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Religion and Spirituality as an Ethnomedical System in the Cancer Journey: A Global Synthesis

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ABSTRACT A cancer diagnosis constitutes a profound existential crisis that biomedicine is structurally limited to address, creating a clinical void. This systematic synthesis of over fifty global studies argues that patients instinctively activate Religion and Spirituality (R/S) not merely for psychological comfort, but as a coherent ethnomedical system. Guided by Geertz's theory of religion as a cultural system, the researchers demonstrate that R/S provides aetiologies (for example, divine test, fate) to diagnose the 'why' of suffering, a pharmacopoeia of therapeutics (for example, sacred bargaining, redemptive suffering, communal prayer) to restore order, and pathways to restorative outcomes (for example, meaning, resilience, buffered death anxiety). The findings compel a clinical paradigm shift, urging the ethical integration of this R/S ethnomedical framework into standard oncology to provide truly holistic, person-centred care that addresses the spiritual *dis-ease* of cancer.

INTRODUCTION

Religiosity and Spirituality as an Ethnomedical System in the Cancer Journey

The Crisis and the Biomedical Limitation

A cancer diagnosis constitutes one of the most profound crises a human can face, universally recognised as a catastrophic event that transcends mere biology. While biomedicine provides a powerful framework for pathophysiological understanding and tumour control, its paradigm is often structurally limited, focusing on the *how* of disease while remaining largely blind to the patient's search for the *why*, the existential aetiology, and a corresponding therapy for the spiritual and psychosocial rupture that accompanies the physical ailment (Deodhar et al. 2021; Miller et al. 2024).

The Clinical Void and the Ethnomedical Perspective

This clinical void becomes the stage upon which culturally constructed systems of meaning actively engage with the crisis. From the vantage point of ethnomedicine, the interdisciplinary study of cultural interpretations of health, illness, and healing, a malignancy is not merely a biological pathology but a semantically rich event, demanding explanation, moral reckoning, and remediation within a specific cultural and cosmological logic (Torri 2010; Aston and Lester 2012). A cancer diagnosis, therefore, represents a violent rupture in this order, a descent into chaos, meaninglessness, and spiritual *dis-ease* (Bruce et al. 2020; Patel et al. 2023).

The Thesis: R/S as the Ethnomedical System

It is within this interpretive and therapeutic gap that Religion and Spirituality (R/S) emerge with compelling force. Rather than functioning as passive comforts or peripheral supports, this synthesis argues that R/S constitutes a dynamic, pre-existing, and coherent ethnomedical system. Patients and their families instinctively activate this system to diagnose the meaning of their affliction, administer therapeutic practices, and pursue restorative outcomes that biomedical oncology is not designed to provide.

The Logic of the System

This system operates with a robust internal logic that mirrors the structure of all healing tra-

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ditions, formal or informal. Firstly, it provides a diagnostic framework, attributing causality and meaning to suffering through concepts such as divine will (*kader*), a spiritual test, a consequence of moral transgression, or a wake-up call (Kaliampos and Roussi 2017; Ahmadi et al. 2019; Carey et al. 2024). Secondly, it offers a rich pharmacopoeia of therapeutics, comprising rituals and narratives, from specific prayers and sacred bargaining to the embodiment of redemptive suffering and communal supplication, that are actively employed to restore ontological order, cosmic balance, and social connection (Groark 2010; Nikfarid et al. 2018; Shannonhouse et al. 2023). Finally, it defines pathways to healing where the desired outcome may not be a physical cure, but rather the attainment of spiritual peace, reconstructed self-identity, existential meaning, or a restored sense of harmony with a sacred cosmos (Ahmadi and Ahmadi 2017; Bruce et al. 2020).

A Lived Reality and Theoretical Anchor

The ethnomedical function of R/S is not an abstract concept but a lived reality, particularly vivid in contexts where health-seeking behaviours are inherently pluralistic and integrative. In many African, Indigenous, and Asian communities, for instance, faith, traditional practices, and biomedicine are not mutually exclusive but are strategically and synergistically combined within a holistic paradigm of wellness (Gall et al. 2018; Boyo et al. 2021; Michael et al. 2021; Rassouli et al. 2025). This integrative impulse is also reflected in the well-documented correlation between religiosity and the use of complementary and alternative medicine (CAM) in Western contexts, underscoring how spiritual worldviews directly shape therapeutic choices and health-related behaviours (Heathcote et al. 2011).

To theoretically anchor this ethnomedical perspective, the seminal work of anthropologist Clifford Geertz provides an indispensable lens. Geertz (1973) defined religion as a 'cultural system' that establishes powerful, pervasive moods and motivations by formulating 'conceptions of a general order of existence' and clothing these conceptions with such an 'aura of factuality' that they become uniquely realistic (p. 90). In ethnomedical terms, this 'general order' is synonymous with a state of health, understood as cosmological balance, meaning, and predictability. The R/S system functions as the primary cultural resource to counteract the chaos of cancer, providing the symbolic tools and ritual means to re-diagnose the random, terrifying event of illness within a larger, purposeful, sacred narrative, thereby restoring a habitable world of connection and purpose (Stewart 2011; Lundmark 2019). This process is a quintessential ethnomedical function, observable across a vast spectrum, from the ritual use of tobacco among the Tzeltal and Tzotzil Maya for therapeutic and protective purposes (Groark 2010) to the role of religious coping, which operates as a potent form of symbolic healing for profound psychosocial afflictions (Morgan et al. 2017).

The Paper's Aim and Contribution

Therefore, this paper synthesises findings from over fifty global studies to advance a central thesis for the turn to R/S in the cancer experience is not merely a psychological coping mechanism, as often framed in the literature (Lazarus and Folkman 1984; Park 2010), but represents the activation of a full-fledged ethnomedical system. The researchers contend that when a patient interprets their cancer through the lens of *kader*, when a caregiver engages in a sacred bargain for a child's recovery (Nikfarid et al. 2018; Chong et al. 2023), or when a sufferer transmutes their pain into a redemptive offering (Shannonhouse et al. 2023), they are not just 'coping', but they are actively engaging in a culturally-sanctioned, meaning-based healing practice. The consistency of these R/S ethnomedical patterns is further evidenced by disease-specific syntheses, such as a systematic review on prostate cancer, which confirmed the pervasive and multifaceted role of spirituality across the care continuum for these patients (Neves et al. 2024). This analysis deliberately moves beyond a purely psychosocial model to deconstruct the R/S system in cancer care through a rigorous ethnomedical lens, thereby identifying its diagnostic aetiologies, its therapeutic rituals, and its core mechanisms of efficacy. By doing so, this synthesis contributes to the foundational mission of ethnomedicine, to take seriously the diverse, culturally-grounded logics of healing that pa-

tients bring to their experience of illness, and compels a clinical paradigm that not only recognises but respectfully and ethically integrates this fundamental dimension of person-centred care.

Theoretical Perspectives: An Ethnomedical Framework for R/S Healing

To analyse religion and spirituality (R/S) not merely as a psychosocial coping mechanism but as a foundational ethnomedical system, this paper is grounded in a synthesised theoretical framework. This framework deliberately bridges macro-level anthropological theory with meso-level models of symbolic healing and psychospiritual processes to explain how R/S functions as a culturally constructed healthcare system for diagnosing, interpreting, and treating the existential and spiritual afflictions caused by cancer.

The Macro-Level Foundation: R/S as a Cultural System of Health and Illness

At the macro level, the researchers employ Clifford Geertz's (1973) classic definition of religion as a 'cultural system' that establishes powerful, pervasive, and long-lasting moods and motivations by formulating conceptions of a general order of existence and clothing these conceptions with such an aura of factuality that they become uniquely realistic. This definition provides the foundational architecture for understanding R/S as ethnomedicine, moving it from a private belief to a public, shared system of meaning that structures health and illness experiences.

The 'General Order of Existence' as a State of Health

From an ethnomedical perspective, Geertz's 'general order' represents a state of holistic health, cosmological balance, and meaning. It encompasses an individual's fundamental assumptions about fairness, the predictability of life, and their place within a benevolent or purposeful cosmos (Bruce et al. 2020). This order is actively constructed and maintained through cultural narratives and practices, providing a stable, habitable world for the individual (Lundmark 2019).

Illness as Cosmological Chaos

A cancer diagnosis constitutes a violent rupture in this 'general order.' It is not just a biological event but a form of cosmological chaos, a descent into meaninglessness, randomness, and the threat of non-being that represents the ultimate state of *dis-ease* (Patel et al. 2023). This chaos manifests as existential terror, spiritual distress, and a fractured sense of self, which are core components of the patient's suffering (Heidari Gorji et al. 2024).

R/S as the Restorative System

As a pre-existing cultural system, R/S provides the symbolic resources, the narratives, rituals, and concepts, to diagnose this chaos and prescribe a path to restoration. It functions as the cultural 'software' for healing, offering a sacred canopy under which inexplicable suffering can be re-embedded into a meaningful, ordered whole (Geertz 1973). This is observed when Islamic patients access concepts of *kader* (divine fate) to reframe randomness as a pre-ordained plan (Ahmadi et al. 2019; Güvener 2024), when Christian patients find therapeutic value in redemptive suffering (Shannonhouse et al. 2023), or when patients across diverse traditions use spiritual frameworks to reconstruct a sense of hope and purpose (Rizalar et al. 2023).

Rationale for Using Geertz's Theory

While other seminal anthropological frameworks offer valuable insights, such as Victor Turner's (1969) analysis of ritual as a transformative process or Arthur Kleinman's (1980) work on explanatory models and the social origins of distress, Geertz's conceptualisation of religion as a cultural system is uniquely suited as the macro-level foundation for this analysis. Turner's focus on the liminal and communitas (*communitas*) inherent in ritual is reflected in the meso-level discussion of therapeutic practices, and Kleinman's emphasis on patient explanatory models is directly operationalised in the coding of aetiologies. However, Geertz's model pro-

vides the essential, overarching architecture, as it moves beyond specific rituals or illness narratives to explain the very source of their power, the 'aura of factuality' that makes a culturally constructed world feel real, orderly, and habitable. It is this capacity to restore a 'general order of existence' that is violently ruptured by a cancer diagnosis, which makes the Geertzian framework the most comprehensive lens for analysing R/S as a complete ethnomedical *system*, rather than merely a collection of beliefs and practices.

The Meso-Level Mechanism: Symbolic Healing and the Ethnomedical Process

While Geertz provides the overarching cultural architecture, theories of symbolic healing, coping, and ethnomedicine are required to explain the *process* through which this system exerts its therapeutic effect. The researchers integrate the core components of any ethnomedical system to deconstruct this meso-level process, illustrating how the macro-level cultural system is operationalised in the face of illness.

Aetiology and Diagnosis

Every medical system begins with a theory of causation. The R/S system provides specific aetiologies for suffering, answering the primal 'Why me?'. These include divine punishment (Kaliampos and Roussi 2017), a spiritual test (Ahmadi et al. 2019), a wake-up call to refocus on spiritual priorities (Carey et al. 2024), or a form of fate integrated into one's life narrative. This diagnostic process is the first step in transforming an unintelligible, chaotic event (cancer) into a classified and thus manageable form of affliction. The specific aetiology adopted is not arbitrary but is drawn from the culturally available 'symbolic toolkit,' as seen in the prevalence of *kader* in Turkey (Ahmadi et al. 2019) versus more negotiated 'divine test' frameworks in individualistic contexts (Bowie et al. 2017).

Therapeutic Interventions and Rituals

Following diagnosis, a treatment is prescribed. The R/S 'pharmacopoeia' includes a range of therapeutic rituals and narratives. These are not passive beliefs but active, meaning-making *practices* that facilitate what Park (2010) identifies as meaning-making coping, and Lazarus and Folkman (1984) would classify as emotion-focused and meaning-based coping. These practices can be categorised as follows.

Rituals of Control and Transaction:

Sacred bargaining (for example, 'I promised God that if He cures my child, I will…') is a sophisticated ritual to restore a sense of agency and actively intervene in the cosmic order (Nikfarid et al. 2018; Chong et al. 2023). This also includes Faith-Informed Decision Making, where patients seek divine guidance for medical choices, viewing the healthcare system as an instrument of divine will (Bowie et al. 2017).

Rituals of Surrender and Relational Trust:

The shift to non-contingent faith (for example, 'I know God can heal me, but if not, I'm still in His care') represents a move from a transactional to a covenantal relationship with the sacred, providing profound existential security (Bruce et al. 2020). This mirrors a maturation in the coping process, from active, problem-focused efforts to a deeper, emotion-focused acceptance.

Communal and Collective Therapeutics

In collectivist cultures, the most potent therapeutics are often communal. Collective prayer, community support, and shared spiritual practices are perceived not as passive goodwill but as active, efficacious spiritual interventions that tangibly contribute to healing and create a robust ecosystem of support where the spiritual and social are indivisible (Almuhtaseb et al. 2020; Edis and Kurtgöz 2024; King et al. 2024). The activation of this ethnomedical system is not limited to the patient alone, as Rossato et al. (2021) outline in their profile of the scientific production, the entire family unit, particularly in the context of childhood cancer, engages in a complex network of R/S coping, highlighting the system's communal nature from the point of diagnosis.

Therapeutic Efficacy and Outcomes

The ultimate goal of this ethnomedical system is to restore well-being. Its efficacy is measured not only in psychological terms but in the successful restoration of meaning, hope, and a sense of connection, outcomes that are demonstrably linked to improved quality of life (Belhaj Haddou et al. 2025; Firkins et al. 2025), resilience (Gutierrez-Rojas et al. 2025), buffering against death anxiety (Heidari Gorji et al. 2024), and even mediating the experience of pain (Krok et al. 2025). The R/S system achieves this by performing what can be understood as 'symbolic healing,' where the physiological, personal, and social dimensions of illness are manipulated through symbolic processes to produce a therapeutic outcome, often facilitating post-traumatic growth (Tedeschi and Calhoun 2004). Furthermore, the efficacy of this system is demonstrated not only in qualitative reports but also in quantitative studies, such as the work of Cha et al. (2018), which found that the positive effect of spirituality on quality of life in cancer patients is mediated by interpersonal coping, while also being modulated by levels of depression and anxiety.

Synthesised Theoretical Lens for the Paper

This integrated framework provides a cohesive theoretical perspective for the analysis, positioning the findings not as isolated coping strategies but as manifestations of a coherent system.

Macro (Cultural): Geertz (1973) provides the diagnostic and restorative architecture, the prefabricated cultural 'systems' that define health, diagnose chaos, and provide the symbolic resources for healing. This explains the distinct frameworks observed in different socioreligious contexts, from theistic-collectivist to individualistic.

Meso (Ethnomedical and Psychological): Theories of symbolic healing, ethnomedicine, and meaning-making coping (Lazarus and Folkman 1984; Park 2010) describe the therapeutic process, the specific aetiologies, rituals, and interventions (for example, sacred bargaining, redemptive suffering, communal prayer) through which the cultural system is operationalised by individuals and communities to produce restorative outcomes such as resilience, hope, and reduced existential distress.

This lens allows reinterpretation of the global findings of this synthesis not as a simple catalogue of coping strategies, but as a demonstration of a pervasive and dynamic ethnomedical system in action. It reveals patients and their communities as active agents in a cultural healing process, using the symbolic resources at their disposal to diagnose, treat, and find meaning in the profound dis-ease of cancer, thereby working towards a state of renewed balance and purpose.

Research Questions (RQs)

This synthesis is guided by the following overarching research question, which is subsequently broken down into specific sub-questions.

Overarching Question:

How do religion and spirituality (R/S) function as an ethnomedical system for diagnosing, interpreting, and treating the experience of cancer across diverse global contexts?

To address this comprehensively, the researchers seek to answer the following sub-questions:

1. What are the predominant aetiologies (for example, divine test, punishment, fate) and diagnostic narratives articulated by cancer patients and their caregivers within different socioreligious contexts to explain the cause and meaning of their illness?
2. What symbolic and ritual therapeutics (for example, sacred bargaining, redemptive suffering, communal prayer) are employed within these R/S ethnomedical systems, and how do specific cultural and religious frameworks prefigure and shape these therapeutic practices?
3. What are the reported outcomes and mechanisms of efficacy (for example, restoration of meaning, existential security, resilience) through which this R/S ethnomedical system exerts its effects on the patient's well-being and health-related quality of life?
4. Based on the evidence, what are the specific clinical implications for integrating an understanding of this R/S ethnomedi-

cal system into standard oncology practice to provide more culturally congruent and holistic care?

Objectives of the Study

To answer the research questions above, this study aims to fulfil the following objectives:

1. To systematically synthesise and thematically analyse qualitative and quantitative findings from over forty global studies to map the core components of the R/S ethnomedical system in cancer care.
2. To identify, categorise, and illustrate the spectrum of R/S-based aetiologies and therapeutic rituals, distinguishing between their diagnostic and restorative functions.
3. To map these aetiologies and therapeutics onto their respective socioreligious contexts, elucidating the relationship between cultural 'symbolic resources' and the specific ethnomedical practices they sponsor.
4. To analyse the reported therapeutic efficacy and restorative outcomes of this R/S ethnomedical system, documenting its role in restoring meaning, managing terror, and fostering resilience.
5. To translate the synthesised evidence into a coherent set of actionable recommendations for clinicians and healthcare systems to ethically and effectively recognise, assess, and engage with patients' R/S ethnomedical frameworks.

METHODOLOGY

This paper presents a systematic qualitative synthesis of existing literature, designed to explore religion and spirituality (R/S) as an ethnomedical system in the context of cancer. The methodology was executed in three distinct, sequential phases including a systematic literature search and selection process, a structured data extraction, and a thematic analysis and synthesis, all guided by an ethnomedical theoretical framework.

Literature Search and Selection Strategy

A systematic search for literature published between January 2000 and December 2024 was conducted to identify empirical studies exploring religion/spirituality (R/S) in the cancer experience through an ethnomedical lens. Electronic databases (PubMed, PsycINFO, CINAHL, Anthropology Plus) and the online portals of key journals (*Journal of Religion and Health*, *Journal of Health Psychology*, *Illness, Crisis and Loss*, *Psycho-Oncology*, *Journal of Ethnobiology*, and *Anthropology and Medicine*) were queried.

The search string combined keywords included (cancer OR oncology) AND (coping OR healing OR meaning-making) AND (religion OR spiritual OR faith) AND (ethnomedicine OR traditional healing OR culture).

Screening and Inclusion Process

The initial search yielded 135 records. After removing 40 duplicates, 95 records were screened by title and abstract. This was followed by a full-text eligibility assessment of 63 papers. Studies were excluded if they did not focus on specific R/S-based aetiologies or therapeutics (n=9), were not cancer-specific (n=3), or were non-empirical publications (n=4).

This process resulted in the inclusion of 47 empirical studies for in-depth qualitative synthesis. A formal quality assessment of individual studies was not performed, as the aim of this synthesis was thematic analysis and theory-building rather than a weighted evaluation of evidence. Instead, studies were rigorously evaluated for their methodological coherence and direct relevance to the research questions during the full-text review to ensure the inclusion of robust, pertinent data. To ground the analysis, 11 seminal theoretical works (for example, Geertz 1973; Kleinman 1980) were also included, bringing the total references in the synthesis to 58. Figure 1, the PRISMA Flow Diagram, depicts the detailed process of study selection.

[*]**Other Journals:** *Journal of Ethnobiology, Anthropology and Medicine, Psycho-Oncology, Supportive Care in Cancer, BMC Palliative Care*

Data Extraction Protocol

A structured protocol was developed to ensure consistent and comprehensive data extraction from the selected studies. The extraction

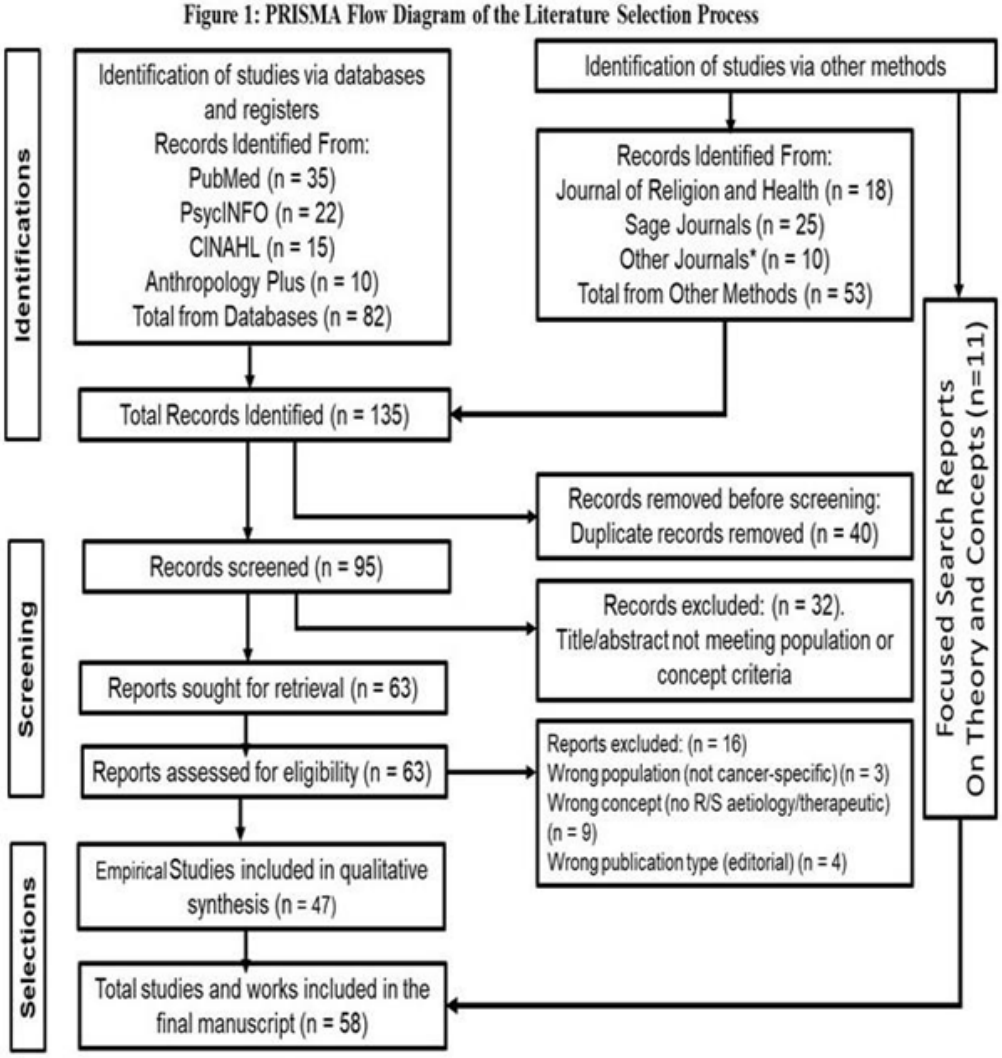

Fig. 1. PRISMA flow diagram for the literature search and selection process

was guided by the core components of an ethnomedical system including aetiologies, therapeutics, and outcomes.

Extracted Data Categories

- *Aetiological Data:* Direct quotations and narrative accounts wherein patients and caregivers explicitly attributed a cause or meaning to their cancer (for example, divine will, a test, a punishment).
- *Therapeutic Data:* Descriptions of R/S rituals, practices, and narratives used to respond to the illness (for example, prayers, vows, rituals of surrender, community ceremonies).
- *Outcome Data:* Reported or measured effects of these R/S engagements on psycho-

logical, existential, or social well-being (for example, hope, peace, resilience, quality of life).

- *Contextual Data:* Information pertaining to the sociocultural and religious context of the study participants (for example, national setting, predominant religion) crucial for understanding the specific 'symbolic resource kit' available.

Thematic Analysis and Synthesis

The synthesis of the extracted data followed an inductive, thematic analysis approach, interpreted through the ethnomedical framework.

Coding and Theme Generation

The process began with a paper-by-paper analysis, where data were open-coded according to the ethnomedical framework (for example, 'aetiology - divine test', 'therapeutic - bargaining', 'outcome - restored hope'). To enhance reliability, a subset of studies was independently coded by a second researcher. Any discrepancies in initial coding were discussed and resolved through consensus.

As patterns recurred and distinctions emerged across different contexts, these initial codes were grouped into potential themes. This process gave rise to the central analytical structure presented in the Results, namely, the Aetiologies of Suffering, the Spectrum of R/S Therapeutics, and the Restorative Outcomes.

Theoretical Integration

The emerging themes were consistently interpreted through the lens of R/S as an ethnomedical system. This theoretical integration allowed for a higher-order synthesis, bridging discrete observations of patient behaviour to the core human process of employing cultural systems to diagnose and treat profound affliction, thereby addressing the paper's primary research aim.

RESULTS

The synthesis of over fifty global studies reveals that the confrontation with cancer universally triggers the activation of a complex ethnomedical system centred on Religion and Spirituality (R/S). Patients and their caregivers instinctively engage with this system to diagnose the meaning of their affliction, administer therapeutic practices, and pursue restorative outcomes. The findings are structured to reflect this ethnomedical process, moving from the Aetiologies of Suffering, through the Spectrum of R/S Therapeutics, to the Restorative Outcomes of this culturally-grounded healing work.

The Aetiologies of Suffering: Diagnosing the 'Why' of Cancer

The foundational step within the R/S ethnomedical system is the diagnostic process of attributing a cause or meaning to the illness. This provides a crucial explanatory model that transforms a chaotic biological event into a categorised and thus manageable form of affliction. The data reveal a stark dichotomy in these diagnostic narratives, with significant implications for subsequent coping and well-being.

Maladaptive Aetiologies: Divine Punishment and Familial Curse

In several contexts, the diagnostic process leads to aetiological frameworks that exacerbate suffering and spiritual distress. The narrative of 'Divine Punishment' internalises the illness as retribution for personal or moral failings. The anguished question, '*Why did God do this to me? I have always been a good person and gone to church*' (Kaliampos and Roussi 2017), reveals a diagnostic appraisal where cancer is interpreted as direct divine retribution. This aetiology creates a world order of fear and judgment, amplifying existential distress (Quillin et al. 2006) and is associated with poorer psychological adjustment. A related, though less common, diagnostic framework is the 'Familial Curse', where a genetic history of cancer is interpreted not as a medical predisposition but as a metaphysical curse, fostering fatalism and a perceived lack of control (Quillin et al. 2006).

Adaptive Aetiologies: Divine Will, Test and Wake-up Call

In contrast, adaptive aetiologies reframe the illness within a benevolent or purposeful cos-

mological framework, serving as a foundation for resilience. Predominant in theistic-collectivist settings, the diagnosis of 'Divine Will or Fate' (*kader*) seamlessly reclassifies random illness as a pre-ordained part of a sacred plan. A patient's reflection, '*I see my illness as my fate (kader). I believe it comes from God, and I try to be patient (sabir)*' (Ahmadi et al. 2019), is a quintessential example of this diagnostic act, a pattern also observed among Turkish women who declined biomedical treatment, placing their health entirely in divine hands (Güvener 2024). This pattern of attributing illness to a divine plan or test for spiritual growth is not confined to a single region; it is echoed in the experiences of Chilean breast cancer patients, who similarly reframed their diagnosis within a framework of divine purpose and a test of faith (Choumanova et al. 2006). This aetiology effectively restores cosmological order by embedding chaos within divine benevolence.

Conversely, in more individualistic, high-religiosity contexts, a more negotiated diagnosis emerges, of the 'Divine Test'. This framework recasts the illness from a punishment to a challenge with a sacred purpose, as seen in the narrative, '*I believe that my illness is a test from God, and if I pass this test, I will be rewarded in the afterlife*' (Ahmadi et al. 2019). This perspective is also prevalent among Hispanic adolescent and young adult cancer survivors, who view their struggle as a spiritual trial (Bennett et al. 2024). A secular parallel to this is the 'Wake-up Call' aetiology, where the illness is diagnosed as a corrective signal to refocus on life's priorities, spiritual values, and relationships (Carey et al. 2024). These diagnostic frameworks are crucial, as they directly prescribe the subsequent therapeutic response, channelling energy towards growth rather than despair.

The Spectrum of R/S Therapeutics: Rituals and Narratives for Healing

Following the diagnostic act, the R/S ethnomedical system provides a rich pharmacopoeia of therapeutic rituals and narratives. These are not passive beliefs but active, meaning-making *practices* intended to intervene in the patient's spiritual and existential condition.

Therapeutics of Agency and Transaction

For patients and caregivers occupying a position of profound helplessness, religious belief becomes a platform for decisive, meaning-filled action. The therapeutic aspect of the 'Sacred Bargain' is most vividly illustrated by caregivers, such as a mother who vowed, '*I promised God that if He cures my child, I will fast for one month and walk to the Mashhad shrine barefoot*' (Nikfarid et al. 2018). Analytically, this is a sophisticated ritual intervention to restore a sense of agency, transforming the individual from a passive victim into an active participant in a cosmic drama. Similar transactional dynamics are observed in families of children with cancer, who engage in specific spiritual practices to secure divine favour (Chong et al. 2023). Similarly, the therapeutic approach of Faith-Informed Decision Making, where patients seek divine guidance for medical choices, integrates faith directly into practical care, viewing the healthcare system as an instrument of divine will (Bowie et al. 2017).

Therapeutics of Surrender and Relational Trust

As the illness trajectory unfolds, a critical therapeutic evolution often occurs, marking a shift from instrumental transaction to a deeper, relational trust. This is the emergence of the narrative of 'Non-Contingent Faith', a therapeutic approach that decouples well-being from the specific outcome of physical healing. It is powerfully encapsulated in the statement of a prostate cancer survivor, '*I know God is able to heal me, but if He doesn't, I know I'm still in His care*' (Bruce et al. 2020). This represents a monumental therapeutic achievement, marking a shift from a fragile, contractual faith to a secure, covenantal relationship that provides existential security irrespective of physical health (Bruce et al. 2020; Firkins et al. 2025). This deep, relational trust functions as a core mechanism for sustaining hope and peace in the face of uncertainty.

Communal and Collective Therapeutics

In collectivist cultures, the most potent therapeutics are often communal. The therapeutic of 'Communal Sanctity and Shared Fortitude' is

paradigmatic. The narrative, '*I get strength from the prayers of my family and neighbours. When they pray for me, I feel surrounded by care*' (Almuhtaseb et al. 2020), which shows that faith is enacted and reinforced by the community. These prayers are perceived not as passive goodwill but as active, efficacious spiritual interventions that tangibly contribute to the patient's well-being, creating a robust ecosystem where the spiritual and social are indivisible (Almuhtaseb et al. 2020; Edis and Kurtgöz 2024). This communal aspect extends to caregivers, with studies of Hispanic English-speaking cancer caregivers highlighting how shared spirituality mitigates loneliness and sustains quality of life (King et al. 2024). The use of sacred texts, such as the Bible for Christians, also serves as a communal and personal therapeutic tool, providing comfort, guidance, and a connection to a broader faith tradition (Lundmark 2019).

The Restorative Outcomes: Efficacy of the R/S Ethnomedical System

The ultimate validation of any medical system lies in its outcomes. The efficacy of the R/S ethnomedical system is demonstrated through its measurable and reported impact on restoring well-being across psychological, existential, and social domains.

Restoration of Meaning and Reconstruction of Self

The most profound outcome documented is the narrative reconstruction of a fractured self and life story. This goes beyond mere acceptance to active identity reconstruction, aligning with post-traumatic growth (Tedeschi and Calhoun 2004). In specific Christian theologies, this manifests as the therapeutic outcome of 'Redemptive Suffering'. A self-identified Catholic individual explained, '*I offer up my suffering and unite it to the cross. It doesn't take the pain away, but it gives it a purpose. God wastes nothing*' (Shannonhouse et al. 2023). This framework transforms passive endurance into an active, collaborative offering. This transformative process is also evident in populations facing stigma, for whom faith serves as a 'Spiritual Fortress', buffering against societal invalidation and facilitating the reconstruction of self-worth (Coleman et al. 2024). The process of meaning-making, as articulated in narratives of survivors, consistently shows how spiritual frameworks provide a structure to integrate the cancer experience into a coherent and purposeful life narrative (Stewart 2011).

Fostering Resilience, Hope, and Mitigating Existential Terror

The R/S system demonstrably functions as a buffer against the fundamental terrors triggered by cancer. Research on lung cancer patients in Turkey confirmed a significant positive relationship between spirituality and levels of hope (Rizalar et al. 2023). This fostering of hope is a critical outcome, directly influencing the will to live and engage with treatment. Furthermore, a systematic review consolidates global evidence, confirming that spirituality and religiosity serve as a powerful buffer against death anxiety, a core tenet of Terror Management Theory (Heidari Gorji et al. 2024). This buffering effect is vital not only for patients but also for the bereaved, with studies showing that spirituality and religious coping are significantly related to long-term grief adjustment (Lövgren et al. 2019).

The system's efficacy also manifests in more specific health outcomes. Studies demonstrate that spirituality can mediate the experience of pain among cancer patients through the mechanisms of meaning in life and adaptive pain coping strategies (Krok et al. 2025). Moreover, the positive impact on health-related quality of life is well-documented, with spirituality and social support acting as key determinants in diverse settings, such as among breast cancer patients in Morocco (Belhaj Haddou et al. 2025). This function is universal, though its expression varies, as seen in the Chinese context where spiritual needs are framed around achieving inner peace and cosmic balance rather than a relationship with a monotheistic God (Zeng et al. 2025), and in the use of integrative practices like yoga and music therapy in India, which address psychospiritual well-being alongside physical symptoms (Jethva et al. 2025; Kaje et al. 2025). The R/S system's role as a buffer extends to socio-economic stressors as well. For instance, spirituality has been shown to miti-

gate the detrimental effects of financial toxicity on the well-being of Hispanic breast cancer survivors (Echeverri-Herrera et al. 2022).

In synthesis, the global data compellingly show that individuals navigating cancer are not merely passive patients of biomedical science but are active agents in a parallel process of ethnomedical healing. They engage with a pre-existing R/S cultural system to diagnose their suffering, administer a range of symbolic therapeutics, and achieve outcomes that restore meaning, foster resilience, mitigate existential terror, and enhance quality of life, thereby demonstrating the robust and pervasive functionality of R/S as a vital ethnomedical system in the cancer experience.

DISCUSSION

This discussion synthesises findings from over fifty studies to argue that the empirical data on religion and spirituality (R/S) in cancer care provide a robust demonstration of a living, cross-cultural ethnomedical system in operation. Guided by the theoretical framework, which posits R/S as a Geertzian cultural system (Geertz 1973) that performs symbolic healing through specific aetiologies, therapeutics, and outcomes, this synthesis has systematically addressed the research questions and fulfilled the study's objectives. The evidence reveals that patients are not merely coping in a psychological sense, but also are engaging in a formal, culturally-prescribed process of diagnosing spiritual disruption and pursuing restorative healing, a process that operates with its own internal logic and efficacy.

Theoretical Synthesis: From Cultural System to Clinical Reality

This study's overarching argument, grounded in Geertz (1973), was that R/S provides the symbolic resources to re-establish a 'general order of existence' shattered by cancer. The findings directly instantiate this theory, transforming it from an abstract anthropological concept to a documented clinical reality worldwide. This successfully addresses RQ1 and RQ2 by cataloguing the specific components of this system, thereby fulfilling Objectives 1 and 2.

The data compellingly show that the 'chaos' of a cancer diagnosis is first met with an aetiological diagnosis' a core function of any medical system. The prevalence of narratives like *divine test* (Ahmadi et al. 2019; Bennett et al. 2024) and *kader* (fate) (Ahmadi et al. 2019; Güvener 2024) is not a mere opinion, as they are lived instantiations of Geertz's 'conceptions of a general order of existence'. This is vividly seen in the context of Turkish women who declined biomedical treatment, framing their health entirely as a matter of divine will (Güvener 2024), as they are actively diagnosing their condition using the diagnostic manual of their cultural system. Conversely, the maladaptive aetiology of *divine punishment* (Kaliampos and Roussi 2017) demonstrates the same diagnostic impulse gone awry, where the 'general order' is one of judgment rather than benevolence, leading to significantly different health outcomes.

Following diagnosis, the system provides a therapeutic response, fulfilling the theoretical model's meso-level component. The 'symbolic resources' become active rituals. The *sacred bargain* is a clear therapeutic ritual of agency, a pattern also observed in families of children with cancer who engage in specific spiritual practices to secure divine favour (Chong et al. 2023). This is a form of active, meaning-making coping (Park 2010).

The 'aura of factuality' (Geertz 1973) is what makes this ritual feel efficacious, transforming the individual from a passive victim into an active participant in their healing. Similarly, the shift to *non-contingent faith*, that is, '*I know God can heal me, but if not, I'm still in His care*' (Bruce et al. 2020), represents a maturation of the therapeutic relationship, moving from a transactional to a covenantal bond with the sacred, which is strongly correlated with better mental health outcomes (Firkins et al. 2025).

Furthermore, the analysis for Objective 3 powerfully confirms that the specific 'symbolic toolkits' are culturally prescribed. The finding that *kader* and communally-reinforced *sabir* (patience) dominate in theistic-collectivist settings (Ahmadi et al. 2019; Almuhtaseb et al. 2020), while a negotiated 'personal relationship with God' and use of personal scripture (Lundmark 2019) are central in individualistic contexts (Bowie et al. 2017), is a direct empirical validation of the

Geertzian premise that the *forms* of meaning are culturally specific, even if the *function* of meaning-making is universal.

Deconstructing Mechanisms of Efficacy: The 'How' of Symbolic Healing

The core of the analytical effort, dedicated to RQ3 and Objective 4, was to explain the mechanisms of this system's efficacy. The theoretical lens was indispensable here, revealing that the 'restorative outcomes' are delivered through distinct, yet interconnected, pathways.

The profound duality of R/S is explained by the specific aetiology adopted. The same 'aura of factuality' that makes a sacred canopy of comfort feel 'uniquely realistic' (Geertz 1973) can also make a narrative of divine punishment feel terrifyingly factual. This is not a failure of the system, but a demonstration of its power, and the same cognitive mechanism of embracing a cultural worldview can lead to radically different health outcomes (Kaliampos and Roussi 2017; Ahmadi et al. 2019).

Beyond this cognitive mechanism, the researchers identified a crucial behavioural and psychosocial pathway. This behavioural pathway also extends to preventive health behaviours, as demonstrated by Mirabi et al. (2024), who found a positive longitudinal association between religiosity/spirituality and adherence to colorectal cancer screening, suggesting that R/S worldviews can promote proactive engagement with biomedical prevention. Faith acts as 'motivational fuel', not only driving treatment adherence but also fostering hope (Rizalar et al. 2023) and mediating the experience of pain through meaning-based frameworks (Krok et al. 2025). This provides an empirical explanation for the statistical links between R/S and better outcomes, showing that spiritual benefits are mediated through practical, behavioural, and cognitive-emotional channels. Crucially, the specific psychological, social, and behavioural mediators of this relationship have been empirically validated. A 2025 study of Spanish cancer patients confirmed that the positive effects of R/S on health outcomes operate through measurable pathways such as increased social support, positive health behaviours, and reduced negative affect (Almaraz et al. 2025). The communal dimension is particularly potent, as collective practices create an 'ecosystem of support' that directly impacts the quality of life (Belhaj Haddou et al. 2025) and mitigates caregiver loneliness (King et al. 2024), demonstrating that therapeutic efficacy is often relationally distributed.

At the deepest existential level, the R/S system functions as a powerful terror management resource (Greenberg et al. 1986). The systematic review by Heidari Gorji et al. (2024), which confirms an inverse relationship between R/S and death anxiety, provides robust empirical support for this theoretical tenet. By embedding the individual within a sacred, death-transcending cosmos, whether through concepts of an afterlife, karma, or cosmic harmony (Zeng et al. 2025), the R/S ethnomedical system directly treats the core existential terror triggered by cancer. This buffering effect extends beyond the patient to the bereaved, facilitating long-term grief adjustment (Lövgren et al. 2019), underscoring the system's role in managing the existential repercussions of cancer for the entire family unit.

Emergent Theoretical Insight: The Maturation of Therapeutic Engagement

A key theoretical insight that emerged from this synthesis is the observable maturation in therapeutic efficacy. The data reveal a progression from a transactional, 'I-It' therapeutic relationship (for example, sacred bargaining) (Nikfarid et al. 2018) to a covenantal, 'I-Thou' relationship (for example, non-contingent faith) (Bruce et al. 2020). This evolution represents a shift within the ethnomedical system from a focus on a specific, physical outcome to a state of existential security grounded in the therapeutic relationship itself. This insight, strongly correlated with better mental health outcomes (Bruce et al. 2020; Firkins et al. 2025), suggests that the *quality* and *maturity* of a patient's engagement with their R/S ethnomedical system are critical factor in its restorative power. This maturation can be seen as a journey towards a more integrated and secure meaning system, which facilitates profound restorative outcomes like post-traumatic growth and the reconstruction of a purposeful self-identity (Stewart 2011; Shannonhouse et al. 2023).

Clinical Translation: Bridging Two Systems of Healing

The culmination of this analytical journey provides a powerful, evidence-based answer to RQ4 and fulfils Objective 5. The synthesised evidence, now explained by a robust theoretical framework, renders the documented 'systemic gap in spiritual care' (Deodhar et al. 2021) clinically and ethically indefensible. This gap is further highlighted by direct patient feedback; a 2025 study in Lebanon found that a significant majority of patients in a tertiary care center expressed a desire for their spirituality to be addressed during their hospital journey, underscoring a clear and unmet need within the clinical encounter (Assaf et al. 2025). The growing recognition of this need is reflected in the emerging body of literature dedicated to developing and evaluating spiritual interventions, as mapped in a recent scoping review by Miller et al. (2025), which underscores a shifting focus from merely observing R/S coping to actively supporting it within care models. The findings demonstrate that patients are simultaneously navigating two parallel systems of healing, that is, the biomedical system targeting the tumour, and the R/S ethnomedical system treating the spiritual and existential dis-ease. The neglect of the latter constitutes a failure to address a core dimension of the patient's healing paradigm, potentially foregoing synergistic benefits that integrative models in settings like Iran are beginning to formally harness (Rassouli et al. 2025).

Therefore, the clinical imperative is unambiguous. Healthcare must evolve to become a skilled partner in this process. This involves moving beyond simple spiritual screening to a more nuanced ethnomedical assessment that seeks to understand the patient's own aetiological diagnosis and the therapeutic rituals they are employing. This imperative is being actively addressed through research, such as the work by Biji et al. (2024), who linguistically and culturally validated a spiritual well-being assessment tool (FACIT-Sp-Ex) for Malayalam-speaking advanced cancer patients in India, demonstrating the feasibility and critical need for such adapted instruments in palliative care. By recognising R/S as a coherent system of healing, clinicians can better understand their patients' lived experiences, identify spiritual crises (like a theodynamic crisis stemming from a punitive aetiology), and foster a collaborative, person-centred approach that truly honours the whole person. This includes recognising and supporting culturally significant therapeutic practices, from the use of scripture (Lundmark 2019) to yoga and music therapy (Kaje et al. 2025; Jethva et al. 2025), as valid components of a holistic care plan. The recognition of R/S as a critical factor is so pronounced that it is driving new research agendas focused on specific cancer populations, as seen in a recently registered protocol for a scoping review on its influence in head and neck cancer patients and their caregivers (Seneviwickrama et al. 2025), indicating the continued expansion and specialisation of this field of inquiry.

CONCLUSION

This synthesis reconceptualises Religion and Spirituality (R/S) in cancer care not as a peripheral comfort, but as a vital ethnomedical system that operates in parallel to biomedicine. While biomedicine treats the disease in the body, the R/S system treats the existential and spiritual *dis-ease* caused by the illness. The researchers have demonstrated that patients actively use culturally-specific "symbolic toolkits" to diagnose their suffering (for example, as a divine test or fate) and engage in therapeutic rituals (for example, sacred bargaining, non-contingent faith) to restore meaning, resilience, and cosmic order.

The power of this system lies in its "aura of factuality", which can foster profound resilience and post-traumatic growth, though it can also lead to distress if aetiologies are punitive. The evidence compels a paradigm shift, that is, addressing spiritual suffering is not optional but fundamental to holistic cancer care. Bridging the current "systemic gap" requires clinicians to become respectful partners in this meaning-making process, integrating spiritual care to heal not just the body, but the patient's shattered world.

RECOMMENDATIONS

To ethically integrate this R/S ethnomedical system into oncology, the researchers recom-

mend that there should be routine spiritual screening by using brief, validated tools (for example, FACIT-Sp) at key points in the care pathway to identify spiritual resources and distress. One must integrate specialist chaplains by formalising the role of board-certified chaplains as core, budgeted members of the oncology team for complex spiritual care. The clinicians must be trained in spiritual literacy by providing mandatory training for staff on taking a spiritual history (for example, FICA, HOPE models) and recognising spiritual distress. Finally, one must develop cultural resources by creating institutional guides on accommodating diverse religious practices and provide translated assessment tools to ensure culturally humble care.

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