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Resilience as a Socially Embedded Process in Cervical Cancer Care: A Qualitative Study

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ABSTRACT

Introduction: Cervical cancer continues to pose significant health and psychosocial challenges in low- and middle-income countries (LMICs), including Indonesia. This study aimed to explore how women with cervical cancer and their caregivers construct resilience in the face of illness, focusing on the roles of emotional, informational, and spiritual supports. By examining these dimensions within an Indonesian LMIC context, the study contributes to a deeper understanding of resilience as a socially embedded process shaped by cultural frameworks and clinical interactions.

Methodology: A qualitative research design was employed, drawing on in-depth interviews with eight women diagnosed with cervical cancer and one caregiver at Undata General Hospital (RSUD Undata), Palu, Indonesia. Informants were selected purposively to capture diverse illness trajectories, and thematic analysis was applied to verbatim transcripts. Analytical rigor was ensured through triangulation, iterative coding, and interpretive synthesis, conducted under formal ethical approval from the institutional review board and with informed consent from all participants.

Results: Findings indicate that resilience is not a fixed personal trait but a negotiated and dynamic process. Emotional reassurance from family and colleagues, clear and compassionate communication by clinicians, and the grounding of experiences in spirituality and religious practices all facilitated adaptation and treatment adherence. At the same time, resilience revealed ambivalence: moralized expectations of being a “good patient” encouraged compliance but risked silencing distress, while some informants engaged in resistance through treatment hesitation or refusal—manifesting in delays in care and underreporting of symptoms. Interpreting these findings through subjectivation, psychological, and ecological lenses illustrates that resilience is discursively produced, individually enacted, and structurally conditioned.

Conclusion: This study concludes that resilience in cervical cancer care is best understood as a culturally embedded and multi-layered phenomenon. Its implications underscore the need for context-sensitive psychosocial oncology practices that integrate family support, culturally grounded spiritual care, and dialogic communication. By situating Indonesian experiences within broader international debates, the research contributes new insights to global psycho-oncology scholarship and highlights avenues for future inquiry, including longitudinal research, intervention-based studies, and the development of culturally validated assessment tools that advance psychosocial oncology in LMIC contexts.

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INTRODUCTION

Cervical cancer remains a major global health challenge, consistently ranking among the leading causes of morbidity and mortality among women. Smoking-related cervical cancer burden continues to be substantial, with regional variations persisting during the past decades (1). The presence of HIV infection has been identified as an additional factor exacerbating cervical cancer burden in many regions, particularly in low- and middle-income countries (LMICs) (2). Recent studies highlight disparities in care, with quality-of-care indices demonstrating stark inequalities between high-income and low-resource contexts, directly contributing to poorer health outcomes (3). Country-specific investigations, including those in China, emphasize variations in cervical cancer incidence and management, further underscoring the complex global patterns of disease burden (3,4).

Within this global landscape, LMICs—including Indonesia—face disproportionately higher burdens of disease, linked not only to structural healthcare limitations but also to sociocultural contexts shaping health-seeking behavior and adherence. While progress has been made in screening and treatment, psychosocial factors such as coping, social support, and resilience have not been sufficiently addressed. These gaps are particularly relevant as oncology care is increasingly understood not only as biomedical treatment but also as an integrative process encompassing patients' psychological, social, and spiritual dimensions (1,5).

Despite advances in oncology treatment protocols, a persistent challenge in cervical cancer care lies in addressing the psychosocial needs of patients. Social support mechanisms—including emotional, informational, instrumental, and spiritual support—are central to patient adaptation, but these dimensions are rarely prioritized in cancer management models in LMICs (1,5). The neglect of these factors creates vulnerabilities, particularly where structural health system inequities amplify patient distress. This neglect in turn contributes to treatment refusal, delays, or poor adherence, thus widening existing disparities in cancer care outcomes (3). Addressing these issues demands culturally sensitive interventions that integrate communication training for health workers and family-based psychosocial support within national cancer care programs.

Solutions proposed in oncology literature emphasize resilience as a protective construct in cancer contexts. Resilience enables positive adaptation to illness-related stressors, supports psychological well-being, and contributes to improved quality of life (6,7). Within caregivers, resilience is examined as both an outcome and predictor of patient well-being, often mediated by spiritual and social support resources (6,8). For patients, resilience has been operationalized as "personal resilience" or as part of structural equation models, linking coping strategies to adaptation outcomes (9,10). These findings point to resilience not as an inherent trait but as a dynamic capacity shaped by social environments and discourses.

In the Indonesian context, resilience is deeply influenced by religious and cultural frameworks. Islam, alongside local spiritual traditions, provides meaning-making resources that shape responses to illness. Studies report that patients draw strength from prayer, family support, and religious rituals, enabling acceptance and endurance during cancer treatment (11,12). Specific devotional practices, such as Sufi ritual participation, have also been identified as sources of coping during the COVID-19 pandemic, illustrating how spirituality intersects with health adaptation (13). The development of culturally grounded instruments such as the Indonesian Brief RCOPE further facilitates research into religious coping within cancer care (14). However, its psychometric validation among oncology-specific populations remains limited, highlighting the need for further adaptation and testing. These findings demonstrate the central role of religion in shaping coping, health decisions, and engagement with biomedical treatment in Indonesia and neighboring Southeast Asian countries (12,15).

Qualitative research has illuminated the role of social and spiritual support in shaping resilience. Spiritual coping is consistently cited as a protective factor enabling positive adjustment in cancer care contexts (8,16). Social networks, including family and workplace support, are equally important, providing emotional and practical assistance during treatment. These dimensions, when analyzed through a Foucauldian lens, can be understood as discourses of power and subjectivation that normalize patient identities and coping behaviors (7,16). Integrating this approach with psychological and ecological models allows for a more comprehensive understanding of how power, discourse, and emotional regulation intersect in shaping meaning-making and adaptive responses among patients. This perspective adds depth to psychosocial oncology research by highlighting how patient subjectivities are shaped not only by personal resilience but also by the social, cultural, and clinical environments in which care occurs.

Nevertheless, significant gaps remain in psychosocial oncology research in LMIC contexts. Most studies rely on cross-sectional designs, limiting insight into longitudinal coping trajectories and interventions (11,14). Moreover, there is limited availability of culturally validated psychosocial tools beyond the Indonesian RCOPE, restricting the ability to measure and evaluate religious coping systematically (14). Caregiver- and family-centered psychosocial research also remains underdeveloped, despite evidence of their critical roles in patient support (6). Additionally, there is insufficient integration of spirituality into routine oncology care, even though evidence suggests its relevance in influencing treatment decisions and engagement (12,17). Comparative psycho-oncological studies from non-Muslim majority LMICs—such as Thailand, Vietnam, and Brazil—also indicate similar structural barriers and highlight the need for contextually adaptive, cross-cultural frameworks that decolonize resilience research and promote epistemic justice in global oncology.

The current study addresses these gaps by examining the lived experiences of women with cervical cancer and their caregivers at Undata General Hospital (RSUD Undata), Palu, Indonesia. Drawing on both quantitative service data and qualitative interviews, it explores how social support and resilience intersect with cultural and religious coping practices. By applying a Foucauldian framework integrated with psychological and ecological perspectives, the study highlights how discourses of discipline, normalization, and subjectivation operate in oncology care, shaping patient subjectivities and their responses to illness. The novelty of this research lies in its integration of these theoretical lenses with psychosocial oncology in an LMIC context, offering a culturally situated analysis of resilience and social support. The scope encompasses both patient and caregiver experiences, situating them within broader clinical and sociocultural power relations. Ultimately, the study aims to advance understanding of how resilience is constructed in oncology care and to identify practical implications for more holistic, culturally responsive, and policy-relevant cancer care models.

METHODOLOGY

Research Design

This study employed a qualitative research design, focusing on phenomenology and interpretive phenomenological analysis (IPA) to capture the lived experiences of cervical cancer patients and their caregivers at Undata General Hospital (RSUD Undata). The qualitative approach allowed for in-depth exploration of coping, social support, and resilience within cultural and clinical contexts, aligning with established oncology psychosocial research practices (18–20). To enhance transparency and trustworthiness, we followed COREQ reporting guidance and maintained an audit trail documenting sampling decisions, code development, and memoing throughout the study.

The qualitative strand drew primarily on phenomenology and interpretive phenomenological analysis (IPA), widely recognized as robust methodologies in oncology psychosocial research (18–20). The phenomenological orientation facilitated exploration of patients' lived experiences, particularly their emotional and spiritual coping mechanisms, while IPA allowed for in-depth interpretation of how resilience and subjectivities were constructed within clinical and familial discourses. Analytically, we combined first-cycle descriptive/emotion coding with second-cycle pattern/theoretical coding to link excerpts to subthemes and then to the integrated lenses (subjectivation, psychological, ecological). Disagreements were resolved through consensus meetings and peer debriefing.

Study Setting

The research was conducted at Undata General Hospital (RSUD Undata), a referral hospital in Central Sulawesi, Indonesia, serving a diverse population of cancer patients. Interviews were undertaken in private consultation rooms or quiet ward corners to protect confidentiality. Quantitative data from hospital records between 2019 and 2024 provided the service utilization context, while qualitative interviews were conducted with patients and caregivers in oncology units. This setting was chosen for its relevance as a representative LMIC oncology environment, where biomedical treatment intersects with cultural, familial, and spiritual coping practices.

Research Informants

A purposive selection strategy was employed to identify research informants, a common practice in qualitative oncology research designed to capture varied experiences (21,22). Nine informants participated: eight patients with cervical cancer at different stages of treatment and one caregiver. We sought variation in age, treatment stage, and occupational/family contexts to capture heterogeneous trajectories. Selection criteria included diagnosis of cervical cancer, willingness to share experiences, and ability to participate in semi-structured interviews. Caregiver inclusion ensured perspectives on family support and resistance were represented.

Recruitment continued until data saturation was reached, consistent with best practices in phenomenology and thematic analysis (21,22). Saturation was operationalized as the point at which no new codes emerged over two consecutive interviews and theme properties were stable during constant comparison. This ensured that recurring themes such as emotional distress, acceptance, spiritual coping, and micro-resistance were adequately documented.

Data Collection

Semi-structured interviews were conducted with each informant, lasting between 45 and 90 minutes, and were audio-recorded with consent. Interviews focused on experiences of diagnosis, treatment adherence, emotional and spiritual coping, and perceived social support. This approach aligns with international qualitative oncology research standards, where semi-structured interviews are considered the most effective means of capturing depth and nuance in psychosocial contexts (19,21,22). We obtained written informed consent for participation, audio-recording, and the use of anonymized quotations; participants were reminded of their right to pause, skip questions, or withdraw at any time without consequences for care.

In addition to interviews, field notes and limited observations in oncology wards were used to contextualize findings, documenting interactions between patients, caregivers, and healthcare providers. Observation checklists and reflexive memos captured contextual cues (privacy, family presence, religious practices) that informed interpretation and triangulation. This triangulation of sources enhances the richness and credibility of the qualitative data and meets the methodological expectations of reputable international publications.

Data Analysis

Interview transcripts were transcribed verbatim and analyzed using thematic analysis, guided by phenomenological and interpretive principles. Thematic analysis is a widely used approach in qualitative cancer psychosocial research, enabling the identification of key themes such as emotional support, informational guidance, spiritual coping, and resilience pathways (21,22). IPA provided deeper interpretive insight into how informants constructed meaning around resilience and how clinical discourses shaped their subjectivities (20).

Themes were iteratively coded, categorized, and refined until conceptual clarity was achieved. A subset of transcripts (≈30%) was double-coded by two analysts; intercoder discussions prioritized conceptual agreement over raw kappa, with discrepancies resolved by negotiated consensus. To ensure rigor, triangulation across informant interviews, caregiver accounts, and observational notes was employed, along with peer debriefing and maintenance of an audit trail (protocol versions, codebook iterations, analytic memos), enhancing the validity and trustworthiness of the findings (23–25).

RESULTS

Informants' Characteristics

Nine informants participated in this study, comprising eight women diagnosed with cervical cancer and one caregiver. Recruitment was purposive, ensuring heterogeneity across treatment stages, including early diagnostic engagement, initial chemotherapy cycles, long-term adaptation, and caregiver-mediated negotiation of care. This strategy facilitated the exploration of multiple experiential dimensions, ranging from rapid acceptance to delayed treatment, thereby highlighting not only individual agency but also systemic and cultural constraints. Each participant was assigned a pseudonym to protect identity, and contextual identifiers such as age, occupation, and village of residence were omitted or generalized to ensure anonymity.

Table 1. Informant Roster (Qualitative Interviews)

Subject	Code	Interviewee	Date/Time (WITA)	Status
1	MT	Patient	7 Apr 2025, 13:00	Early acceptance
2	UK	Patient	25 Jun 2025, 10:30; 10 Jul 2025, 12:41	Chemo; improved acceptance
4	FW	Patient	6 Jul 2025, 00:22; 16 Jul 2025, 10:22	Chemo; initial hesitation
5	IB	Patient	9 Apr 2025, 13:00	Workplace empathy
6	RM	Patient	28 May 2025, 10:11	Early shock; spiritual reframing
7	EL	Patient	18 Jun 2025, 10:28	Pain/fatigue management
8	YE	Patient	25 Jul 2025, 10:01	Family & clinician support
9	SS	Caregiver-mediated	25 Jul 2025, 11:36	Comorbidity; chemo refusal/delay

Description: Informants demonstrated heterogeneous illness journeys. Some transitioned toward acceptance through faith and family support, while others exhibited hesitation or refusal. This heterogeneity provided a rich lens to interrogate adaptation and resistance as multi-layered constructs.

Typologies of Social Support

Three forms of support—emotional, informational, and spiritual—consistently surfaced across narratives, whereas instrumental support was less visible. Families acted as emotional anchors by mitigating fear and despair. Clinicians functioned as the primary providers of informational guidance, shaping treatment decisions and adherence. Spirituality provided interpretive frameworks, enabling informants to situate illness within broader existential and cultural meanings. Instrumental support, operationally defined as tangible aid such as transportation, household help, or financial assistance, appeared less articulated—likely reflecting cultural expectations of reciprocity that render such help implicit.

Table 2. Support Types Evidenced per Informant

Subject	Emotional	Informational	Instrumental	Spiritual
MT	✓	✓		✓
UK	✓	✓		✓
FW		✓		
IB	✓	✓		✓
RM				✓
EL	✓	✓		✓
YE	✓	✓		✓
SS	✓	✓		✓

Description: The dominance of emotional and informational supports is consistent with cross-cultural psycho-oncology literature, where relational and communicative dimensions of care strongly predict resilience. Spirituality's centrality underscores cultural embeddedness, particularly in Muslim-majority contexts where faith informs meaning-making (15,26,27). These patterns substantiate the analytic interpretation that social and spiritual networks serve as both psychological buffers and socio-moral regulators shaping adaptive behavior.

Narratives of Emotional Support

The affective dimension of social support surfaced as a primary driver of resilience. Informants described how reassurance from family members and colleagues alleviated the psychological rupture following diagnosis.

IB (Patient): "My colleagues supported me; they allowed me flexibility at work. It made me feel I was not alone." **MT (Patient):** "When I first heard the diagnosis, I felt broken. But my family prayed with me and the doctor explained step by step what to expect. That gave me courage."

Such accounts reveal how affective networks recalibrated existential distress, providing the foundation for biomedical engagement. This finding resonates with studies showing that emotional ties not only buffer distress but also cultivate agency in negotiating treatment (28,29). Beyond personal comfort, these emotional networks created a socio-moral obligation to persist, demonstrating how social bonds extend resilience from individual to communal domains.

Narratives of Informational Support

Informational clarity proved decisive in shaping willingness to proceed with treatment. Fear, uncertainty, and resistance diminished when clinicians provided stepwise explanations.

UK (Patient): "At first, I was very afraid of chemotherapy. But after the nurse explained the process, I accepted it and now I feel stronger." **SS (Caregiver):** "She often cried and refused chemotherapy. We tried to convince her, but she resisted until the doctor explained again."

These accounts illustrate how trust was negotiated at the interface of biomedical authority and patient vulnerability. When information was timely, transparent, and compassionate, it catalyzed acceptance; when absent or delayed, it reinforced hesitation. These patterns echo global findings that underscore the importance of information delivery timing and participatory dialogue in oncology (30). The informants' narratives demonstrate that communication functions not only as a technical exchange but also as a discursive mechanism that shapes patient subjectivities. These accounts are analytically mapped to the ecological level, where clinician–patient dialogue acts as a structural determinant of resilience.

Narratives of Spiritual Coping

Spirituality was repeatedly described as a source of existential reorientation. For many informants, faith was not peripheral but central to adaptation.

RM (Patient): "It was very hard in the beginning. I thought of giving up, but then I prayed and believed this was God's will."

This narrative illustrates how suffering was reinterpreted as divine will, transforming despair into acceptance. Spirituality was not merely solace but a framework that aligned biomedical treatment with transcendental purpose. Such insights affirm international evidence that religious orientation functions as a coping system in oncology, especially within collectivist and faith-based societies (8,31). In this sense, spirituality was both a personal practice and a culturally embedded discourse that structured resilience across individual and communal levels. This subtheme corresponds to the spiritual-resilience dimension within the subjectivation lens, where faith discourse produces acceptance while delineating moral expectations of endurance.

Resistance and Negotiation of Normalization

Resistance emerged through treatment delays, refusal, or selective disclosure of distress. Informants FW and SS epitomized these dynamics. FW initially hesitated to undergo chemotherapy, while SS's caregiving narrative highlighted repeated refusals. These acts represent micro-resistances to biomedical normalization.

Such resistance was neither absolute nor pathological. Rather, it illustrated how power is contested and renegotiated in clinical spaces. Informants asserted agency by delaying, questioning, or reframing medical imperatives. This corresponds with Foucauldian perspectives, which conceptualize resistance as embedded within power itself, producing dynamic negotiations rather than unilateral compliance (30). The findings reveal that resilience is not linear but interspersed with contestations that reflect both vulnerability and autonomy. This theme bridges subjectivation and agency: participants' selective refusals exemplify micro-resistances that paradoxically reinforce and contest biomedical authority.

Integrated Themes

Synthesizing across informants, the results depict resilience as a trajectory from shock to gradual adaptation, punctuated by ambivalence and negotiation. Emotional reassurance provided the affective infrastructure necessary for endurance. Informational clarity facilitated cognitive reorientation, allowing informants to reframe biomedical procedures as manageable rather than threatening. Spirituality imbued experiences with transcendent significance, bridging biomedical imperatives with existential reconciliation. Yet resistance complicated this narrative, underscoring the ambivalent subjectivities of patients who simultaneously conformed to and contested medical authority. A schematic conceptual diagram (Figure 1) visually integrates the three analytical lenses—subjectivation, psychological, and ecological—showing how emotional, informational, and spiritual supports converge to produce negotiated resilience.

This multilayered construction of resilience aligns with broader scholarship that critiques reductionist views of resilience as an individual trait. Instead, resilience is understood here as discursively and socially constituted, embedded within networks of care, belief systems, and power relations (6,7,31). The integration of verbatim narratives demonstrates how resilience is not abstract but lived, performed, and negotiated within everyday encounters.

DISCUSSION

Interpreting Resilience Through Multiple Frameworks

The findings from this qualitative study underscore that resilience in cervical cancer care is not an innate, static quality but rather a socially constructed, multi-dimensional process produced through dynamic interactions of emotional, informational, and spiritual supports. Informants' narratives depict a trajectory that begins with shock and existential despair, which is gradually transformed into acceptance and adaptive coping through sustained familial reassurance, relational support, clinician communication, and cultural-spiritual practices. To interpret these complex trajectories, it is necessary to situate the analysis within three overlapping but distinct theoretical perspectives: resilience as subjectivation, psychological resilience, and ecological frameworks. Taken together, these perspectives provide a nuanced understanding that situates individual agency within broader discursive, relational, and structural environments.

Resilience as subjectivation emphasizes the ways in which power/knowledge relations in clinical and cultural contexts produce particular kinds of patient subjectivities. Informants' descriptions of being "strong," "obedient," or "accepting God's will" can be read as more than individualized coping strategies; they represent the internalization of cultural, biomedical, and religious discourses that privilege compliance, endurance, and the moral virtue of perseverance (16,32). Within a Foucauldian frame, these coping scripts reflect disciplinary processes that shape what it means to be a "resilient" cancer patient. The capacity to endure, accept, and comply is thus simultaneously an act of survival and an enactment of normalized subjectivity.

In contrast, psychological models frame resilience as a dynamic capacity rooted in individual-level resources such as self-efficacy, coping styles, and supportive relationships. These models are often operationalized through structural-equation modeling, linking resilience outcomes to variables such as spirituality and social support (6,9,10). Narratives from this study echo these frameworks: patients often drew on family support, informational clarity, and spiritual meaning-making to sustain adaptation and continue treatment. However, this study demonstrates that psychological resilience is co-produced within relational ecologies—families, clinicians, and workplaces—that either enable or constrain emotional regulation. Thus, resilience cannot be reduced to an individual attribute; it is embedded in broader social and institutional arrangements.

Ecological frameworks, such as the Social Ecological Model (SEM), broaden the analytic scope by situating resilience within multiple, interacting levels of influence: intrapersonal, relational, organizational, community, and policy (33,34). Informants' experiences vividly illustrate this ecological layering. Families provided affective scaffolding that softened the trauma of diagnosis. Clinicians shaped decision-making through the provision—or omission—of information. Workplaces either exacerbated or alleviated stress depending on their capacity for accommodation. Religious communities infused existential meaning through shared rituals and spiritual orientation. These multi-level dynamics indicate that effective resilience-building interventions must operate across levels—combining patient education, family counseling, clinician empathy training, and community-based spiritual engagement. Recognizing this ecological embeddedness is particularly crucial in LMIC settings where fragile health systems intersect with deeply rooted cultural frameworks.

The Role of Spirituality and Culture in Resilience

Spirituality consistently emerged across narratives as a central axis of resilience, functioning not merely as consolation but as a cultural and existential practice through which patients reframed suffering. Prayer, faith, and narratives of divine testing provided coherence to the uncertainty of illness, transforming despair into endurance and aligning biomedical treatment with religious purpose. These accounts resonate strongly with psycho-oncology scholarship emphasizing spirituality as a cornerstone of adaptation in LMIC oncology settings (8,14,31). This aligns with established frameworks of spiritual resilience and faith-oriented palliative care (e.g., Pargament et al.; Fitchett & Risk, 2022), which emphasize meaning-making, transcendence, and relational spirituality as adaptive mechanisms. The current findings extend these models by illustrating their cultural contextualization within Indonesian Islam, where sabar (patience) and ikhlas (sincere acceptance) are enacted as moral imperatives in coping.

From a psychological vantage, spirituality augmented resilience by strengthening personal meaning-making capacities. Patients articulated their perseverance as part of a broader narrative of divine will or spiritual trial, enabling them to accept biomedical procedures as integral to fulfilling religious obligations of perseverance. From a subjectivation perspective, however, these religious discourses not only sustained individuals but also produced compliant subjectivities. The dual role of spirituality—as both a coping facilitator and a normative disciplining force—highlights its ambivalence within psychosocial oncology. Embedding structured spiritual care within clinical pathways can transform this ambivalence into a constructive dialogue between faith and medicine. (16,32). Thus, spirituality is not solely an internal resource but a socio-discursive mechanism that shapes identity, agency, and clinical engagement.

Negotiating "Good Patient" Norms and Resistance

The moralized construction of the "good patient" emerged as a recurring theme in the data. Informants frequently described themselves in terms that aligned with cultural and clinical ideals of the compliant, persevering, and spiritually grounded subject. These narratives generated social validation, reinforced adherence, and enhanced self-conceptualizations of worthiness. Yet they also risked silencing authentic expressions of distress, since deviation from these ideals could be interpreted as weakness or moral failure. This mirrors findings from qualitative studies of oncology care in which normative discourses around strength and endurance constrained disclosure of vulnerability and reduced the willingness to engage in frank conversations about prognosis and suffering (28,30,35). Addressing these moralized norms through empathy-based communication training can help clinicians recognize emotional suppression cues and normalize patient expressions of fear or doubt.

Nevertheless, resistance was also visible. Informants who delayed or refused chemotherapy, questioned clinical recommendations, or selectively disclosed distress exercised micro-level forms of agency that disrupted dominant discourses. Such acts did not simply signify denial but were active negotiations within structural, emotional, and cultural constraints. Resistance thus functioned as an integral dimension of resilience, illustrating that resilience and resistance are co-constitutive rather than mutually exclusive. This aligns with Foucauldian understandings of power as diffuse and contested, where resilience involves not only compliance but also strategic contestation (30). Recognizing this ambivalence invites practical strategies: reflective dialogues, narrative consultations, and participatory care planning can create space for patients to articulate resistance without stigma, transforming it into collaborative agency.

Implications for Psychosocial Oncology in LMICs

The findings of this study hold significant implications for psychosocial oncology practice in LMICs. First, they highlight the necessity of moving beyond individualistic conceptions of resilience. Effective psychosocial support must acknowledge resilience as a socially produced process, mediated by cultural narratives, systemic inequities, and familial scaffolding. Clinicians need to engage with these realities by providing information in transparent, dialogic, and culturally sensitive ways, recognizing that inadequate communication often fueled patient resistance, whereas clarity and empathy promoted acceptance. To operationalize this, we propose a structured communication framework combining empathy training, narrative-based consultations, and participatory family dialogues—components adaptable to national oncology care guidelines.

Second, the findings underscore the importance of family-inclusive care. Families served as primary providers of emotional and spiritual support, often more influential than formal clinical encounters. Embedding family-support protocols—joint counseling sessions, pre-treatment briefings, and shared decision-making—can strengthen adherence and reduce psychological distress. Programs that intentionally incorporate family networks into psychosocial interventions may therefore enhance effectiveness and sustainability.

Third, spirituality must be integrated as a structural element of care. Far from being a peripheral coping mechanism, spirituality represented a central cultural resource through which patients sustained resilience. Institutionalizing this integration may involve trained hospital chaplains, referral pathways to faith leaders, and culturally tailored psycho-spiritual education for health workers. Such integration aligns care with patient values and may reduce resistance while enhancing engagement.

Theoretically, this study calls for the integration of subjectivation, psychological, and ecological models of resilience. Subjectivation analyses reveal the risks of discursive normalization and moralized compliance; psychological models provide insight into individual capacities; ecological frameworks situate resilience within multi-level contexts. Integrating these three lenses yields a composite framework for policy and practice: subjectivation informs ethical sensitivity, psychological insights guide therapeutic skill-building, and ecological analysis informs system-level intervention design. Together, these perspectives provide a comprehensive account of resilience suitable for intervention design, clinician training, and policy development in LMIC oncology.

Contribution to International Scholarship

This study contributes to psycho-oncology by bringing into focus the underexplored context of cervical cancer resilience in Indonesia. It extends Foucauldian analyses of subjectivation into LMIC oncology, demonstrating how resilience emerges through discursive practices embedded in medicine, religion, and family life. It also reinforces psychological and ecological perspectives by illustrating empirically how multi-level supports—from intimate familial ties to institutional and community networks—collectively construct resilience pathways. By foregrounding Indonesian epistemologies of endurance (sabar and ikhlas), the study aligns with global calls to decolonize resilience research and promote epistemic justice in psycho-oncology, ensuring that non-Western constructs inform theory-building and practice.

Importantly, the study highlights the ambivalence of resilience: while it promotes adaptation and adherence, it can simultaneously suppress disclosure, mask suffering, and enforce compliance. This paradox underscores the importance of conceptualizing resilience not as a singular good but as a contested and contextually situated process. By situating resilience within patient narratives, this research expands international debates by showing how resilience is lived, negotiated, and resisted in everyday clinical encounters. Future research should pursue multi-site, interdisciplinary, and interventional designs to test this integrated model across spiritually pluralistic LMIC contexts, enabling comparative and longitudinal evaluation of psychosocial outcomes. These insights are particularly significant for global health scholarship, which increasingly seeks to integrate psychosocial dimensions into oncology beyond the narrow confines of biomedical outcomes.

CONCLUSION

This study investigated resilience among women with cervical cancer and their caregivers in Indonesia, emphasizing how adaptation is constructed through social, clinical, and spiritual supports. The qualitative findings highlight that resilience is not an inherent trait but a dynamic and negotiated process shaped by family reassurance, effective communication with clinicians, and culturally embedded religious practices. Patients' narratives demonstrate both compliance with biomedical expectations and moments of resistance, underscoring resilience as an ambivalent phenomenon rather than a singular outcome. By integrating emotional, informational, and spiritual dimensions, the study advances an empirically grounded model of "socially embedded resilience," applicable to oncology settings across LMICs.

The main findings reveal that emotional reassurance and informational clarity provide critical foundations for adaptation, while spirituality offers existential grounding that reframes suffering into acceptance. These supports facilitate treatment adherence but also expose vulnerabilities, particularly when moralized norms of the "good patient" discourage disclosure of distress. The discussion situated these findings within subjectivation, psychological, and ecological frameworks, illustrating how resilience is simultaneously discursively produced, individually enacted, and structurally conditioned. This theoretical integration—visualized in the study's conceptual diagram—clarifies the mechanisms through which power, discourse, and emotion regulation intersect to produce both compliance and agency. It moves beyond individualist paradigms by operationalizing resilience as a relational and culturally mediated process.

The implications are significant for psychosocial oncology practice in LMIC contexts. Clinicians should prioritize dialogic and culturally sensitive communication, strengthen family-inclusive approaches, and formally recognize spirituality as a structural element of care. Implementing structured empathy training, narrative-based consultations, and chaplaincy-linked referral pathways can translate these insights into actionable practice. At the same time, policies and interventions should be attentive to how normative discourses may both empower and constrain patients. Recognizing resilience as a socially embedded process provides opportunities for more equitable and context-sensitive care strategies.

This study contributes to international scholarship by amplifying patient voices from a setting underrepresented in psycho-oncology research. It demonstrates that resilience is lived and contested within daily encounters, thereby challenging universalist assumptions and enriching global debates with insights from LMICs. By situating Indonesian experiences within frameworks of decolonizing resilience and epistemic justice, the research foregrounds non-Western moral vocabularies such as sabar (patience) and ikhlas (acceptance) as valid theoretical contributions to global psycho-oncology. Future research should pursue multi-site, longitudinal, and interventional designs to capture resilience trajectories over time, evaluate the efficacy of culturally responsive psychosocial interventions, and develop validated assessment tools integrating patient–caregiver dyads.

AUTHOR'S CONTRIBUTION STATEMENT

All authors made substantial intellectual contributions to this study. HS led the study conception, conducted interviews, and prepared the initial manuscript draft. JAL and AH contributed to the refinement of the theoretical framing, data interpretation, and substantive revision of the manuscript. MRN provided methodological oversight, guided analytic rigor, and supervised manuscript development. All authors reviewed, revised, and approved the final submitted version.

CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest related to the study design, conduct, analysis, or reporting of this research.

DECLARATION OF GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

In preparing this manuscript, the authors used ChatGPT to improve clarity, fluency, and technical consistency of the text. All AI generated suggestions were subsequently reviewed, verified, and edited by the authors to ensure factual accuracy, interpretive integrity, and originality. The authors retain full responsibility for the final content.

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