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UNDERSTANDING THE EXPERIENCES OF COLO-RECTAL CANCER PATIENTS IN IRAQI KURDISTAN: A PHENOMENOLOGICAL STUDY

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Abstract: Pediatric oncology nursing represents a highly specialized healthcare domain that requires nurses to provide comprehensive care to children with cancer while simultaneously managing profound emotional demands. Colorectal cancer (CRC) incidence is rising in the Kurdistan Region of Iraq (KRI). While the clinical aspects are documented, the psychosocial and cultural dimensions of the patient experience remain unexplored, creating a gap in providing holistic care.This qualitative study employed a hermeneutic phenomenological design, guided by Diekelmann's interpretive framework. Twelve CRC patients were purposively recruited from two major teaching hospitals in Erbil. Data were collected through in-depth, semi-structured interviews (March–July 2025) and analyzed using Diekelmann's seven-step process.Analysis revealed four interrelated themes that capture the profound disruption caused by CRC: (1) Shattered Certainty: characterized by initial shock and pervasive existential fear; (2) Fractured Selfhood: encompassing loss of identity, social roles, and altered self-image; (3) Embodied Struggle: involving severe physical suffering and the burdensome nature of treatment; and (4) Fractured Foundations: stemming from significant financial strain and the disruption of daily life and family routines. A CRC diagnosis causes a comprehensive rupture of normalcy, affecting patients emotionally, physically, socially, and financially. The findings underscore an urgent need in the KRI to move beyond purely biomedical models of care. Developing integrated support services that address psychological distress, financial counselling, and cultural nuances is essential for improving patient outcomes and quality of life.
Keywords: Colorectal cancer, Phenomenology, lived experience, Iraq, Kurdistan, Psychosocial burden, Biographical disruption, financial toxicity

INTRODUCTION

Cancer is a broad term encompassing a group of diseases that can affect any part of the body, each characterized by distinct causes, clinical features, treatments, and prognoses (Mishra et al., 2018; Kerr and Baumann, 2016). Colorectal cancer (CRC) is the third most common cancer and the second leading cause of cancer death worldwide (Mattiuzzi and Lippi., 2020). Colorectal Carcinoma (CRC) is defined as the growth of abnormal cells in the colon and rectum with the potential to spread and metastasize to other organs (Assi et al., 2016). According to the WHO, approximately, 1.8 million people worldwide suffer from CRC (Mattiuzzi and Lippi., 2020).

The journey of patients with colorectal cancer is lengthy and challenging, often involving intensive treatments such as surgery, radiotherapy, antineoplastic agents and targeted therapies (Brincat et al., 2025). Surgery, which may involve the creation of a temporary or permanent stoma, is the main treatment modality, while chemotherapy or radiotherapy, or both, are used in selected cases before (neoadjuvant) and or after (adjuvant) surgery (Eriksen et al., 2021). Treatment for colorectal cancer can be life-changing for patients depending on needs specific to the individual (Drury et al., 2017). Common symptoms include fatigue, nausea, psychological distress, and issues related to sexual and urinary function, which can all impact on quality of life (Hannah et al., 2025). Given the chronic nature of colorectal cancer, patients endure years of treatment that impact their quality of life (Brincat et al., 2025; Siddiqui and Cruz, 2019).

Also in the Kurdistan region of Iraq, colorectal cancer (CRC) ranks among the top three most prevalent cancers (Al-Madhaqi et al., 2019). However, the experiences of CRC patients in this region are deeply influenced by unique cultural and social factors. Prolonged conflict and political instability have disrupted healthcare infrastructure, limiting timely diagnosis and access to oncology services (Khalaf et al.,2020). Additionally, widespread social stigma attached to cancer, along with traditional beliefs about illness and health, often delay patients from seeking early medical care and contribute to significant psychological distress (Al-Ani and Al-Obaidi ., 2018), Economic challenges and limited health literacy further compound these barriers, creating a complex environment where both medical and psychosocial factors shape the trajectory of CRC diagnosis and treatment in Kurdistan (Saleh et al., 2021).

Several studies have been conducted on the experience of colorectal cancer (CRC) patients in other countries such as Syria, Canada, USA and Egypt (Kafi et al., 2024; Mksyartinian et al., 2024., Gebreal et al., 2024; Beusterien et al., 2013). Various studies have explored factors impacting the quality-of-life among colorectal cancer survivors and their effects on health outcomes (Lynch et al., 2008; Stegina et al., 2009; MecSorley et al., 2014).

Understanding the lived experiences of individuals with colorectal cancer is essential to deliver truly holistic and person-centered care. Beyond the direct impact of the disease, treatments involving multiple modalities often lead to complex physical, emotional, and social burdens such as severe side effects, changes in body image, and disruptions to daily life. Gaining a deeper understanding of these experiences enables healthcare professionals to more effectively respond to patients' needs, enhance symptom management, and provide individualized psychosocial support (Lee et al., 2023; Zubair et al., 2023).

Despite extensive research on cancer survivorship globally, limited attention has been given to the lived experiences of colorectal cancer patients in specific cultural and healthcare contexts such as Kurdistan. While clinical outcomes are well studied, emotional, social, and psychological aspects remain underexplored. Understanding these experiences through qualitative research can reveal unmet needs and guide the design of culturally sensitive interventions. Such insights are crucial for improving psychosocial support, enhancing quality of life, and informing health policies. Therefore, exploring patients' lived experiences is essential to advancing holistic and person-centered cancer care in the region.

METHODS

Qualitative Approach and Research Paradigm

This study adopted a hermeneutic phenomenological approach, rooted in Heidegger's philosophy of interpretive understanding. Hermeneutic phenomenology was deemed appropriate for exploring how individuals living with colorectal cancer (CRC) in the Kurdistan Region of Iraq construct meaning from their illness experiences. This paradigm emphasizes interpretation rather than description, acknowledging that human experiences are contextually situated within cultural, historical, and relational dimensions.

Guided by Diekelmann's interpretive framework, this approach facilitated a comprehensive exploration of the emotional, social, physical, and existential dimensions of living with CRC. It allowed the researcher to move beyond surface-level accounts to uncover the deeper meanings embedded in patients' narratives. The interpretive process was dialogical, emphasizing the co-construction of meaning between researcher and participant. This framework was particularly suitable for investigating how sociocultural and healthcare structures shape illness experiences in a region marked by economic constraints, traditional beliefs, and limited oncology resources.

Context

The research was conducted in the Kurdistan Region of Iraq (KRI), an autonomous area in northern Iraq comprising the governorates of Erbil, Sulaimaniyah, Duhok, and Halabja. The region's healthcare infrastructure has been affected by years of conflict and economic challenges, resulting in delayed cancer diagnosis and limited access to specialized oncology services. Cultural beliefs, social stigma, and restricted psychosocial support further complicate patients' adaptation to chronic illness.

Data collection took place at Rizgary Teaching Hospital and Nanakali Teaching Hospital in Erbil, both of which serve as key referral centers for oncology care in the region. These hospitals provide chemotherapy, surgical oncology, and limited radiotherapy services, and were selected for their accessibility to diverse groups of patients receiving treatment for CRC.

Sampling Strategy

A purposive sampling strategy was employed to ensure the inclusion of participants with diverse backgrounds and experiences related to living with CRC. The recruitment process was coordinated through oncology departments at the two study sites, with collaboration from hospital administrators and senior nursing staff to identify suitable participants.

Participants were included if they had a medically confirmed diagnosis of colorectal cancer, had lived with the disease for at least six months, were able to communicate in Kurdish or Arabic, and willingly provided informed consent. Those who were unconscious or in critical medical condition were excluded from participation.

A total of twelve participants were recruited, representing variation in age, gender, stage of illness, and treatment trajectory. The sample size was determined based on the principle of data saturation, achieved when no new information or themes emerged from the interviews.

Data Collection

Data were collected between March and July 2025 through in-depth, semi-structured interviews that encouraged participants to share their lived experiences in their own words. The interview guide was developed based on existing literature and study objectives and was pilot-tested with two participants to assess the clarity, sequence, and relevance of the questions. Minor refinements were made following the pilot phase.

Interviews were conducted in a private and comfortable setting within Rizgary and Nanakali Hospitals to ensure confidentiality and minimize distress. Each session lasted between 45 and 90 minutes, was audio-recorded with participants' consent, and was supplemented by field notes documenting non-verbal cues, emotional expressions, and contextual observations. Participants were encouraged to narrate their illness journey from diagnosis to treatment and survivorship, focusing on its personal, social, and cultural dimensions.

All interviews were transcribed verbatim and translated into English, followed by back-translation to preserve accuracy and cultural meaning. Data collection continued until thematic saturation was reached, ensuring depth and richness of information. The transcripts and field notes were organized and managed using MAXQDA 22 software.

Data Analysis

Data analysis was conducted following the seven-step interpretive process outlined by Diekelmann and Ironside (1998). Initially, the first researcher repeatedly listened to audio recordings and read the transcripts to gain a holistic understanding of each participant's narrative. Interpretive summaries were written to identify preliminary meaning units, which were then coded to highlight recurring ideas and patterns. The first researcher engaged in continuous reflection and discussion with peers to compare emerging interpretations, revisit the original texts, and ensure fidelity to participants' meanings. Themes were then synthesized across cases to reveal shared patterns that captured the essence of the experience of living with CRC in the Kurdish cultural context. Throughout this process, reflexivity was maintained through journaling and memo-writing to minimize bias and enhance interpretive transparency. Data organization and coding were supported by MAXQDA 22 software, which facilitated systematic retrieval and comparison of codes across transcripts.

To ensure methodological rigor, the study adhered to Lincoln and Guba's criteria for trustworthiness. Credibility was established through prolonged engagement with participants, member checking of transcripts and summaries, and peer debriefing with supervisors. Transferability was achieved by providing detailed contextual and participant descriptions, allowing readers to assess the applicability of findings in other settings. Dependability was ensured by maintaining a comprehensive audit trail of methodological decisions and analytic steps, while confirmability was strengthened through reflexive journaling and direct linkage between interpretations and participant quotations.

Ethical Considerations

Ethical approval was granted by the Ethics Committee of Kerman University of Medical Sciences (IR.KMU.REC.1403.430). Written informed consent was obtained from all participants. Permission was secured to record interviews. Anonymity and confidentiality were maintained, participation was voluntary, and participants retained the right to withdraw at any time. Data were stored securely and used solely for research purposes. Given the sensitive nature of discussing personal illness experiences, the researcher was attentive to signs of emotional distress during interviews. If a participant became upset or expressed distress, the interview was paused, and they were offered the option to discontinue or reschedule. Participants were also offered referrals to psychological support services available within the hospital if needed. Confidentiality was maintained by assigning pseudonyms and securely storing all data in password-protected files accessible only to the research team.

RESULTS

Participant Characteristics

Twelve participants (seven females and five males) aged between 45 and 63 years took part in the study. Most were married, with a few widowed or divorced. Educational backgrounds ranged from no formal education to secondary school, and most participants had occupations typical of middle- to working-class families, such as farmers, shopkeepers, taxi drivers, and homemakers. The majority lived in urban or semi-urban Erbil, while a smaller number resided in rural areas. All participants were undergoing or had completed chemotherapy, with several also receiving surgery or radiation therapy. Support systems were largely family-based, reflecting the strong cultural value of kinship in Kurdish society (Table 1).

Table 1. Demographic Characteristics of Participants (N = 12)

Participant	Sex	Age (years)	Marital Status	Education Level	Occupation (Before Illness)	Residence	No. of Children	Support System	Treatment Type
1	Male	48	Married	Secondary school	Office worker	Urban Erbil	2	Wife and children	Chemotherapy
2	Male	58	Marrie7vd	Primary school	Shop owner	Urban Erbil	3	Wife and children	Chemotherapy
3	Female	60	Married	Primary school	Construction worker	Urban Erbil	3	Strong family support	Chemotherapy
4	Female	58	Widowed	No formal education	Housekeeper	Rural Erbil	0	Limited extended family	Chemotherapy
5	Male	63	Married	Secondary school	Retired teacher	Urban Erbil	4	Wife and children	Surgery + Chemotherapy
6	Male	55	Married	Primary school	Farmer	Rural Erbil	6	Wife and children	Surgery + Chemotherapy
7	Female	48	Widowed	Secondary school	Shopkeeper	Urban Erbil	3	Children	Surgery + Chemotherapy
8	Female	45	Married	Secondary school	Housewife	Rural Erbil	5	Family and neighbors	Chemotherapy
9	Female	54	Married	Primary school	Housewife	Rural Erbil	4	Husband and children	Surgery + Chemotherapy
10	Male	52	Married	Secondary school	Taxi driver	Urban Erbil	5	Wife and children	Surgery + Chemotherapy
11	Female	47	Divorced	Secondary school	Tailor	Urban Erbil	2	Children	Chemotherapy + Radiation
12	Male	57	Widowed	Secondary school	Retired government worker	Urban Erbil	3	Children	Chemotherapy

Thematic Findings

Four major, interrelated themes emerged from the interpretive analysis, reflecting the multidimensional disruption caused by colorectal cancer: (1) Shattered Certainty, (2) Fractured Selfhood, (3) Embodied Struggle, and (4) Fractured Foundations.

Each theme encapsulates participants lived meanings of fear, loss, adaptation, and resilience within the sociocultural fabric of Kurdish society (Table 2).

Theme 1 — Shattered Certainty (Emotional Shock & Existential Disruption)

This theme captures the profound emotional and existential upheaval that followed participants' cancer diagnoses. The diagnosis was experienced as a sudden rupture in the sense of safety, predictability, and continuity of life, compelling individuals to confront their mortality and re-evaluate their existence.

Sub-theme 1: Shock & disbelief at diagnosis

Participants consistently described the moment of diagnosis as emotionally devastating and disorienting. Many entered consultations expecting minor or benign explanations, only to be confronted with the life-altering reality of cancer. This abrupt disclosure induced numbness, disbelief, and cognitive paralysis, leaving some unable to absorb the information immediately. As one participant stated, "Hearing the word 'cancer' was like a punch to the gut. I still don't fully understand why it happened to me" (P1). Others described how the diagnosis shattered their sense of control and security.

For many, this shock persisted long after the initial consultation. Participants recounted repeated cycles of realization as the implications for treatment, family life, and the future gradually emerged. One remarked, "I was stunned. It was hard to believe. I kept asking myself how this could happen to me—I'm not a smoker, I've been healthy most of my life" (P2). Another added, "I was stunned and scared. Hearing the word 'cancer' shook me to the core. I felt like the ground had disappeared beneath my feet" (P11). These narratives reveal that the initial shock evolved into sustained emotional dislocation and existential confusion.

Sub-theme 2: Existential fear & uncertainty

Beyond initial shock, participants described profound existential fears. Thoughts of mortality, uncertainty about survival, and fear of the unknown became daily companions. One man shared, "I kept thinking about my wife, my children—how would they manage without me? The thought of leaving them behind made me

feel helpless" (P2). Others noted that fear was not just about death but about unfinished roles and responsibilities.

This uncertainty often led to cycles of despair and questioning. A construction worker reflected, "At first, I couldn't believe it. Cancer was something I'd heard about, but I never thought it would happen to me. I felt angry and scared. I couldn't stop thinking about the future—about what my family would do without me" (P3). For widowed participants, the fear was amplified by solitude: "Hearing the word cancer just crushed me. All I could think about was, how will I survive this alone? I had no family to help me, and I felt so lost" (P3). These testimonies show how existential fears were shaped not only by illness but by social and personal contexts.

Theme 2 — Fractured Selfhood (Identity, Role, and Self-Perception)

This theme reflects the profound disruption cancer imposed on participants' sense of identity and social roles. Illness not only altered their physical capacities but also dismantled long-held perceptions of self-worth, purpose, and belonging.

Sub-theme 1: Loss of identity & role

Participants described how illness eroded their established social and occupational identities. The inability to fulfil roles as providers, workers, or caregivers led to feelings of inadequacy and diminished self-esteem. As one noted, "I can't be the husband or father I used to be, and that weighs heavily on me" (P1). Another expressed frustration, "I can't work anymore, and my appetite has diminished. I've lost weight quickly and just don't have the same energy I used to. It's frustrating" (P2).

Dependence on family members often generated guilt and emotional distress. A farmer shared, "I can no longer work the farm as I did. My sons have taken over many tasks, but I still try to help when I can. It's hard to accept being less useful" (P6). Similarly, a taxi driver said, "My role in the family shifted from provider to patient. It's stressful not to be the main provider anymore" (P10). Collectively, these accounts illustrate how illness fractured participants' sense of identity; undermining dignity previously anchored in autonomy and productivity.

Sub-theme 2: Altered self-image

Physical changes resulting from cancer and its treatment profoundly affected participants' self-perceptions. Hair loss, weight loss, and visible frailty generated alienation from one's own body. As one widow reflected, "It's hard to look at myself in the mirror. I don't recognize the person staring back. I've lost weight, and my hair is falling out" (P3). These visible reminders of illness intensified psychological suffering and social withdrawal.

Participants also reported embarrassment and avoidance of social interactions. "I feel embarrassed about my appearance after chemotherapy. I don't want to go out or meet people because I don't feel like myself," a widow explained (P7). Another shared, "Chemotherapy caused hair loss and weight loss. I used to take pride in how I looked, but now I feel like I've lost everything. Cancer has changed me, inside and out" (P3). These reflections demonstrate that altered body image compounded emotional isolation and diminished confidence.

Theme 3 — Embodied Struggle (Physical Suffering & Treatment Burden)

This theme captures the pervasive physical toll of cancer and its treatments. Participants described their bodies as both the site of suffering and the battleground for survival.

Sub-theme 1: Bodily suffering

Participants experienced persistent fatigue, pain, appetite loss, and weight loss, which eroded independence and control. One stated, "The fatigue is unbearable. I've lost over 10 kilograms since I started treatment, and I can't eat the foods I used to love" (P1). Another explained, "Since starting chemotherapy, I've felt completely drained. I wake up tired, and my body aches all over" (P3).

Many described their bodies as betraying them. "Physically, it's been tough. I've always been active, but now my body feels like it's betraying me. I've lost weight, and my strength has vanished" (P3), said one housekeeper. A farmer similarly noted, "The pain became severe, and I began losing weight rapidly. I felt fear but didn't tell anyone at first" (P6). Such accounts reveal the intertwining of physical deterioration with emotional vulnerability.

Sub-theme 2: Treatment burden

While chemotherapy and surgery were viewed as essential for survival, participants described them as harsh and exhausting. "Chemotherapy feels like poison running through my veins. After each session, I'm left feeling broken," one participant shared (P1). Another added, "Chemotherapy brought side effects like nausea, hair loss, and fatigue. Managing my shop became difficult; I had to close it for periods" (P7).

Treatment regimens disrupted daily routines and livelihoods. "Chemotherapy made me feel weak and nauseous. I had to stop working, which affected our income," explained a taxi driver (P10). Similarly, a tailor remarked, "The radiation sessions were exhausting, and chemotherapy caused severe nausea and hair loss. I had to close my business temporarily" (P11). These experiences illustrate how treatment burden extended beyond physical suffering to reshape social and economic life.

Theme 4 — Fractured Foundations (Financial & Practical Disruption)

This theme represents the destabilizing financial and practical consequences of illness, where loss of income and disruption of daily routines compound emotional distress.

Sub-theme 1: Economic burden

Financial hardship was a dominant concern among participants. Many were forced to suspend work or close businesses, resulting in depleted savings and increased dependence on family or loans. A shopkeeper shared, "My shop had to close down since I can't run it anymore. That was our main source of income. Now, it's just the savings that we have left" (P2). A construction worker echoed, "Financially, it's been tough. I was the main breadwinner, and now that I can't work, we've had to adjust" (P4).

The financial burden often evoked guilt and anxiety. "I can't work anymore, and I don't have anyone to rely on. My savings were small, and now they're gone," said one housekeeper (P3). Another participant added, "Medical costs and travel expenses have been a heavy burden. My family had to borrow money and make sacrifices" (P6). These narratives underscore how economic instability magnified the psychological weight of illness.

Sub-theme 2: Practical disruption

Cancer and its treatments disrupted everyday life and family routines, diminishing participants' ability to manage household tasks or maintain employment. "I can't work anymore, and my appetite has diminished. I've lost weight quickly, and I just don't have the same energy I used to," shared one participant (P2). Another explained, "I had to close my tailoring business temporarily because I lacked energy and had frequent hospital visits" (P11).

These role shifts often evoked mixed emotions of gratitude and guilt. "My sons have taken over many tasks, but I still try to help when I can. It's hard to accept being less useful," said a farmer (P6). Similarly, a housewife recounted, "I couldn't cook or clean as before, and my children helped with chores. I felt frustrated and sad not to be able to care for my family fully" (P9). Such accounts illustrate how practical disruptions reverberated through familial relationships, challenging established roles and dependencies.

Table 2. Themes, Subthemes, and Sample Interview Questions

Themes	Sub-themes	Sample Interview Questions
Shattered Certainty	Shock & disbelief at diagnosis	What was your experience when you were first diagnosed with cancer? How did you feel when you first heard the diagnosis?
	Existential fear & uncertainty	
Fractured Selfhood	Loss of identity & role	How has your diagnosis affected your relationships and social life? How has the illness changed your daily life and responsibilities?
	Altered self-image	
Embodied Struggle	Bodily suffering	What kinds of physical problems did you encounter during and after your diagnosis and treatment? How has your physical health been since starting treatment?
	Treatment burden	
Fractured Foundations	Economic burden	How has your financial situation been affected by your illness? Has the illness affected your financial situation?
	Practical disruption	

DISCUSSION

This study explored the lived experiences of individuals diagnosed with colorectal cancer in the Kurdistan region of Iraq, revealing profound disruptions to emotional stability, identity, bodily integrity, and socioeconomic security. The four emergent themes—Shattered Certainty, Fractured Selfhood, Embodied Struggle, and Fractured Foundations—together portray the diagnosis and treatment of cancer as a multidimensional crisis that extends far beyond the biomedical domain. Consistent with phenomenological inquiry, participants' narratives illuminated how cancer transforms one's sense of being, rupturing assumptions about normalcy, control, and the continuity of life.

Shattered Certainty: Emotional Shock and Existential Disruption

A dominant theme in this study was the profound emotional and existential devastation that followed the disclosure of a colorectal cancer diagnosis. Participants described the moment of diagnosis as a violent rupture that shattered their assumptions of stability, continuity, and safety. This emotional shock extended beyond transient disbelief; it represented a sustained sense of unreality that persisted through treatment and daily life. Such experiences mirror Bury's notion of biographical disruption, where chronic illness dismantles the continuity of one's life story and challenges established meanings (Bury, 1982). Participants' narratives

also reflected Van Manen's concept of lived time, as illness distorted temporal experience—compressing the future into uncertainty and prolonging moments of fear (Van Manen, 1990).

In line with global literature, patients articulated overwhelming existential fears related to mortality, unfinished family duties, and concern for dependents. These anxieties echo findings from Mosher and Danoff-Burg (2007) and Loughan et al. (2021), who observed that fear of death, recurrence, and the unknown dominate the psychological landscape of cancer survivors. Importantly, our findings suggest that this existential fear in Kurdish patients is compounded by strong familial interdependence and cultural norms emphasizing responsibility and honor. For many participants, the anticipation of leaving children unsupported or spouses alone evoked deeper anguish than the illness itself. This is consistent with evidence from Middle Eastern studies showing that family bonds act as both protective and distressing forces providing emotional support yet intensifying guilt and fear of dependency (Zeilani et al., 2022; Doumit et al., 2008; Alsirafy et al., 2021).

Furthermore, several participants reported that the shock of diagnosis was amplified by the stigma surrounding cancer, which is often perceived in Iraq as a silent and fatal condition. Limited health literacy and cultural reluctance to discuss life-threatening illness may further exacerbate this existential disorientation. Such findings are in line with Temraz et al. (2019), who found that sociocultural taboos surrounding cancer communication in Arab societies often lead to delayed emotional processing and internalized fear. Thus, for Kurdish patients, the experience of "shattered certainty" is both an intrapsychic and cultural event—reflecting the collapse of personal coherence within a collective framework of silence, fear, and moral duty. To mitigate this, oncology care should include culturally sensitive communication practices, ongoing emotional follow-up, and opportunities for patients to reconstruct meaning beyond the initial diagnostic moment.

Fractured Selfhood: Identity, Role, and Self-Perception

The second major theme revealed how illness fragmented participants' sense of identity and social belonging. For both men and women, cancer disrupted the social scripts through which they had previously derived dignity and purpose. Male participants described deep frustration and loss of pride in no longer being able to fulfill their roles as breadwinners, while women expressed guilt and sadness at being unable to manage household and caregiving responsibilities. These experiences resonate strongly with Charmaz's theory of loss of self, which describes how chronic illness undermines identities anchored in autonomy, competence, and productivity (Charmas, 1995). In our participants, this identity erosion was intertwined with cultural expectations that equate worth with contribution to family welfare.

The bodily transformations accompanying treatment—hair loss, weight loss, weakness, and scars exacerbated this identity fracture. Participants reported feeling alienated from their own bodies and reluctant to appear in public, echoing the "dys-appearing body" described by Leder, in which the body becomes an intrusive presence rather than a transparent vehicle of self-expression (Leder,1990). Research consistently demonstrates that altered appearance after cancer treatment leads to psychological distress, lowered self-esteem, and social withdrawal (Fingeret et al., 2010). However, within collectivist and appearance-conscious cultures such as those of the Middle East, visible signs of illness may be perceived not merely as physical but as moral or social blemishes, contributing to stigma and concealment (Aloloul et al., 2025).

Our findings further suggest that this identity disintegration was not solely individual but relational. Participants perceived themselves through the eyes of others, who are no longer the provider, mother, or respected elder but a dependent patient. Such redefinition of self by social context is consistent with symbolic interactionist views of illness (Corbin and Strauss, 1988), where the self is continually constructed through social roles and interactions. Hence, when illness alters the social gaze, selfhood itself becomes unstable. Addressing this requires interventions that facilitate identity reconstruction helping patients articulate new meanings of self-worth and continuity. Therapeutic modalities such as narrative therapy, dignity therapy, or role-preserving occupational rehabilitation may help re-anchor identity within new capabilities rather than lost functions. Within Kurdish society, culturally attuned psychosocial care should also engage family members, emphasizing that care dependence does not negate value or honor.

Embodied Struggle: Physical Suffering and Treatment Burden

The third theme illuminated the body as both the site of suffering and the locus of resistance. Participants depicted their physical experiences as relentless cycles of pain, exhaustion, appetite loss, and nausea that dismantled bodily trust and independence. The description of the body as "betraying" them mirrors Leder's phenomenological concept of the dys-appearing body, wherein illness forces the once-invisible body into oppressive awareness Leder, 1990). This shift from bodily transparency to bodily intrusion has been widely described in the cancer literature as a hallmark of existential distress (Little et al., 1998).

Participants' relationship with treatment was marked by ambivalence—viewing chemotherapy and radiation as both essential and punishing. They likened chemotherapy to "poison" that both saves and destroys, reflecting what Frank (2013) termed the "remission society," where patients live in the paradox of cure and harm. Previous studies have similarly shown that cancer therapies, while life-prolonging, generate physical and psychological suffering that sometimes surpasses the disease's symptoms (Bower, 2014; Foster et al., 2009). This duality was vividly expressed in our participants' narratives, where the effort to survive often entailed enduring unbearable fatigue and social withdrawal.

Moreover, the embodied struggle extended beyond symptoms to encompass moral and spiritual dimensions. In Kurdish culture, endurance of pain is often framed as an act of faith or divine testing. Some participants drew strength from religious acceptance, interpreting suffering as a means of purification or patience. While such beliefs may foster resilience, they can also lead patients to normalize or underreport pain, delaying access to palliative support. Similar findings were reported by researchers, who observed that Middle Eastern patients often spiritualize suffering in ways that limit open discussion of distress (Abu Khait and Lazenby, 2021). Therefore, effective cancer care must integrate physical symptom control with culturally sensitive exploration of patients' beliefs about suffering and treatment. The close interplay between the physical and existential underscores the need for holistic, multidisciplinary supportive care where oncology, nursing, palliative, and psychosocial services collaborate to restore a sense of bodily coherence and control.

Fractured Foundations: Financial and Practical Disruption

The final theme exposed the socioeconomic destabilization that accompanied cancer. Nearly all participants reported financial hardship, including business closure, job loss, and depletion of savings. This economic collapse compounded the psychological burden of illness, transforming cancer into both a medical and social catastrophe. These findings align with the growing literature on "financial toxicity," which describes the material and emotional costs of cancer care (Zafar and Abernethy, 2013). In low- and middle-income contexts such as Iraq, where out-of-pocket expenses predominate and social insurance is minimal, the economic shock of a serious illness often leads to catastrophic spending or debt.

Beyond the monetary loss, participants described disruption of everyday routines and family functioning. Household chores, farming, or caregiving roles were interrupted, forcing family members often women or children to assume new responsibilities. While such familial solidarity reflects the collectivist ethos of Kurdish society, patients expressed guilt and sadness over their reduced participation, perceiving dependency as a moral failure. This resonates with studies across Middle Eastern settings that identify role incapacity as a central source of distress in chronic illness (Samir, 2025). The overlap between economic deprivation and moral guilt illustrates how illness undermines not only livelihoods but social belonging.

These findings underscore that cancer care must be conceptualized as a socioeconomic as well as medical intervention. Policies addressing treatment affordability, income support, and transportation assistance are essential to reduce inequities. At the clinical level, the integration of social work, financial counseling, and community-based patient navigation could buffer the cascade of hardship. Moreover, psychosocial programs should acknowledge patients' guilt and help families renegotiate caregiving roles in ways that preserve dignity and mutual respect. By addressing these fractured foundations, healthcare systems can transform ancer care from an individual struggle into a collective act of resilience and solidarity.

Implications for Practice, Policy, and Research

Collectively, the findings call for a holistic, culturally sensitive model of cancer care. For clinical practice, oncology nurses and multidisciplinary teams should integrate psychological, existential, and family-based support into all phases of care. Training in culturally competent communication and distress screening should become standard practice. Family-inclusive interventions can strengthen coping and reduce isolation by validating both patient and caregiver experiences.

At the policy level, efforts must prioritize financial protection and psychosocial infrastructure. Expanding insurance coverage, subsidizing travel and medication costs, and institutionalizing psycho-oncology and social work services are urgent needs in Iraq. Public education campaigns to reduce stigma and promote early screening should engage religious and community leaders to enhance trust and awareness.

In research, future studies should examine gender and generational differences in coping and identity reconstruction, and longitudinal designs should explore how meaning and resilience evolve over time. There is also a need for intervention studies that evaluate culturally tailored psychosocial and family-based programs, as well as implementation research assessing the feasibility of multidisciplinary supportive care models in low-resource oncology systems.

Limitations

As a qualitative phenomenological study, these findings reflect the lived realities of a small, region-specific sample and are not statistically generalizable. Cultural sensitivity and social desirability may have constrained participants' openness regarding personal or financial struggles. Additio**na**lly, data were limited to individuals receiving hospital-based care, excluding those managed in community or traditional settings. Researcher interpretation though guided by reflexivity and peer review may also carry inherent subjectivity. Future studies involving diverse participants, caregivers, and health professionals across multiple sites would deepen understanding and strengthen transferability.

CONCLUSION

In sum, this study illuminates how colorectal cancer fractures the psychological, social, and material foundations of life in profound and culturally specific ways. Patients' narratives reveal that healing extends beyond medical treatment it requires reconstructing meaning, identity, and dignity amid uncertainty. Integrating existential care, family involvement, and financial protection into oncology practice and policy

can transform the cancer experience from isolation and fear toward resilience, coherence, and compassionate recovery.

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