an educated person, she perceived early and annual mammogram as a health prevention action to detect cancer at an early stage when it is most treatable.

Marwa (a pseudonym), who was a refugee immigrant, was diagnosed with breast cancer at the age of 43. She believed that experiencing psychological distress was the risk factor for developing cancer in her lifetime as she stated, *"I think that the reasons behind developing cancer are from being sad all the time, living a very stressful life."* Marwa specified that she experienced tremendous psychological distress due to experiences challenging life events such

as the war in her home country, having unstable life and looking for a safe environment for herself and her family as she stated:

*I have been through so many hard things in my life, such as the war, being poor, living far from my loved family, and moving a lot to find a safe place. It is all a stressful life.*

Marwa also believed that having a low socioeconomic status combined with hard life events was another reason to upsurge her psychological distress. Furthermore, being an immigrant meant that she was far from family. Hence, lack of social support due to living distantly from a supportive and loving family was also a significant cause for these participants to have additional psychological distress. It is clear that this participant had experienced the highest number of challenging life events that caused significant psychological distress in her lifetime.

The participants of this study believed that there were different risk factors for developing cancer, including family history, psychological distress that was caused by challenging life events, having low socioeconomic status, lack of social support due to living at a distance from supportive and loving family members, and living in an unbalanced social and physical environment.

## **2. Their Cancer Survivorship Journey was Fear-Inducing and Anxiety-Provoking which was Persistent Throughout the Entire Journey**

The participants perceived their cancer journey as extraordinarily fear-inducing and anxiety-provoking because of their cultural beliefs about cancer and previous experiences. There were different sources and causes of fears and anxiety based on each participants' experiences and perceptions of the disease. For the participants, a cancer diagnosis and treatment were the first source of fear and sadness because cancer had taken the lives of their family members. The participant Marwa, based on her previous experience, perceived her cancer diagnosis as a death sentence, and communicating and delivering this news to her family members was another challenging and stressful aspect she had to manage as her father passed away of cancer:

*I lost my dad to blood cancer... So, telling them [her family] that I have cancer was very hard. I was very sad and upset. I started to think that death is coming soon.*

The participant Nora (pseudonym), who was an educated, economic-class immigrant, and diagnosed with cancer at the age of 37, on the other hand, was feared the treatment process and was scared of death after every chemotherapy session. This fear of the treatment process was generated based on her previous experiences as her father had passed away after his first chemotherapy session as she stated:

*In every single chemotherapy session, I was afraid of death because my dad had died after three hours of his first chemotherapy dose.*

The second source of fear and anxiety was that being a cancer survivor increased their distress with fear and worry about their children's future. Marwa stated that as an immigrant woman, she is the primary source of social support for her children. There are no other family members to help in taking care of their children. Therefore, her anxiety increased due to overthinking about her children's future in Canada.

*If anything happens to me here in Canada, I feel my children will not have anybody to support them. I do not want to lose my children, and I do not want my children to lose me.*

The third source of fear and anxiety for the participants was the dramatic changes in their lifestyle and social environments during their survivorship journey. These changes were caused by the changes in their physical and psychological health and wellbeing, body image, and relationships. Nora stated that her deteriorating health and wellbeing, body image, social relationship with her spouse, and socioeconomic status made her experience darkness in all aspects of her life, which were a significant source of her fear and anxiety as she stated:

*... my life was going to the abyss... I became weaker; my appearance changed as well as my husband's treatment toward me had changed ... During my treatment period, I was mentally suffering in all aspects of life: health, social, marital, physical and income status.*

Nora described the treatment stage as being a challenging stage because she perceived her life with no essence “*I felt that my life had not any meaning.*” Nora perceived her treatment stage as a challenging life event, making her believe that living in this world did not have any indispensable quality.

The last source of fear and anxiety of the participants of this study was the fear of cancer metastasis. Any kind of test the oncologist requested was anxiety-provoking for them because they feared cancer reoccurrence or cancer metastasizing. Eman lived in fear during the waiting time between the test and finding out about the results. She even needed medical attention to reduce her anxiety as she stated:

*I remember when my doctor asked me to do a CT scan for my bones to see if cancer had spread all over my body. I was very scared; I cried; I was shaking. They gave me medications to make me relax.*

The participants believed that there were many sources of fear during the survival journey, making their survivorship extraordinarily fear-inducing and anxiety-provoking. These sources of anxiety were unavoidable due to their cultural beliefs about cancer and cancer treatment outcomes, previous experiences, and fear of being a cancer survivor.

### **3. Social Support is the Key to Persistence for Participants**

This theme explains how social support as a social determinant of health is an important aspect of the cancer survivorship journey. As cancer survivors, social support was precious for them during the cancer survivorship journey. Some participants appreciated the support from close family members who lived with them in Canada. For example, Eman declared that her spouse and mother were the primary sources of social support during her survivorship and without them, she would not have been able to fight cancer: “*Without my husband and my mother, I would not make it. They were there for me.*”

Marwa appreciated and valued social support from her friends and community. It helped her to fight cancer and appreciate the Canadian community:

*When I go to English classes, all the instructors at the multicultural associations are very supportive. They give me hugs when I go there. I love to cook and share it with them.*

The social support from family members was perceived differently from the support that was provided by health service providers or their community members because their family members would understand their cultural needs. Family social support was a liberation for them because family members would comprehend their cultural and religious values, beliefs, needs, and responsibilities. Eman described that her mother's support as spiritual and culturally wise as she provided her with a support based on her cultural and spiritual needs stating:

*My mom was great support for me ... Being alone would be so hard. Talking to someone who understands your culture and belief was a relief as well because she understands our culture and responsibilities. Her support was not like the councillor. Like we were on the same page understanding each other and knowing everything about our cultural needs.*

One participant, in a positive and healthy relationship with her spouse, received unconditional support that contributed positively to her cancer survivorship journey. In contrast, another participant, who was in a distressed relationship with her spouse, did not receive any social support, which negatively impacted her journey and her survivorship experience. For example, Eman described how her partner was supportive, understanding, and patient, which made her appreciate his unconditional support: *"I was angry, very angry most of the time. My husband was very calm and supportive, and he tolerated me and respected my feelings."*

Nora, on the other hand, experienced continuous psychological distress during her cancer survivorship journey because her partner was not supportive and did not try to be involved in her cancer care process. Nora stated that she was desperately in need of social support during her survivorship for not only being a cancer survivor but also for being a new immigrant in Canada. Nora stated that she had no friends or family except her spouse, who not only refused to socially and psychologically support her but also refused to join her in attending her medical appointments at the hospital as she stated:

*He did not really support me psychologically... I used to go to the hospital on my own, where my husband did not like to accompany me, and how much I wished as one of the newcomers to have company at that time.*

Furthermore, living far from their beloved families increased their anxiety because physical presence for support was not possible. The participants stated that being an immigrant and a cancer survivor was very stressful as they had limited social support from their family members who live far from them, and inviting someone to be with them in Canada during the survivorship was not an easy process. Marwa described:

*Sometimes, I feel distressed because I live very far from my family [parents and siblings]. Sometimes, I feel distressed because living far from my loved family means no social support. I feel that I want to go back there and be with them. However, I think about my kids, who are everything for me in this life.*

#### **4. They Used Various Coping Mechanisms to Harmonize their Life**

The participants used several coping mechanisms to mitigate their distress levels and to maintain strength during their cancer survivorship journeys. During the treatment stage, they practiced religious prayers and turned to God to maintain control of their feelings. The participants praised God (Allah) by saying *"Alhamdulillah"* (which means praise to be to

God/Allah) many times during the interviews, indicating that the participants decided to accept that the cancer survivorship journey was their destiny in this life, and they had to fight to live and stay strong. Marwa stated:

*Before the surgery, I was very scared, and then I started to recite the holy Quran [Muslim's holy book] and prayed and asked Allah [God] to help me to go through this. .... I always say Alhamdulillah [Praise be to God/Allah]. This is my destiny, and I must accept it.*

The participants found refuge in God/Allah and believed that their religious practices and their faith helped them during their stressful cancer journeys and stopped them from hurting themselves. Eman described how her faith and prayers were sources of strength during her cancer survivorship journey, and they prevented her from contemplating suicide when she was desperate.

*Faith and prayers were also great to go through the whole process, especially when I was weak and had no interest in anything.... I had suicidal thoughts, but I could not do it... you know... I am a Muslim, and this action is prohibited in our faith.*

During the diagnosis stage, the participants had different reactions to their cancer diagnoses. Nora tried to hide her feeling of fear and worry in front of her healthcare providers. Marwa, on the other hand, expressed feelings of fear and anxiety by crying and voicing her feelings to her spouse and healthcare providers. Eman, however, was calm but afraid to deliver the news to her family. The second coping mechanism that was used by the participants was that they tried to hide their physical and psychological symptoms associated with the treatment stage because they were worried about their family members' feelings. The participants tried to conceal their feelings to look strong in the eyes of their children and spouses. Marwa stated:

*During chemotherapy, I lost my hair and my eyebrows. I also got a wig. That really affected my mental health. I tried to hide the symptoms from my children and my husband by covering my head all the time. I did not want them to feel sad.*

The participants also used venting mechanisms by expressing and sharing all their feelings about cancer survivorship and life challenges with others. They vented with friends, family members (as Eman stated earlier), and counsellors. Marwa practiced venting with her friends or family members whenever she felt distressed as expressing her thoughts to her friend made her feel less distressed. She stated:

*Sometimes, when I feel distressed, I go to my neighbour. She is my friend. I tell her about everything inside me to release the stress.*

Eman, meanwhile, sought counselling, stating that she needed to vent and tell everything to someone as there were things she could not tell her family members. After each consultation session, she felt relieved and less stressed, as she stated:

*You know there were things I could not say to my mom and my husband. However, when I went to the counselling session, I would say everything inside me. After every session, I felt very light and better.*

The last coping mechanism, which was pragmatic for participants during the follow-up care stage, was to create new meanings for their lives and to regain control of their lives. Nora stated: “*During that period, I was trying hard to recover my life and to make another meaning to my life.*” The participants attempted to regain control of their lifestyles by making their lives busy and full of activities such as pursuing education, learning English, reaching out/meeting new people, surrounding themselves with sympathetic people, volunteering, finding employment, and supporting people from their communities. Eman stated that these activities helped to empower her and retrieve her a normal life:

*Between the radiation and second operation, I tried to push myself by taking a course...I got a course in immigration counselling... and volunteering. I tried to make myself busy. I found a job at the airport. I was very happy at work. I felt that I am back to my normal life. I felt empowered.*

The participants decided to face the changes in their lives by planning for their futures and trying to grow. They endeavoured to make their lives busy, and full of activities to minimize their stressors. They decided to go back to school and pursuing education or learning the English language. For example, Marwa started to learn English to improve her communication skills to improve her ability to access various services. The participants had a sense of empowerment during this stage of their cancer survivorship journeys because they started to perceive control of their lives. It is clear that the participants felt that they had to feel like strong women again to support themselves and their beloved children. Nora realized the importance of planning for her future when she decided to pursue her education; nevertheless, she found it very demanding and stressful as she was still experiencing other life challenges such as her physiological and psychological health, divorce, child guardianship issues, and low income. She realized that she should have focused on controlling these problems and improving her self-image before going back to school.

*I decided to pursue my studies and meet the requirements of the doctoral program. Alhamdulillah [Thank God], I was accepted. Although it was a period of change and transition from life to life, I felt I was wrong in timing. I had to take a breather from the disease and try other treatments/healing methods such as weight loss, regeneration, and self-development. I tried to get myself out of a suffocating psychological pressure into a more complicated and exhausting life - the life of graduate students. The stage was particularly memorable in the first year as I had so many psychological problems and stressful and difficult issues related to divorce, custody, etc.*

## **5. Survivorship Journey is Combined with Changes in their Physical and Social Environments**

The women experienced changes in their social and physical environments during their cancer survivorship journeys that affected their health and wellbeing. The participants were new immigrants to Canada, which was a novel physical and social environment for them that required physical and psychological efforts to acculturate. The participants declared how their lifestyles dramatically changed when they immigrated to Canada. When they moved to Canada, they were very distressed because they were living in low economic status and did not have jobs, friends, and support from family. For example, Eman mentioned how her lifestyle dramatically changed from being an active working woman to an unemployed and socially isolated woman after immigrating to Canada:

*Before I moved to Canada, I used to work, I had a car, and I was travelling with my friends. Then I moved to Canada. I found myself without a job, no car, and no friends. It was really hard; everything was new to me.*

The second change in the social environment was associated with their social cohesion. The participants' social cohesion and social support network, such as relationships with spouses and making friends, have significantly been affected by the journey. Marwa believed that changes in her social cohesion were caused by her physical and psychological changes and that she was not attractive anymore as she stated:

*I feel that my relationship with my husband has been affected. Maybe he feels distressed when he sees me with one breast. In addition to that, I am older than him. So, I think that he was mentally affected by the whole process.*

Nora, on the other hand, experienced changes in her spouse's treatment and low social support leading to a separation. She believed that these changes related to the changes in her physical and mental health, social environment, and living in a low socioeconomic status made her lose hope in everything and believed that her life had no meaning anymore as she stated:

*What I remember during my treatment period was that I was mentally suffering in all aspects of life: health, social, marital, and economic status. I could not find a person to help me, and my life system was only a housewife. My husband did not allow me to go out or even to the library. My job was to look after the family only. I felt that my life had no any meaning. My marital life was going from bad to worse. Until I started to experience severe bleeding. Then it turned out to be ovarian cancer ... Then, my husband decided to leave our two daughters and me; the eldest was seven years old.*

This theme clearly shows that the physical and social environment determinant of health has a significant impact on the cancer survivorship journey. The changes in the physical and social environment have dramatically affected their mental health and social cohesion with their spouses during their survivorship journeys. Being immigrants and cancer survivors in Canada is combined with various challenges related to their lifestyles, physical and social environments.

## **6. As Women, Their Self-image was Impacted Greatly**

This theme depicts how gender as a social determinant of health impacted their experiences and their perspectives of their cancer survivorship journeys. Prior to their cancer diagnoses, the participants perceived their self-image as self-disciplined, active, and amiable women. Marwa stated:

*I am very good at doing so many things and consider myself a strong woman. I like to keep myself busy with all my housework and my kids ... I am also very nice to people and am an easy-going person ... My husband is even surprised by how I make friends very quickly, and everybody is supporting me.*

However, changes in their body image and physiological health during the treatment stage impacted their psychological health, self-confidence, and social support network (relationships). Eman indicated how the treatment process changed her from an energetic



woman to a person with no motivation to do anything in this world because she was not herself anymore.

*During the treatment stage, I did not have a mode for anything. I used to be a very active and energetic person ... I did not have the energy to give any commitment during the treatment stage. I was emotionally not stable; I lost all my hair. I used to wear a bandana all the time. I lost my hair after my second chemo session.*

The participants expressed their feelings when they had mastectomies and chemotherapy as stressful and sad because they lost important parts of their body that were considered an important part of who they were as women. Marwa even mentioned that looking in the mirror was a very miserable and traumatic experience.

*During chemotherapy, I lost my hair and my eyebrows. I also got a wig ... I also did not feel comfortable letting my kids and husband see me in this shape. It really affected my mental health, and I was distressed all the time. I felt that I lost part of my body ... Whenever I want to change my clothes, I look in the mirror; I start to cry. It is painful and sad to lose part of your body.*

These body-image changes had affected their spouses' relationships with them, negatively impacted their feelings, and amplified their distress. Their spouses' negative reactions to changes in their body image were traumatic to them. Nora depicted how her spouse's negative reaction and distance left her staggered and disappointed:

*And then, I moved to the surgery stage [Mastectomy], and it was a difficult step. It was done successfully (Alhamdulillah); [praise be to God/Allah]. ..... The shock was when I came out of the hospital; I noticed my husband's distaste. He did not even accept to see me changing my clothes in front of him. He even told me literally that "the look and signs of your operation disgust and disturb me.*

The newlywed Eman was concerned about how chemotherapy treatment affected her reproduction system and ability to have children. That made her feel uncomfortable and expected it to affect her relationship with her spouse:

*I did not have my period during the chemotherapy treatment stage, and that really embarrassed me a lot... I do not have children ... When I was diagnosed with cancer, I was newly married. We were married for one year and a half.*

As women (gender as a social determinant of health), the treatment stage and its consequences (changes in body image and reproduction system) deeply affected the participants' mental health and social relationships. They even tried to hide the symptoms of treatment stages to avoid embarrassment. The participants believed that the side effects of the treatment stage made them lose confidence and socially isolate themselves.

## Discussion

This descriptive phenomenological study examined the lived experiences of three MEIW with breast cancer. To date, this has been the first qualitative study that has examined the meaning of the cancer survivorship journey for MEIW in Canada. Previous studies have

examined cancer prevalence, mortality, and screening (e.g., breast and cervical) rates among immigrant women in Canada, including the MEIW (Lofters et al., 2019; McDonald et al., 2017; Vahabi et al., 2016; Woods et al., 2019). However, no Canadian studies have been found to date that focus on the lived experiences of this group of immigrant women during their cancer survivorship journey.

The cancer survivorship journey is challenging and stressful for all cancer survivors and their families. However, for these women, being immigrants made this journey more complicated and stressful. This study has not only explored the meaning of the cancer survivorship journey of these immigrant women but also sheds light on the importance of the social determinants of health in shaping these women's experiences. It is important to point out that the meaning of the lived experiences of these women reflects the complex and interrelated relationship between the social determinants of health. The essences of the general structural description (or meaning) of these lived experiences are discussed in detail in this section.

### **Their Perspectives on Cancer Risk Factors were Considered as being the Cause of their Cancer**

The meaning of living the cancer survivorship journey for the immigrant women of this research involved perceptions that cancer was caused by risk factors. This perspective is consistent with results recorded by Holst-Hansson et al. (2018), who found that immigrant women in Sweden tried to understand what caused their illness (cancer diagnosis). Although other studies found that immigrant women and women from ethnic minorities believed that cancer was caused by God's will or God's punishment (Ashing-Giwa et al., 2004; Holst-Hansson et al., 2018), the participants in this study did not express this perspective. Women in this study perceived different risk factors for their cancer diagnosis based on each woman's experiences and beliefs. Women in this study had a family history of cancer, and they were diagnosed with breast cancer between the ages of 37 to 43, with an average age at diagnosis of 40 years (Table 1). A previous study indicated that the incidence rate among Arab women in Lebanon (a country in the Middle East) with a family history of breast cancer and the age of  $\leq 40$  years is 10.8% (El Saghir et al., 2015). Therefore, one might assume that participants could be carrying a genetic mutation because it has been indicated in previous studies that women who develop breast cancer at an early age (before the age of 65) and have a family history of breast cancer are most likely carrying a genetic mutation (McPherson et al., 2000).

Women in this study also perceived experiencing psychological distress as a risk factor for developing breast cancer in their lives. They perceived that psychological distress was related to experiencing challenging life events, low social support, and being immigrants. Although it is not yet well understood how psychological distress plays a role in developing cancer, there are many epidemiological studies demonstrating the connection between psychosocial factors, social support, life events, and breast cancer (Kruk & Aboul-Enein, 2004; Ollonen et al., 2005; Peled et al., 2008). It has been declared by Peled et al. (2008) that exposure to a cumulative number (more than one) of challenging and meaningful life events is positively associated with breast cancer among young women. Therefore, women who experience more than one severe to mild traumatic life event are at higher risk of developing cancer in their lifetimes.

Furthermore, women in this study perceived that the meaning of being diagnosed with breast cancer was caused by living in a low socioeconomic status. Numerous studies have given tremendous attention to the impact of income and social status on cancer incidence, mortality, and outcomes, which revealed a secure connection between socioeconomic status and cancer incidence rates, stage at diagnosis, and mortality rates (Kumachev et al., 2016; Merletti et al., 2011; Shields & Wilkins, 2009). Lower socioeconomic status is always associated with higher

cancer mortality rates and developed cancer stage at diagnosis (Donnelly et al., 2015; Kumachev et al., 2016; Merletti et al., 2011). However, it is not always associated with higher cancer incidence rates (Coughlin, 2019). There have been different hypotheses to explain the lower cancer outcomes among women with low socioeconomic status. Income and social status have a significant impact on an individual's lifestyle as they shape housing, food security, education, healthy personal behaviour and coping mechanisms, child development, and social life (Evans et al., 1994; Marmot et al., 2008). An unhealthy lifestyle, food, personal behaviour, and coping mechanisms are linked to cancer (Dieterich et al., 2014; Monfared et al., 2017). Patients with lower socioeconomic status also experienced inadequate access to health services and postponed action in seeking help leading to delayed diagnosis. Different treatments are also offered to patients from different socioeconomic status levels (Kumachev et al., 2016; Merletti et al., 2011; Sprague et al., 2011).

### **Their Cancer Survivorship Journey was Fear-inducing and Anxiety-Provoking which was Persistent Throughout the Entire Journey**

For the participants, this journey was extraordinarily fear-inducing and anxiety-provoking because of their cultural beliefs and previous experiences. This is consistent with previous studies, which indicated that women's cancer survivor experiences elicited fears and concerns during their cancer survivorship journeys (Obeidat et al., 2013; Williams & Jeanetta, 2016). Syrowatka et al. (2018) indicated in their study that anxiety was the most prevalent psychological disorder that female breast cancer survivors experienced during their cancer survivorship journeys. For the participants in this study, fear and anxiety started as soon as they were diagnosed with cancer because they perceived the cancer diagnosis as a "death sentence." This view of cancer is associated with their cultural belief that cancer is an incurable illness. It is also associated with their previous experiences because cancer has taken the lives of family members. Different studies have indicated that immigrants, ethnic minorities, and Middle Eastern women view cancer as a "death sentence" because they have the cultural belief that cancer is a fatal illness (Goldblatt et al., 2013; Holst-Hansson et al., 2018; Obeidat et al., 2013).

For the women in this study, changes in physical and psychological health and body images caused by the chemotherapy treatment and Mastectomy made a dramatic change in their lifestyles and social environments. Physiological and psychological health changes, in addition to the thought of recurrence and metastases, were a source of fear and anxiety for these women. These findings are aligned with previous studies, which indicated that breast cancer survivors experience fear related to the treatment stage, body-image loss, sexuality loss, and recurrence (Novick, 2008; Williams & Jeanetta, 2016). Further, cancer-related stressors combined with external life stressors such as low income and social status, poor access to health services, and challenging life events lead to poor health outcomes among immigrant women (Paek & Lim, 2016).

Furthermore, being a cancer survivor and having thoughts of death increased the participants' fear of not being able to be in the lives of their children, take care of them, and support them. In the Middle Eastern culture, mothers play an essential role in their families, where they are the pillar of their homes and provide physical and emotional support for their family members at the expense of their own needs and difficulties (Doumit et al., 2010; Goldblatt et al., 2013; Ziadeh et al., 2018). These responsibilities towards their families and children increased their fear and anxiety levels during their cancer survivorship journeys. Various other studies also indicated that Asian immigrant women believed that obligation and duty to their family increased their stress and made them work harder to stay healthy (Ashing-Giwa et al. 2004; Ashing et al. 2003).

## **Social Support is the Key to Persistence for Participants**

The participants in this study received exceptional and sympathetic social support from their healthcare providers and communities (i.e., cancer agency and multicultural association). They also received unconditional support from at least one family member (i.e., mother, spouse) who accompanied them in Canada. This support was precious and a source of strength for them during the cancer survivorship journeys. It is consistent with other studies which revealed that social support from family, friends, healthcare providers, coworkers, and other cancer survivors was very helpful because it provided them with the strength to fight cancer, hope, and the ability to accept their conditions (Doumit et al., 2010; Duffy & Aquino-Russell, 2007; Williams & Jeanetta, 2016).

The social support provided by healthcare providers assists in the development of a sense of emotional comfort and security among breast cancer patients (Holst-Hansson et al., 2018). For the participants in this study, social support from family members was perceived differently from the support that was provided by health service providers because their family members could understand their cultural needs. This is because of the strong cohesion amongst family members, which is very common in the Middle Eastern culture. Stronger emotional support is associated with family cohesion, which is positively related to better adjustment to illness in breast cancer patients (Muhamad et al., 2011). Previous studies have also indicated that family support encourages cancer survivors to practice healthy behaviours to cope with the stressful cancer survivorship journey, enhance their health and wellbeing, and have a better quality of life (Bevan & Pecchioni, 2008; Muhamad et al., 2011; Williams & Jeanetta, 2016). The findings of this study also revealed the impact of a spouse's social support on the woman's cancer survivorship journey. According to Muhamad et al. (2011), a partner's social support is essential and cannot be compared with any other resources. Furthermore, this support depends on the strength of the relationship and significantly influences the cancer patient's health and wellbeing.

In Middle Eastern culture, the family is a fundamental social unit that presents the primary source of support and care for cancer survivors. For the participants, cancer survivorship was very challenging and increased their anxiety because living at a far distance from their beloved families meant limited social support. The family's physical presence was not possible to provide the required support care. In addition, immigrant and ethnic minority women are less likely to participate in support group programs due to difficulty in locating culturally competent and language-specific support groups (Leng et al., 2014). This limited social support is associated with social isolation, psychological distress, and limited communication with the cancer care team (Goldblatt et al., 2013; Holst-Hansson et al., 2018; Joulaee et al., 2012).

## **They Used Various Coping Mechanisms to Harmonize their Lives**

The participants in this study went through five major cancer care stages: diagnosis, chemotherapy, Mastectomy, radiotherapy, hormone therapy (excluding the participant Marwa), and follow-up care (Table 2). The participants used several coping mechanisms to mitigate their distress levels and to maintain strength during their cancer survivorship journeys. They also used a combination of problem-focused coping strategies and emotional-focused strategies. Problem-focused coping strategies such as acceptance, emotional support, planning, and religion are considered active coping mechanisms (Barinková & Mesároová, 2013; Tuncay, 2014). Conversely, emotional-focused strategies such as self-distraction, venting, and behavioural disengagement are considered non-active coping mechanisms (Barinková & Mesároová, 2013; Tuncay, 2014). Using a combination of both active and inactive coping

mechanisms reflects the realistic acknowledgment of the meaning of the cancer survivorship journey for these participants and their exploration of the effective ways to cope with their cancer survivorship journeys.

During the whole journey, the participants practiced religious prayers and turned to God to maintain control of their feelings. They also used the Arabic phrase, “*Alhamdulillah*” many times during the interview. This term means “*Praise be to Allah,*” (or “*God*”) or, “*Thank God,*” which is used by Muslims, Arab Christians, and Arab Jewish conversations. A phrase is a complimentary act that praises God for what He is, for His virtues and excellence, as well as for what He has done for us (Huda, 2019). Faith in God and using this religious phrase and prayers indicated the participants’ coping and acceptance of their illness and gave them optimism to survive. Their religious beliefs also stopped them from doing any harm to their bodies. Numerous studies from around the world reported that religious beliefs in God and spirituality provided strength, hope, and a better quality of life for cancer survivors (Doumit et al., 2010; Gurm et al., 2008; Holst-Hansson et al., 2018). They also give cancer patients the ability to accept their illness, cope, and long-term psychological adjustment (Alhusban, 2019; Doumit et al., 2010; Joulaee et al., 2012).

During the diagnosis stage, participants experienced fear and anxiety of their cancer diagnoses but had different reactions to them. The participants perceived communicating their diagnoses with their family members as a challenging step in their survival journeys to avoid psychological distress for their families. Zhang et al. (2003) found in their study that two-thirds of cancer patients and their families experience communication problems during the cancer survivorship journey, and psychological distress and mutual protection were the main reasons for avoiding communication during the diagnosis stages. During the treatment stage, participants tried to hide their physical and psychological features associated with the treatment stage because they were worried about their family members’ feelings. Hiding and avoidance are considered self-disengagement coping strategies that are associated with adverse health outcomes among cancer patients (Tuncay, 2014). It is common in the Middle-Eastern culture for breast cancer patients to conceal their cancer diagnosis, illness, and physiological and psychological changes associated with cancer treatment (Doumit et al., 2010; Goldblatt et al., 2013; Obeidat et al., 2013). Middle Eastern women have concealed their feelings and illness to avoid being pitied by others, the negative cancer stigma, and losing their employment, as well as to prevent harm to their children’s emotions. These cultural attitudes regarding cancer diagnosis lead to social isolation, lower social support, and increasing of women’s psychological distress (Doumit et al., 2010; Goldblatt et al., 2013).

Two participants in this study used venting mechanisms by expressing and sharing their feelings about cancer survivorship and life challenges with others. Venting is a coping mechanism used by cancer patients. However, various studies have indicated that lack of venting as an emotional coping strategy has been linked with poor quality of life and higher depression and anxiety levels, and adverse health outcomes (Barinková & Mesároová, 2013; Tuncay, 2014). It has been suggested by Tuncay (2014) that emotional-focused coping mechanisms may likely reduce cancer patients’ problem-solving capacities.

During the follow-up care stage, participants attempted to regain control of their lifestyles and give meaning to their new lives as cancer survivors. The participants decided to face the changes in their lives by planning for their futures and trying to grow. They endeavoured to make their lives busy, full of activities, and surround themselves with sympathetic people to minimize their stress. Searching for meaning in life is a very important coping mechanism for cancer patients during their cancer survival because it influences the way they perceive their illness and changes their perceptions of future goals (Krok & Telka, 2018). Cancer survival includes being aware of having a purpose and meaningful life, which helps them to interpret and manage their stressful experiences and perceive their cancer

survival positively (Krok & Telka, 2018). The participants also realized the importance of planning for their future and follow-up care. These findings confirmed the importance of planning for the future as a coping mechanism to confront problems, perceive control, reduce psychological distress, and enhance satisfaction with life (Dubey & Agarwal, 2007).

### **Survivorship Journey Is Combined with Changes in their Physical and Social Environments**

The participants experienced changes in their social and physical environments during their cancer survivorship journeys that affected their health and wellbeing. They were new immigrants to Canada, which involved a novel physical and social environment for them that required physical and psychological effort to acculturate and integrate into society. Before moving to Canada, they were used to having active lives, employment, and friends in their homeland. When they immigrated to Canada, they found themselves without employment, income, friends, or support while living in a system and culture that was different for them. This experience caused distress and uncertainty. The participants in the study were experiencing immigration stressors combined with cancer-related distress.

Previous studies indicated that the physical and psychological health of refugee and immigrant families is at high risk because of the experience of various sources of stressors in the new host country including culture shock, acculturation, unemployment, lack of social support, new physical environment, low income, and discrimination (Dow, 2011; Thomas, 1995). Other researchers studied the impact of acculturation and social support on immigrant cancer survivors' quality of life in the USA, which identified that acculturation was connected to a better quality of life through the development of a social network (Lim & Ashing-Giwa, 2013; Lim et al., 2009). Therefore, female immigrant cancer survivors experience a better quality of life with fewer depression symptoms when they have more social networks and are more acculturated, while less acculturated women experience lower social support, lower quality of life, and more depression symptoms.

Furthermore, social cohesion, social connection, and social network, such as relationships with spouses and making friends, have been significantly affected by the journey. The participants experienced changes in their relationships and social roles. Harmful changes in relationships and social networks with family members and friends among different ethnic groups during the cancer survivorship journey have been previously reported (Joulaei et al., 2012; Schultz et al., 2004). In the Middle Eastern culture, marriage relationships are very important; thus, losing the support of a partner during this challenging stage is commonly very difficult (Joulaei et al., 2012). Various studies indicated that a spouse's support is vital for breast cancer patients as spouses can enhance women's self-esteem and coping strategies (Muhamad et al., 2011).

### **As Women, Their Self-image was Impacted Greatly**

The women in this research perceived their self-image as self-discipline, active, and amiable. However, changes in their body image (losing their hair, and a part of their body) and physiological health (fatigue, nausea, loss of appetite, pain in the bones, ceasing of menstruation) during the treatment stage impacted their psychological health, self-confidence, social support network (relationships), and sexuality. The participants in this study lived in isolation and depression during the treatment stage, particularly the chemotherapy stage. They tried to hide all the physical changes in their bodies by covering their bodies and heads all the time, even in front of their spouses and children. Using this ineffective coping strategy indicates losing control of health and wellbeing (Doumit et al., 2010; Holst-Hansson et al., 2018).

Changes in physical appearance (e.g., losing hair) during the treatment stage was a significant factor that negatively affected cancer survivors' ability to cope during the treatment stage (Doumit et al., 2010; Williams & Jeanetta, 2016). Further, poor body image in young breast cancer survivors is associated with lower quality of life, chronic fatigue, and mental distress (Paterson et al., 2016).

These findings are in parallel with previous studies, which showed that changes in women's physical health and appearance caused anxiety, isolation, and emotional distress for many female breast cancer survivors (Alhusban, 2019; Joulaee et al., 2012). Reed (n.d.) indicated that Middle Eastern women perceive themselves as open-minded and empowered women. Obeidat et al. (2013) indicated that health and changes in appearance associated with the cancer diagnosis and treatment negatively challenged Jordanian women's self-image as strong and independent women.

Middle Eastern women perceive femininity, similar to other cultures, as a perfect and attractive body with beautiful hair and breasts (Alhusban, 2019; Archangelo et al., 2019). In the Middle Eastern culture, women still like to have a partner, family, and children (Doumit et al., 2010; Joulaee et al., 2012). Therefore, for breast cancer survivors, losing femininity and attractiveness after the treatment stage impacts their sexual life, relationships, and psychological health (Archangelo et al., 2019; Joulaee et al., 2012). It has been suggested by Joulaee et al. (2012) and Alhusban (2019) that the spouse's positive reaction to the physical and psychological changes caused by breast cancer can have a significant impact on the relationship, women's self-confidence, and psychological health.

During the follow-up care stage, the women focussed on improving their body image and self-image to regain their confidence choosing to undergo breast reconstruction procedures to improve their body image and self-confidence. Archangelo et al. (2019) compared breast cancer survivors who had undergone breast reconstruction and who underwent Mastectomy alone and found that women who did breast construction surgery experienced better sexual function, fewer depressive symptoms, and better body image. In this study, the participant Marwa perceived more confidence in her self-image through dressing well, wearing makeup every day, and maintaining her social role (housekeeping, taking care of her children).

These findings are in agreement with previous studies which indicated that body image in women with breast cancer has three characteristics: (1) affective, which is related to feeling feminine and attractive, (2) behavioural, which is related to avoiding people and hiding, and (3) cognitive, which is related to the satisfaction with appearance and scars (Paterson et al., 2016). Using multidimensional strategies, such as self-care, physical appearance improvement, and maintaining wife roles by having breast cancer survivors recall femininity has been reported as important for coping (Mohammadi et al., 2018).

## **Limitations**

The findings in the study are not generalizable but are circumscribed to the stories of the three immigrant women who participated in this study and to our ability to translate, transcribe, and describe the text through writing. However, we believe the stories of these women offered an empirical understanding of the phenomenon under study. The three participants were Arabic-speaking, Middle Eastern, Muslim, immigrant women, and breast cancer survivors. This does not reflect the variability of Middle Eastern women who speak languages other than Arabic, who have a different faith, or who are survivors of different types of cancer than breast cancer, which in turn may limit the transferability of the findings. This study also represented the lived experiences of the immigrants who only lived in Canada. The sample size of this study was small ( $n = 3$ ) but was enough to understand this unexplored area of research in Canada. Further, recruiting immigrant women for this study was a difficult and

challenging process. Limited participation of immigrant women in health research is widespread (Renert et al., 2013; Waheed et al., 2015). Recruiting participants who were eligible to participate was challenging because some participants were anxious to share their lived experiences while other participants were hesitant because they were not aware of the qualitative research process and its importance for health. Some participants were scared to participate because they had a misconception that their data might be used against them and influence their immigration status in Canada. In this study, we used three data collection methods because the participants lived far from the research team, and therefore, personal face-to-face interviews were not convenient for all participants. In this study, we used the population health theory as a lens to study the phenomenon under study. The same results can be analyzed using different lenses such as Nursing or other health-focused theoretical frameworks. Despite these limitations, the results of this study are still significant as they uncovered the meaning of the lived experiences of MEIW during their cancer survivorship journeys. The findings of this study demonstrate the resilience of MEIW in Canada from three different immigration categories with unique lived experiences. Although they were battling cancer and making new lives in Canada as new immigrants, they perceived their experiences positively by finding new meaning in their lives.

### **Implications, Conclusion and Recommendations**

MEIW in Canada are underrepresented in health research, and very little is known about their cancer survivorship journey in Canada. Therefore, the results of this study will help to reduce the knowledge gap in the literature. This study was foundational, and it would be used as a first step in the development of a research program where further action and interventional research can be built.

More studies are recommended to recruit other MEIW during their cancer survivorship journeys who speak different languages, have different faiths, and have differing cancer diagnoses than the participants of this study. The findings from this study can be used to develop a quantitative research program to study the effects of cancer on the quality of life of immigrants and their families in Canada. Communication in cancer care can help cancer survivors to cope and improve their experiences (Sheppard et al., 2011). Therefore, healthcare professionals are encouraged to communicate with MEIW to identify their unmet needs of support during their cancer survivorship journeys. This particularly applies to women who manage their cancer survivorship journeys without support from family or who cannot speak the English language. Healthcare professionals can encourage MEIW to communicate their feelings and concerns with them through interpreters if needed. Continued research would give practical guidance to healthcare providers and policymakers to reform or promote culturally competent health services for this group of women.

From a health services perspective, where the patients are partners in their care and where treatment aims to empower persons, participatory non-patriarchal interventions that are based on knowledge emerging from cancer survivors would be more applicable to achieve this aim. Therefore, conducting this descriptive phenomenological study was significant because the cancer survivorship experience was captured and understood by the participants who have lived the experience.

There appear to be similar and homogenous lived experiences among participants, demonstrating that their own cancer survivorship experiences were shaped by mutual contributions from different factors and circumstances. Importantly, when they described their experiences, they related their personal, familial, cultural and immigrational, gender, economic, social support, self-image, and other related factors that contributed to their illness and wellness journeys. Based on the results of this study, it is recommended to incorporate all



factors that shape the lived experiences of MEIWI during their cancer survivorship journeys early in medical and social sciences curricula to enhance students' knowledge and understanding of the social determinants of health influence on the illness and wellness, as well as enhancing students' competencies in implementing culturally sensitive care in the future. The findings from this study can be used to develop an assessment tool to understand immigrants' perceptions of cancer, coping strategies, socioeconomic status, social and physical environments, and cultural beliefs as an approach to patient-centred care. Incorporating these factors and understanding the lived experiences of immigrant women must be part of the healthcare protocols to guarantee to provide culturally sensitive healthcare.

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