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THE PSYCHOLOGICAL EXPERIENCE OF BREAST CANCER AMONG MUSLIM WOMEN LIVING IN BELGIUM AND FRANCE

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Abstract

This study aims to explore and understand the experiences of Muslim women who have been diagnosed with breast cancer in Belgium and France. To collect our data, we conducted semi-structured interviews with five Muslim women, aged 27 to 52. Our results show that receiving the diagnosis is a significant challenge, but both religion and family are essential in helping them cope with breast cancer. Living in France or Belgium allows our participants to perceive breast cancer as a disease that may be treated. The physical consequences of treatment, especially hair loss, negatively affected their body image, but they reported a gradual improvement over time.

Keywords: *Breast cancer, Muslim women, quality of life, body image.*

1. Introduction

Breast cancer is the most diagnosed cancer worldwide, affecting more than 2.3 million people (WHO, 2025). In Belgium, over 10,000 new cases are recorded each year (Institut Jules Bordet, 2024), and in France, the number exceeds 60,000 (Institut National du Cancer, 2025). Breast cancer often has a profound psychological impact, significantly transforming a person's life (Pasquier, 2015). Both patients and their close relatives face a long and complex trajectory of treatment and care (Ménoret, Becchio, Tremblay, & L'Heureux, 2010). Many Muslims, including those of Maghrebi origin, now live in Belgium and France. As personal attitudes towards illness can vary according to cultural and religious backgrounds and take on new meanings in the context of migration, it is crucial to consider the experiences of these Muslim women. In Islam, the relationship between the body and nudity is considered taboo. Women are expected to embody discretion, modesty, and simplicity (Guerraoui, 1997). In Islamic beliefs, illness is seen as something that comes from Allah, and only He determines its outcome (Jourdan, 2007). Family dynamics often provide limited opportunities for intimate discussions about women's bodies. Furthermore, religion plays a central role in the experience of illness. These taboos can have a negative impact on patients, sometimes even leading to refusal of care. Some Muslim women are reluctant to discuss their breast health with healthcare professionals (Moey et al., 2022).

2. Methodology: Research objectives, instrumentation and sample

In this exploratory qualitative study, we adopted an inductive approach to examine the experiences of Muslim women of Maghrebi origin residing in Belgium or France affected by breast cancer. We conducted semi-structured interviews to explore participants' subjective experiences and the meanings they attribute to their illness. Participants also completed two self-administered questionnaires: the Medical Outcome Study Short Form (MOS-SF36), which assesses quality of life across eight dimensions spanning the physical, emotional, and social domains (Leplège, Ecosse, Pouchot, Coste, & Perneger, 2001), and the Body Image Scale (BIS), which evaluates body image disturbances in oncology settings (Hopwood, Fletcher, Lee, & Al Ghazal, 2001).

3. Results

3.1. Sociodemographic characteristics of the sample

The sample consists of five women aged between 27 and 52 years old. Two participants live in Belgium. They were born in Morocco and have Moroccan nationality. The other three live in France.

They have Algerian nationality. Two were born in France, and the last one was born in Algeria. Table 1 provides an overview of their sociodemographic characteristics.

Table 1. Sociodemographic characteristics of the sample.

Woman	*Age*	*Nationality*	*Country of*		*Familial situation*	*Children*	*Professional situation*
			birth	*living*			
1	52	Algerian	Algeria	France	Widow	0	Housekeeper
2	48	Algerian	France	France	Married	3	Housewife
3	44	Moroccan	Morocco	Belgium	Widow	3	Housewife
4	27	Moroccan	Morocco	Belgium	In a relationship	0	Manager of a restaurant
5	40	Algerian	France	France	Married	2	Housewife

3.2. Perception of the disease at diagnosis and received treatment

Receiving the diagnosis was challenging, although it seemed to affect their relatives more than the participants themselves. Family members were the most anxious. What frightened the participants was not death itself, but the idea of leaving their family or children behind. Participant 3 expressed fear of never seeing her family in Morocco again. Participant 4 felt into depression after her ex-partner left her upon learning about the illness.

All five participants underwent both chemotherapy and radiotherapy. Three of them had a mastectomy (removal of the breast), while two underwent a lumpectomy (surgical removal of a mammary tumour) along with axillary lymph node dissection. The treatment period was exhausting for all of them: they felt physically weak, reported that the pain was unbearable, and had side effects such as nausea, sensitivity to smells, and nail damage. Participant 5 reported having difficulty performing daily household tasks (cooking and cleaning). Hair loss was also a difficult experience for all participants.

3.3. Quantitative results at the BIS and the MOS SF-36

Table 2 shows quantitative results from the two self-administered questionnaires. The BIS scores were low for four of the women, indicating a positive body image. Participant 4, however, obtained a high score, suggesting a negative body image. She is the youngest, was diagnosed in early adulthood, and reported feeling self-conscious in front of her new partner. The MOS SF-36 scores indicate that, on average, physical dimensions score slightly higher than mental dimensions (65.38 vs 58.77). Participants 1, 2, and 5 obtained high values, reflecting a generally favourable quality of life. Participant 3 obtained consistently low scores across all dimensions, indicating a reduced quality of life in both physical and emotional domains. Participant 4 shows intermediate scores, indicating moderate well-being, with physical pain (D3), chronic fatigue (D5), and emotional difficulties (D7) being the most problematic dimensions.

Table 2. Results at the BIS and MOS SF-36.

Woman	*Age at the diagnosis*	*BIS*	*MOS SF-36*							
			Physical dimensions				*Mental dimensions*			
			D1	*D2*	*D3*	*D4*	*D5*	*D6*	*D7*	*D8*
1	48	0	80	100	57.5	87.5	55	75	100	72.5
2	44	3	80	75	100	66.67	50	100	100	68
3	33	9	35	0	22.5	16.67	10	37.5	0	12
4	21	16	80	75	20	50	30	62.5	33.33	44
5	38	8	95	100	100	66.67	70	87.5	100	68
Mean	**36.8**	**7.2**	**74**	**70**	**60**	**57.50**	**43**	**72.5**	**66.66**	**52.9**
			65.38				**58.77**			

3.4. Social and cultural experiences

Religion plays an important role for four participants. The fifth participant explained that, although religion helped her cope with the illness, it does not occupy a central place in her life. Religious beliefs facilitated acceptance of the disease. Participant 4 indicated that Allah does not punish people with disease but tests them to reveal their strength. Participants 3 and 5 reported that Allah determines the outcome of the illness. Therefore, they must trust Him and accept their fate. According to the family of participant 3, cancer is linked to death. Her family still believes she will die soon. Moreover, we found that two participants did not seek medical consultation immediately, although they had noticed something unusual in their breast. Such behaviour may be linked to their beliefs that only Allah determines the outcome of the cancer.

The five participants initially struggled to accept the physical changes caused by treatment, often accompanied by pain and discomfort. Over time, most of them reported feeling increasingly comfortable with their bodies. Four participants explained that they were raised with strong values of *modesty* and respect for the body. Only one participant felt uneasy with male healthcare providers, although the medical teams were predominantly composed of women. To avoid the gaze of others, four women chose to conceal their illness as much as possible, an attitude that also reflects their sense of *modesty*. They preferred to discuss it only with people they felt truly close to.

All five participants described the *support* of their families or close friends as essential throughout their experience. Four of them also emphasized how the kindness and attentiveness of the medical team played a crucial role in helping them cope. Participant 3 received psychological counselling, which she found particularly beneficial. Participant 4 explained that support groups with other patients had been invaluable to her.

4. Discussion

According to Islamic beliefs, cancer is inevitably linked to death (Baider & Goldzweig, 2016). Our findings indicate that Muslim women living in France or Belgium, along with their families, no longer hold this view. Only one participant reported that her family members residing in Morocco continue to perceive cancer in this way. However, these findings should be interpreted with caution, as selection bias may be present. Those who agreed to participate in the study are likely Muslim women who feel more comfortable discussing issues related to breast cancer. Previous research has shown that many Muslims are generally reluctant to talk about their disease. Women with deeply religious convictions might have chosen not to participate. Another limitation of this study concerns the limited number of participants. We suggest that future research should aim to include a larger number of participants. Moreover, some religious values, such as upholding their modesty, can influence their health behaviour (Moey et al., 2022). They tend to rely on fate and adhere to the belief that “what is meant to happen will happen”. This study underscores the importance of increasing awareness among women about breast cancer screening. The WHO (2025) highlights that treatments are more effective when the disease is detected early.

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