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Idioms of resilience among cancer patients in urban South Africa: An anthropological heuristic for the study of culture and resilience

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Abstract

Despite the large body of research on idioms of distress in anthropology and transcultural psychiatry, few scholars have examined the concepts that people use to describe social and psychological resilience. The experience of social and psychological resilience is embedded in and shaped by social, political, and economic contexts—much like the factors that shape idioms of distress. As resilience literature more broadly has adopted a socio-ecological rather than trait-based approach, anthropology has much to contribute. This article investigates what idioms of resilience and cultural scripts emerge among low-income patients with cancer residing in Soweto, a peri-urban neighborhood in Johannesburg, South Africa. We conducted 80 life history interviews to better understand what social and psychological factors led some people to thrive more than others despite extraordinary adversity. We describe one idiom of resilience, acceptance (ukwamukela in isiZulu), and three broader themes of resilience that emerged from life history narrative interviews (social support, religious support, and receiving medical care). We also present two examples from study participants that weave these concepts together. Our findings suggest that rarely is one form of resilience experienced in isolation. A focus on idioms of resilience can help chart the complex dimensions of acceptance and the dynamic social, religious, political, and temporal factors that mediate both suffering and resilience within individuals and communities.

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Introduction

Idioms of distress, as proposed by Mark Nichter (1981, 2010), convey the interpersonal, social, political, economic, and spiritual expressions of distress that are culturally constituted and situated within particular contexts. These idioms or modes of expression are "typically unquestioned normativity" (Hinton & Lewis-Fernandez, 2010, p. 211) that reveal culturally located norms, values, and practices that inform not only experiences with distress but also methods and patterns of care-seeking and healing (Guarnaccia, 1992; Kaiser et al., 2015; Yarris, 2011, 2014). Despite decades of inquiry into idioms of distress, few anthropologists have investigated the sociocultural dynamics that shape and promote positive health and well-being (Butt, 2002; Cassaniti, 2019, this issue; Herrick, 2017; Panter-Brick, 2015; Snodgrass, Dengah, Polzer, & Else, 2019, this issue) and the core concepts and expressions that reflect these experiences. We argue that the same adverse interpersonal, social, political, economic, and spiritual situations that elicit idioms of distress may also evoke a complementary range of resilient responses that anthropologists and transcultural psychiatrists have often neglected in their effort to understand social suffering.

This research gap exists against the backdrop of emerging multidisciplinary research that explores the factors that contribute to positive psychological adaptation in the face of adverse social conditions across the life course (Foxen, 2010; Lewis, 2013; Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014), a phenomenon commonly referred to as "resilience." Early research on resilience—pursued within the fields of psychology and psychiatry—focused on the individual-level traits and characteristics that shape an individual's ability to successfully cope with adversity despite living in poor social conditions. More recently, resilience research has adopted a socio-ecological and processual approach, examining contexts that shape positive outcomes despite adversity at the level of individuals, families, societies, and cultures (Luthar, 2015; Ungar and Liebenberg, 2011). Anthropological studies of stress, coping, and health highlight relational, societal, and structural dynamics that undergird both suffering and healing (Bourgois & Schonberg, 2009; Farmer, Walton, & Tarter, 2000; Lewis, 2013; Manderson & Smith-Morris, 2010; Mendenhall, 2012; Mullings & Wali, 2001), and the field is ideally suited to advancing resilience research. Nevertheless, only a few anthropologists have studied the processes that underlie psychological resilience (e.g., Eggerman & Panter-Brick, 2010; Foxen, 2010; Kaiser, 2015; Lewis, 2018, 2019; Mullings & Wali, 2001; Obrist & Büchi 2008; Ulturgasheva, Rasmus, & Morrow, 2015; Zraly & Nyirazinyoye, 2010). Attending to the full spectrum of subjective experiences of health and well-being can helps us understand the social factors that facilitate "resilience" and the complex cultural and sociopolitical dynamics that situate and structure disparities among individuals' responses to adversity. We propose an extension of the idioms of distress framework to explore the culturally significant ways of experiencing and expressing resilience in a given cultural context.

In this article, we analyze some social factors and cultural contexts that facilitate positive outcomes amidst a range of adversities by offering the heuristic of an "idiom of resilience." This article first describes the cross-disciplinary and anthropological research on resilience, explores its numerous conceptualizations, and complicates existing notions of resilience in cross-cultural settings. We then integrate these interdisciplinary perspectives with the idioms of distress framework to propose the idioms of resilience concept and describe its conceptual and methodological contributions in the pursuit of a more culturally grounded study of resilience. Finally, we critically consider the concept and future directions for the anthropology of resilience. We illustrate the application of the idioms of resilience heuristic by analyzing narratives from a sample of cancer patients living in the Soweto township of Johannesburg, South Africa.

Theorizing resilience: Anthropological and interdisciplinary perspectives

The concept of resilience was first explored by developmental psychologist Norman Garmezy in the 1970s to describe the lack of mental illness among healthy children born to mothers experiencing severe psychopathologies (see Garmezy, 1971, 1991; Rolf, 1999). This unexpected outcome led Garmezy and a cadre of future psychologists to examine the reasons behind this paradoxical outcome, later dubbed "resilience." Since then, borrowing from the fields of engineering, environmental science, and ecology (Brown & Westaway, 2011; Nelson, Adger, & Brown, 2007), an extensive research literature on psychological resilience has emerged but has yet to provide a uniform definition of the concept. This is unsurprising due to varying theoretical and disciplinary orientations, units of analysis (ranging from the individual to societies), and systems of inquiry (e.g., neurobiological plasticity, psychological development) (Panter-Brick, 2014; Quinlan, Berbés-Blázquez, Haider, & Peterson, 2016). However, the common thread that runs through different conceptualizations and operationalizations of resilience is the process of positively adapting to a single insult or to sustained adverse conditions (Fletcher & Sarkar, 2013).

Dominant psychological, psychiatric, and biomedical perspectives tend to view resilience as a universal and cross-culturally valid psychological response to trauma and adversity (Ungar, 2005), often characterized as a static trait (Bensimon, 2012; Connor & Davidson, 2003; Hu, Zhang, & Wang, 2015). Research suggests that resilience is strongly tied to interpersonal experiences and social context (Luthar, 2015), is sensitive to developmental processes particularly in children and adolescents (Masten & Obradovi, 2006), and involves socio-ecological and cultural processes (Fletcher & Sarkar, 2013; Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011; Lewis, 2013; Ungar, 2008; Wexler, DiFluvio, & Burke, 2009).

An anthropological lens extends process-oriented and socio-ecological approaches further, to trace how individuals and communities cultivate resilience by drawing on cultural and collective resources and meanings (Kirmayer, Sehdev, Whitley, Dandeneau, & Isaac, 2013; Wexler, 2013; Wexler, Joule, Garoutte, Mazziotti, Hopper, 2013). Here, the anthropological approach incorporates an understanding of life trajectories—from the physical realities of facing adversity, to the social, economic, and cultural factors that foster strength, hope, and joy amidst difficult times (Panter-Brick & Eggerman, 2012). For example, Zraly, Rubin-

Smith, and Betancourt (2011) illustrate how the social role of motherhood bolsters resilience among Rwandan genocide-rape survivors through reducing the stigma of rape, fostering positive emotions and reasons to live, and practicing tolerance. Furthermore, anthropological scholarship has drawn attention to political-economic forces as part of intersectional forms of oppression individuals or communities face. For example, Aimee Cox (2015) has traced how Black women in Detroit experiencing homelessness contest marginalizing stereotypes and exercise creative and non-normative solutions to simultaneously combat poverty, anti-black racism, and sexism in their lives. Additionally, in their study of Afghan adults and children, Mark Eggerman and Catherine Panter-Brick (2010) have described how cultural values like living an "honorable life" (*izzat* in Dari and Pashto) bolster resilience through helping individuals develop a sense of order and meaning to life—even though adherence to such values in the face of material poverty and educational insecurity was ultimately futile, forcing individuals to experience "entrapment," with intense social frustrations brought about by failure to attain cultural milestones.

A second major contribution from anthropology illuminates how collective and cultural ways-of-being shape how people are resilient (Kirmayer et al., 2011; Mullings, 2005; Tobin & Whiteford, 2002; Ulturgasheva et al., 2015), moving beyond predominant resilience research that is "western-based with an emphasis on individual and relational factors" (Ungar, 2008, p. 218). The formation of meaning-making processes that structure resilience is specific to the social histories and cultural systems through which expressions of resilience emerge. For example, Foxen (2010) describes how the K'iche' Mayan community in Guatemala draws on collective memories of successful community resistance against violent land claims and government militarization to heal from historic trauma and stay resilient to future political oppression. Ultimately, it is important to recognize that what fosters resilience for one individual, community, or population cannot be directly applied to another. Significantly, cultural examinations of resilience clarify how seemingly negative or maladaptive reactions to adversity may in fact be processes of resilience that contribute to long-term adaptation. For example, Lewis (2018) describes how Tibetan exiles enact the cultural practice of mind-training (*lojong*) and create more "flexible minds" to accommodate change, distress, and negative emotions. While it may seem that Tibetan exiles are merely coping with the extraordinary violence and suffering in their lives, learning to train one's mind to better deal with adversity fulfills religiously-motivated goals of repaying one's karmic debt and ultimately achieving Buddhist cultural values of happiness.

As these examples suggest, anthropological research can offer multiple theoretical and methodological approaches to understanding how culture shapes resilience. Following these cross-cultural investigations, in this article we will consider resilience as a positive response to adverse situations—whether chronic or acute—which can be achieved by drawing on personal, cultural, social, political, and economic resources.

Idioms of resilience: An anthropological heuristic

We define idioms of resilience as socially meaningful and culturally resonant means of experiencing and expressing positive adaption and well-being in the midst of adversity. They might include forms of positive coping, thriving, and locally situated support systems.

Idioms of resilience highlight the culturally salient processes that individuals use to cope with the complexities they face in their local worlds. Culturally salient expressions of resilience, which also may be conceived of as cultural scripts that people use as a source of resilience, can serve as social markers used to uncover processes that may be otherwise unrecognized or undervalued by the clinician or researcher (Luthar, 2015).

The notion of idioms of distress has been an effective heuristic to identify the wide variety of multi-domain sources and manifestations of distress that are both culturally salient and socially patterned within a given cultural context. Idioms of distress are not only limited to linguistic utterances but also have included a wider array of semiotic expression such as clinically-relevant behavior patterns (e.g., health-care seeking, medication-taking behaviors), particular forms of cultural practice, and coping mechanisms (e.g., smoking, drinking) (Nichter, 2010). Similar to the diverse communicative functions of idioms of distress, we recognize that idioms of resilience can manifest through a wide variety of cultural expressions via language and behavior.

Attention to idioms of resilience can also enrich cross-cultural clinical practice and health promotion by identifying culturally salient resources that structure the process of healing. Idioms of resilience may index certain perspectives of disease or health practices that are individually and culturally understood to promote healing and well-being but that are not considered in biomedical models of disease or are viewed negatively. For example, supernatural expressions of health and illness are typically seen as barriers to healthcare-seeking by humanitarian practitioners in rural Haiti (Khoury, Kaiser, Keys, Brewster, & Kohrt, 2012), but Kaiser (2015) suggests that concepts like "sent spirits" may be protective for well-being and need to be integrated for a more culturally sensitive approach to global mental health.

Attention to idioms of resilience can serve the theoretical and methodological interests of multiple fields and provide an innovative way to understand points of intervention related to how individuals uncover ideas, reasons, and motivations to seek certain types of care within a pluralistic healthcare system. For instance, an idiom of resilience can serve as a methodological tool to develop culturally specific assessments of determinants and dimensions of resilience (e.g., Rasmussen, Katoni, Keller, & Wilkinson, 2011; Weaver & Kaiser, 2015). In what follows, we apply the "idiom of resilience" heuristic to explore the concept of resilience through life history interviews with cancer patients.

Methods

Research setting

Study participants were mostly from Soweto, a prominent township or peri-urban neighborhood on the southwest side of Johannesburg, South Africa. The expansive land-locked city of Johannesburg is the largest city in South Africa, with nearly 8 million people. Nested in the Witwatersrand, Johannesburg was founded in 1886 for its minerals, especially gold (Thompson, 2001). In the early 1900s, an explosion of industrial opportunities, in the mining industry in particular, attracted many rural Black[1] workers and increased urban Black populations by nearly 94 percent, drawing people from agricultural, rural landscapes

to industrial, urban ones (Crais & McClendon, 2014). Many of those who worked in the gold mines resided in Johannesburg, although most were evicted by the British in the early 1900s and relocated to segregated townships (Thompson, 2001). Soweto was a major site of state-sanctioned violence and anti-apartheid resistance during the latter half of the apartheid regime. As a form of resistance to state-sanctioned violence by apartheid, Soweto was organized by the incorporation of six distinct townships to build political representation. Today, Soweto represents more than 1.2 million residents of diverse socioeconomic and ethnic backgrounds, representing multiple histories and language groups, including isiZulu, isiXhosa, Setswana, Sesotho, and Xitsonga. The complex and multiple cultural heritages within Soweto have meant the township has cultivated its own cultural vitality, with many residents spending most of their lives there and integrating multiple languages and traditions into their everyday life. This ethnic and linguistic diversity was represented by our study participants as well, with most people speaking isiZulu, with English, and many speaking two or more languages, even within the same interview. Due to its relative wealth and ethnic diversity, Soweto continues to be a major political and organizing center (Zuern, 2011).

Our study was conducted at the Developmental Pathways for Health Research Unit (DPHRU) at the Chris Hani Baragwanath Hospital ("Bara"). The world's third largest hospital and Africa's largest, Bara is a publicly financed teaching hospital for the Faculty of Health Sciences at the University of the Witwatersrand and others. One building on Baragwanath Hospital's vast campus is the headquarters of DPHRU, a research unit at the University of the Witwatersrand that has conducted research in Soweto and with many of its residents since the early 1990s.

Sample

Data come from interviews conducted for a larger study focused on exploring the social experiences of Black South African men and women with prostate and breast cancer, respectively. Our focus on cancer patients, most of whom had co-morbidities, allows us to investigate the concept of resilience among a group of patients who faced major medical challenges. Fifty women who had been diagnosed with and treated for breast cancer were recruited from the South Africa Breast Cancer (SABC) study. Fifteen women were additionally diagnosed with hypertension and another 15 were diagnosed with HIV. Thirty men who were diagnosed with and treated for prostate cancer were recruited from the Men of African Descent with Carcinoma of the Prostate Consortium (MADCaP) study. Of these men, nine had cancer but not hypertension or HIV, 13 had hypertension, and eight had HIV. Because we recruited participants from ongoing cancer studies, participants were already receiving routine cancer treatment at Bara and had frequently been interviewed at DPHRU. Most sought care at Bara or outlying community clinics, and only some supplemented this with care at private clinics. All had received care from the public system most of their lives.

While early detection of breast and prostate cancers is not uniformly observed throughout South Africa, in Soweto screening is quite effective, meaning that many are identified early

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[1.]We use the racial category "Black" here, despite its problematic origins, because it is a common political category employed in South Africa; however, diverse ethnicities and languages exist within this racial category, in addition to the plurality of experiences in many urban centers.

enough for treatment to be successful. Treatment usually involves some combination of radiation, chemotherapy, and surgery; 70% of all patients undergo surgery combined with eight treatments of chemotherapy spaced every three weeks. In Gauteng (the province including Soweto and Johannesburg), 50% of patients are detected with late stage cancer (Cubasch et al., 2013), compared to 70% of those patients detected elsewhere in South Africa. All patients involved in this study had their breast or prostate cancer identified before it was too severe to treat; those with advanced stage cancer and those with untreatable cancer were excluded from the study in order to respect their privacy and health.

Life history interviews

Our study participants were familiar with our research unit because they were enrolled in studies associated with the unit and we employed staff from the SABC study and MADCaP study to work on this project. These colleagues contacted our study participants and invited them for life history interviews. A DPRHU staff member picked up study participants from their homes and then drove them home after participating in the study.

We conducted 80 life history interviews lasting between two and three hours, between June and August of 2017. Three women conducted the interviews with women, while two women and one man conducted the interviews with men. Of the 50 interviews with women who had been diagnosed with breast cancer, 29 were conducted primarily in English (56%), while 13 were conducted primarily in isiZulu (26%), four in isiSotho, two in isiXhosa, and two in Setswana—many involved a combination of two languages (mostly English and one other). Of the 30 interviews with men who had been diagnosed with prostate cancer, 15 were in IsiSotho (50%), eight in IsiZulu (27%), five in English (17%), and one each in Tswana and Tsonga. We have listed here what language was primarily used in the interview, but many interviews involved a mix of languages (for most English was a secondary language); this created some complexity when identifying idioms. Although this may be uncommon in other settings, in Soweto neighbors converse regularly in multiple languages, sharing ideas and terms within and between their linguistic groups. We therefore interpreted the concepts and idioms associated with resilience in terms of "cultural scripts" that exist within and between the common languages through which people in Soweto converse.

Interviews consisted of life history narratives that addressed family life, stress, chronic illness, co-morbidity, healthcare experiences, and resilience. Targeted questions about resilience were elicited using the following scenario:

> Imagine a person named Sibongile, a middle-aged adult from Soweto who experienced a severe car accident six months ago. Today she is back at work, functioning fine, and not too stressed. Now imagine another person, Grace, also a middle-aged adult from Sophiatown who went through a similar car accident but is continuing to experience a number of health problems, such as migraines, aggressive behavior, and anxiety. What might be the reason that they had different outcomes?

We also probed into how these individuals were able or unable to cope or recover (e.g., What were the main differences between Grace and Sibongile? What helped Sibongile do well after her accident? Why did Grace experience these symptoms after her accident, even

though it was similar to Sibongile's car accident?), and asked them to think about people in their community who may reflect these examples (e.g. Do you know anyone like Grace or Sibongile in your life? Why do you think they reacted well or poorly? What causes people to do well and stay healthy when life is hard?). We also conducted a resilience survey, which was highly problematic and is discussed elsewhere (Mendenhall & Kim, 2019). We then inquired about previously diagnosed disorders and conducted a sociodemographic questionnaire. Study participants were compensated 150 ZAR for their time. All data collection received clearance by the University of the Witwatersrand Human Ethics Committee (Clearance number M170414), and all participants provided informed consent.

Data analysis

Because the interviews were conducted in multiple languages (even within the same interview), all interviews were audio-recorded and transcribed directly into English by a third-party translation company that deals with complex, multiple-lingual dialogue common in contexts like Soweto. Following each interview, the research team wrote extensive field notes summarizing major themes and to communicate any non-verbal interactions or dialogue that was not recorded. Several members of the research team (including AWK, EB, KS, and EM) met to generate themes related to resilience from field notes (including the idioms and cultural scripts). The research team members proposed codes, provided definitions, and then reviewed and revised codes based on mutual agreement. The first and third authors (AWK & EB) applied these codes to field notes and interview transcripts separately and then together. In order to identify potential *idioms* of resilience, we used Dedoose qualitative analysis software (Dedoose, 2019) to conduct axial-coding within the major sub-themes in the life history interview. This narrower analysis of the sub-codes provided a nuanced understanding of the ideas embedded in and around each idiom, focusing mostly on concepts as opposed to explicit terminology because many people in Soweto speak multiple languages.

Results

Participants comprised two distinct groups by gender and cancer type (Table 1). Most participants experienced some form of co-morbidity, and we explicitly recruited some cancer survivors with HIV, hypertension, or neither HIV or hypertension.

We found culturally scripted meaning within the interviews, whether they were conducted in isiZulu only, a combination of isiZulu and English, or a combination of three or more languages. This made the analysis of "idioms" complicated; however, because of the decades of incorporation and continuous settlement of Soweto, and the largely static population (despite different ethnic lineages), we believe that the concepts conveyed around resilience, and even the idioms employed, are congruent within the sample (and not divergent due to linguistic preference). Four themes of resilience emerged from life history interviews: acceptance, social support, religious support, and medical care. Men and women described these themes in different ways, perhaps in part because of their different types of cancer diagnoses and experiences as well as differences in age (men were older). Here, we contextualize these themes through two narratives that were chosen as exemplary: Margaret

(Panel 1), a 40-year-old woman with breast cancer and HIV; and Thomas (Panel 2), a 71-year-old man with prostate cancer and hypertension.

Acceptance (ukwamukela)

Acceptance, or *ukwamukela*[2] in isiZulu, was the most frequent and clearest idiom of resilience expressed across the interviews. Half of the interviewees—both men and women—discussed the role of acceptance in their narratives (Table 2). Ukwamukela and "acceptance" (or the verb "accept") were used in both IsiZulu and English interviews, respectively. The idiom "ukwamukela" was only used in isiZulu-based interviews, while "acceptance" was mainly used in English-based interviews. While the idiom of acceptance may reflect a broader cultural script that is inclusive of the unique linguistic complexity of our interlocutors, we describe these terms as idioms because of their frequency of use and generalizability as a concept in Soweto. Multiple dimensions of acceptance emerged and varied depending on the conditions that individuals faced. Across interviews, acceptance was most commonly discussed in response to the scenario that asked participants to explain why individuals experienced different outcomes after a car accident. Participants explained that Sibongile, the hypothetical "resilient" subject in the car accident scenario, did not exhibit any injuries or distress after the accident because she recognized the event of the car accident, acknowledged the bodily and mental injury she endured, and accepted the effects these events had on her life. Additionally, in response to questions that explored how they responded to their diagnoses and managed their diseases, participants repeatedly described practicing acceptance as a strategy to effectively cope with the experiences of cancer and other illness experiences they faced, including responses to clinical diagnoses, the physical and mental repercussions caused by disease and illness, and the impacts on everyday life.

The idiom of "acceptance" was commonly tied to the concept of acquiescence when speaking about their illness. Individuals frequently described that nothing could be done about their diagnosis, which seemed to protect them against experiencing future distress and exacerbated symptoms. As one participant described:

> You think about things that aren't quite good for your health, like things that you can't get hold of or things you can't own, or you live in other people's shadows, or I want to be like but I'm not able to. If you stop thinking about the impossibilities and accept life as it comes, then things will get better.

This mode of acceptance through acquiescence is also exemplified in Margaret's ability to cope with her past miscarriage, which she explains is a result of the uncontrollable, chance experiences of everyday life—"what happens will happen" (Panel 1). Additionally, viewing the disease as manageable positively influenced the ability to accept one's diagnosis. Interlocutors were more likely to accept their disease when their doctor informed them that their condition was not fatal but was manageable through treatment.

Finally, acceptance was commonly described in relation to the consequences of failing to accept an adverse situation or condition. The common idiom of distress caused by "thinking

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[2]·While interviews were conducted in five separate languages, we only report the Zulu translation for "acceptance" because this was the most spoken non-English language used in the study.

too much" was frequently described as a potential consequence of failing to accept a condition and a lethal driver of poor health. Most individuals described this in reference to the car accident scenario. For example, most interlocutors explained that Grace, the "non-resilient" subject, was affected by her injuries because she continued to think too much about the accident. Our interlocutors often explained the effects of "thinking too much" and acceptance in terms of ethnophysiological processes, or "the culturally-guided apperception of the mind/body rather than actual biological differences" (Hinton & Hinton, 2002, p. 161), particularly in response to questions that asked how individuals dealt with stress. If individuals internalized a negative experience, the adverse experience or stressor was understood to affect the mind and the heart, two important loci involved in stress in this sample, making the individual vulnerable to symptom exacerbation and poor health outcomes (see Panel 2).

Interestingly, while this ethnophysiological understanding of the consequences of embodied stress was very prevalent among men, women rarely described acceptance in terms of bodily consequences. The following excerpt from a 77-year-old man living in Soweto describes this ethnophysiology in detail:

> They differ in their minds and in accepting what happened to them. One accepted what happened to them. The one who's sick didn't accept what happened to them. If something happens to you, you need to take it out of you and talk about it, but if you don't talk about it and bottle it up in your heart, that's when you don't accept… If you don't accept things like Grace, you won't be happy in life and will develop illnesses. Illness develops because you are not talking to other people, seeking help, and it changes your behavior.

The narratives revealed a recurrent pattern of effective coping through acceptance with two distinct and interacting cognitive pathways (i.e., acquiescence). Further study of this idiom might provide insight into a larger cognitive model of mind-body interactions that situates the idiom of acceptance in a network of psychophysiological dynamics involving other constructs of psychological experience (i.e., "thinking too much") and ethnophysiology (i.e. "heart" and "mind").

Social support

The family and friends that surround and support our interlocutors emerged as an important theme reflecting resilience. We coded for both familial and non-familial modes of social support, but we have grouped these together because they were enacted in similar ways and associated with similar outcomes: feeling supported by family, caretaking, talking with others, and financial support. However, we treat these findings on social support as themes of resilience rather than idioms, per se, because they lacked a common, distinctive mode of expression, either linguistically or behaviorally. Instead, we view these *themes* of resilience as potential concepts from which idioms of resilience may emerge in other cultural contexts.

Family support was the most commonly expressed process of resilience and served as an important social, emotional, and financial resource for our interlocutors. Interlocutors typically described instances of family support when describing their relationships with their family, their experiences with stress and disease management, responses to the car accident

scenario, and their most important sources of support. Specifically, feelings of closeness to one's family were seen to both buffer against stress and increase an individual's capacity to cope with stress. As one participant put it, "when we are in unity, nothing can destroy unity." Caretaking was also a frequent method of social support by family members. This included encouraging participants to follow their medication regimen, feeding them, and providing emotional support. In one case, a participant attributed his ability to accept his illness and, more importantly, eliminate the presence of suicidal thoughts to his family's constant support while he was hospitalized and during his recovery. The vital role of family support in promoting positive health was similarly seen in responses to the car accident scenario, where Sibongile was believed to have walked away with better health outcomes than Grace because of the social support she received.

Additionally, talking with others about stressful experiences was another important form of social support that also seemed to be connected to ethnophysiological processes involved in the process of acceptance. The practice of social support often meant family and friends would speak about and talk through distressing thoughts, and in doing so enable the interlocutor to avoid feelings of loneliness and despair. Interlocutors feared being alone while experiencing an illness or chronic social stress because of their tendencies to ruminate on their conditions and "think too much," which was understood to further exacerbate their already poor health and well-being (see Panel 2). "When you're alone, you don't have people to talk to and you become stressed," as one participant noted. Additionally, speaking with other patients who had cancer or other conditions was helpful for our interlocutors to normalize their experience and offer advice to others. In many cases, this involved someone who was a role model, or had had cancer and recovered previously, serving as a source of hope and strength. While "talking with others" emerged as a frequently occurring theme of resilience, interlocutors did not express similar linguistic or behavioral manners of speaking to others across the interviews to be considered an idiom of resilience. Finally, social support frequently co-occurred with financial support, which protected individuals from further financial distress and served as an additional source for procuring necessary resources.

Religion

Speaking to God and attending services and community events at a church served as common and powerful sources of resilience. Participants described these experiences more frequently in response to questions regarding managing stress, important sources of support, and their reactions to their diagnoses. Overall, three in five people described religion as a source of resilience. Half of the women and more than half of the men described engaging or believing in a religious community to reflect the concept of resilience. For instance, many believed that a higher power, specifically God, gave them strength and was able to grant them serenity throughout their cancer treatment. In this way, how people described feeling calm as a result of some form of religious faith or practice, despite the stress of cancer treatment, was a powerful mode of resilience. One participant stated, "I survive because of Him." Others described their faith as driving them throughout this time. As one adult male participant described in his explanation of how he perceives his illness, "he puts his faith in his heart and knows that Jesus knows everything." And, at times, people described prayer and attending church services to cure individuals of illness. This is clearly seen in the

vignette provided in Panel 1 from Margaret, who strongly professes the ability of faith to heal individuals experiencing disease and illness: "if you put yourself in God's hands." Participants often oriented their explanations of the onset of and experience with disease and illness in terms of the work of God. Finally, some interlocutors received social support through relationships with friends, religious groups formed within the church, and pastors.

Medical care

Medical care was often described as central to resilience. For instance, one woman stated, "if you take treatment, you survive." Medical care was most often described in response to questions regarding reactions to diagnoses, most important forms of support, and treatment processes. Most men (80%) and women (74%) reported that medical care enhanced their ability to cope with their cancer diagnosis. Interlocutors frequently praised the positive effects of medication use on mitigating their symptoms of prostate cancer, such as improving urination, easing physical discomfort, and improving their ability to follow their clinical recommendations for self-care. For example, one elderly man exclaimed: "I feel like I don't have cancer" because of the benefit he perceived from his medication, which allowed him to manage his symptoms.

A strong sense of institutional trust in medical attention from the doctors and nurses at Bara was also widely evident. Many people perceived doctors to be "good" people who put their patients' needs first. Participants often expressed unwavering belief in the value of seeking medical treatment at clinics and hospitals and in following prescribed regimens (despite the fact that many had grievances about systemic barriers to care-seeking for other conditions, such as diabetes or hypertension).[3] These statements of trust and confidence in biomedicine were presented without mentioning alternatives for cancer treatment, such as traditional healers (sangomas), and in some instances interlocutors explicitly stated that they did not seek care from sangomas for cancer treatment. Trust in the efficacy of medical care was also evident in participants' responses to the car accident scenario, as interlocutors often explained that seeking medical treatment and receiving quality medical care led to Sibongile's fast recovery and lack of physical and psychological sequelae. Both Margaret and Thomas exhibited a deep sense of trust in their clinical care due to the perceived effectiveness of their respective modes of medical assistance and the mere fact that they were receiving medical care from biomedical providers. As Thomas states, "[i]f you are under a doctor, you are getting good help."

Discussion

This article is among the first to elaborate the concept of "idioms of resilience" as an heuristic to identify and explore the cultural scripts and processes that represent modes of resilience. In doing so, we have applied this heuristic to the experience of cancer patients in a peri-urban South African context. We report on one major idiom of resilience, acceptance

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[3.]Women's narratives of trust in medical care, despite their fears of chemotherapy, may be in part because of a very committed team of physicians who work on the South African Breast Cancer Study at Bara. They are known for having short wait times and few delays for surgery after one is diagnosed with breast cancer. However, this is not the norm within Johannesburg, or more broadly across South Africa.

(in isiZulu, *ukwamukela*), among a sample of recently diagnosed cancer patients across age, gender, ethnicity, and class backgrounds, and identify three major themes in discussion of resilience: social support, religion, and medical care. While these three themes emerged as salient resources or processes that shaped one's ability to be resilient to cancer treatment, poverty, and social adversity at large, we could not clearly identify common, culturally resonant factors within each theme that would constitute a distinct idiom of resilience. In what follows, we critically discuss the themes and idioms of resilience that emerged from the life history narrative interviews and situate them within the broader literature on resilience, coping, suffering, and survival. Finally, we suggest how scholarship on resilience, and the idioms people use to express it, may be applied anthropologically.

Scholarship on resilience suggests that the idioms or cultural scripts people use, such as hope or compassion, convey how people generate strength within suffering, not in spite of it (Kirmayer et al., 2011; Kirmayer, Gone, & Moses, 2014; Lewis 2013, 2018; Mendenhall & Kim, 2019; Trout, Wexler, & Moses, 2018; Wexler, 2013; Zraly & Nyirazinyoye, 2010). The cultural scripts people use in Soweto show how they manage the multiple and overlapping social and medical conditions in their everyday life through the idiom of acceptance and the additional practice of unburdening themselves in medical, family, and religious settings so that they can acknowledge hardship and move beyond it. Ethnographic insights into how people perceive and produce idioms of resilience are fundamental to developing a broader understanding of concepts from place to place. Such an approach supports the shift from a focus on individual traits to recognizing the broader social, cultural, and political factors that affect what makes people "resilient." Many of these also involve relationships with members of a congregation and God that underlie religious involvement, underscoring overlap and messiness in separating what comes from the "social" versus "spiritual" worlds people navigate in their everyday lives. Our data also underscore the importance of feeling heard and supported by the biomedical community: the clinical guidance cancer patients received from counselors, nurses, and doctors cultivated a strong sense of both self and survival in relation to their life-threatening condition. For example, the strong social relationship between Thomas and his wife and his sustained clinical interaction with his psychiatrist enabled him to unburden himself from the major stressors in his life by frequently talking through his problems with his family and sharing his emotions.

One area of theoretical concern that we pose to future research of resilience is the conceptual difference between coping and resilience. Resilience is a related but distinct concept to coping, which psychologists define as "[c]onstantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person" (Lazarus & Folkman, 1984, p. 141). Resilience differs from coping in that coping does not always produce favorable outcomes (Beasley, Thompson, & Davidson, 2003). Parsing out the differences between these two constructs can help researchers and practitioners establish greater conceptual clarity in existing theoretical frameworks of resilience and identify particular qualities of psychological, social, and economic resources that may differentiate the appraisal of social stressors and trajectories of positive adaptation.

Idioms of resilience in context: Acceptance, culture, and temporality

By examining how the notion of "acceptance" serves as an idiom of resilience, we have tried to unravel the cultural dynamics that structure, produce, and give meaning to ukwamukela. We first emphasize here that acceptance is a process, which is necessarily shaped by the collective factors that produce resilience in spite of extraordinary social adversity—Soweto has one of the highest rates of HIV in the world and multiple challenges linked to income, illness, and healthcare. This process of resilience reflects a cultural script of letting go through acceptance. The embodied experience of accepting one's "fate," typically in relation to a disease diagnosis, injury, or social stress, facilitated a positive way of coping with the challenges people diagnosed with cancer face in Soweto. Despite intensive treatment following what was often a delayed diagnosis of cancer, interlocutors were less focused on their cancer and other medical conditions, than on family and social priorities. The idiom of acceptance allowed people to shift their attention away from their own social or medical problems—which for many were multiple—to focus on family members, neighbors, and religious community.

Our interlocutors described how social support from individuals like family members, friends, church members, and, in particular, a higher being (God) facilitated their ability to avoid "holding in" stress by "letting go" of these concerns and eventually accepting their circumstances. This process of acceptance was not associated only with their cancer diagnosis but also with other challenges and traumatic events such as a car crash, family troubles, financial problems, other medical conditions, and so on. Receiving medical care played a similar salutogenic role as social support by allowing people to "let go" of their embodied social stress. The fact that many participants described releasing distress and worry as a form of prevention from disease explained how closely people interpreted the experience of internalizing social stress with materialization of problems in the brain and heart. Understanding the process of cognition through which people perceive acceptance and the release of negative emotion as a form of disease prevention may be beneficial for clinical practice (see Karekla & Constantinou, 2010). Notwithstanding, the roles of social relationships, religious belonging, strong family bonds, and other communities of care in facilitating cancer patients to ultimately accept disease diagnosis could be relevant for clinicians and public health practitioners to promote medical adherence and reduce stigma.

While the acceptance of something like cancer may seem like an expression of fatalism, and thus surrendering to hardship, the utility of acceptance as a tool for resilience is illuminated by situating it in a larger explanatory model and cultural context. Those who did not accept their present state of adversity were thought to develop a suite of stress-related diseases like depression and "high blood" (a cross-cultural idiom for high blood pressure and/or hypertension) (Fairhead, Leach, & Small, 2006; Snow, 1976). Individuals who accepted their cancer diagnosis or injury appeared to have fewer physical and psychological symptoms, such as "thinking too much," and thus appeared more resilient to the deleterious embodied impacts of internalizing distress associated with a new diagnosis and the experience of cancer.

Similar to the particular meanings that arise through a greater sensitivity to culture, examining acceptance through various temporal frames, both separately and simultaneously,

offers multiple historical, social, and political meanings to the significance of this idiom of resilience. In other words, attending to the multiple time-scales of risk and resilience recognizes the numerous challenges individuals and groups, particularly marginalized communities, face in a single moment. For example, in his discussion of Mapuche in southern Chile responding to disaster, Atallah (2016) argues that an exclusive focus on resilience to major disasters obscures the complex and lasting legacies of systemic marginalization and the "daily 'slow onset' sociopolitical disasters" (Atallah, 2016, p. 92) such as xenophobically-charged criminalization, ongoing land disputes, dictatorship, and settler colonialism. These historic and persistent forms of subjugation not only make Mapuche communities vulnerable, but also reveal the cultural processes that have fostered a strong Mapuche identity and resistance to colonial powers for generations. Similarly, recognizing the long history of political oppression and segregation during apartheid and the more recent devastation of AIDS in Soweto challenges us to acknowledge the multiple temporalities of resilience in the lives of our interlocutors. While our findings shed light on forms of resilience to recent experiences with cancer and other sources of adversity, the experiences of sustained and systematic oppression among Black Africans in South Africa through generations of colonial policies and societal marginalization have led to pre-existing and persistent forms of resilience that operate alongside these more recent expressions. The sources of resilience have been learned, passed down across generations as cultural practice and embodied survival.

Similarly, the predominant use and understanding of "acceptance" as an idiom of resilience highlights the obfuscating effect that temporally limited definitions and explorations of resilience manifest. Many studies of resilience examine the immediate impacts of specific traumatic or catastrophic events rather than the chronic adversities that result from structural violence, such as racism, generational poverty, and sexism and their intersections (Kirmayer et al., 2013). In particular, we argue that individuals have adapted to a cultural script of acceptance, learned through a linguistically diverse, but culturally shared way of thinking in Soweto, to garner some form of resilience amidst great adversity, including their recent cancer diagnoses. As Mark Nichter (1981) described decades ago, "as in the case of a wide angle lens, when one subject is focused upon and approached closely, depth of field, the view of the subject in relation to context, becomes problematic and dimensionality is lost" (Nichter, 1981, p. 379). The structural violence of apartheid and HIV risk that plagues historically oppressed Black communities on the outskirts of Johannesburg cannot be divorced from the ways in which they perceive the risk and survival associated with a deadly challenge (see Fassin, 2007). Nor can it be divorced from the ways in which they perceive cancer to be a somewhat ordinary challenge nested within a broader life history of extraordinary stress (see Mendenhall & Norris, 2015). Yet, understanding the ordinariness of suffering without recognizing the cognitive processes through which acceptance is achieved may conceal the collective ways in which power is generated among individuals and communities.

Finally, exploring what fosters resilience requires critical reflection to avoid conflating individual weakness or failure to thrive with subjugation and systemic disempowerment. In other words, we must critically consider the political implications of interpreting an idiom or conceptual action as resilience as something inherently good (Barrios, 2016; Neocleous,

2013). On the surface, acceptance seems to reflect a "resilient" response; however, we caution against valorizing acceptance, such as praising a person's ability to "successfully cope" and indirectly blaming those who do not respond in the same way. Political philosopher Mark Neocleous (2013) warns that the concept of resilience must be critically appraised so that it does not become a form of passive acquiescence, and such an analysis is crucial for the idiom of acceptance we report. Neocleous (2013, p. 7) also argues that "resilience is by definition against resistance." In focusing on how one might foster agency and resilience, we must be careful not to overlook the effort to resist persisting impacts of systemic inequalities associated with gender, class, ethnicity, race, sexuality, and their intersections. This, too, is why a more robust anthropological study of resilience is needed: resilience cannot be divorced from the historical processes associated with neoliberalism and structural violence that ultimately require individuals to be resilient in the first place.

Conclusion

An exploration of the idioms and themes of resilience expressed in our study of cancer diagnosis and experience illustrates how the notion of resilience is locally constructed and may be culturally scripted. We used extensive life history narratives to identify culturally relevant resources of resilience that may be useful for advancing theoretical and empirical discussions in interdisciplinary scholarship on resilience. Further research on "acceptance" as an idiom of resilience may clarify the ways in which people negotiate the self in the face of adversity in Soweto by drawing upon collective notions of society, history, and other cultural dynamics. Examining how the idiom of "acceptance" serves individuals and communities throughout life trajectories and contexts, such as within and between communities in urban and rural South African settings, could show how such an idiom might serve clinical medicine or health promotion. Thus, this exploratory article outlines a useful analytic to continue the move away from a deficit-based paradigm of health and to critically examine the numerous processes that foster collective strength amidst significant adversity.

Acknowledgements

Biography

Andrew Wooyoung Kim, MA, is a PhD candidate in the Department of Anthropology at Northwestern University and an Honorary Associate Researcher at the Developmental Pathways for Health Research Unit at the University of the Witwatersrand. His research explores the biocultural dimensions of embodied oppression, resilience, and mental health among low-income communities of color. His dissertation research explores the intergenerational effects of apartheid-based violence on mental illness risk and stress physiology in Soweto, South Africa.

Bonnie Kaiser, PhD, MPH, is Assistant Professor of Anthropology and Global Health at University of California San Diego. Her research focuses on elucidating cultural models of mental health and illness and exploring their connections to care-seeking; developing and adapting measurement tools for cross-cultural research and interventions; improving cultural adaptation of global mental health interventions; and critically exploring concepts of trauma, risk, and resilience.

Edna Bosire, MA, is a PhD candidate at the Developmental Pathways for Health Research Unit, Faculty of Health Sciences at the University of the Witwatersrand, Johannesburg, South Africa. Edna's scholarship investigates various dimensions of syndemic interventions for diabetes and poverty, from policy-level interventions like taxation for sugar sweetened beverages to clinical-level interventions like integrated chronic care at the Chris Hani Baragwanath Hospital in Soweto, South Africa.

Katelyn Shahbazian, BSFS, is a Program Assistant at Population Services International. Previously she was a student in the Science, Technology, and International Affairs Program at the Walsh School of Foreign Service at Georgetown University.

Emily Mendenhall, PhD, MPH, is a Provost's Distinguished Associate Professor in the Edmund A. Walsh School of Foreign Service at Georgetown University and holds an Honorary appointment at the University of the Witwatersrand. Dr. Mendenhall researches how social and economic inequalities are expressed and embodied in mental and physical health, with a special emphasis on the intersections of social trauma and diabetes. Her published work focuses on syndemics, or how social and health problems travel together, with a focus on urban centers in the United States, India, Kenya, and South Africa, and a rural region in Ethiopia.

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Panel 1:

Margaret

Margaret is a 40-year-old woman from Soweto with no children or grandchildren. She lives with her large family, including her mother, brother, sisters, and four nieces. Nine people live in their home and the adults share all financial obligations. Margaret sells sweets on the side of the road but is not formally employed. She grew up in a rural area and moved to Soweto when her father left their family when she was around 12 years of age. She described his leaving to "go home", and it is not clear if he returned to the rural home or passed away. Margaret's home life was positive with the support of her parents, grandmother, and her brother who remains a very close friend.

In her early 20s, Margaret had a serious partner, and they experienced a miscarriage, which was a difficult experience. Their relationship did not last much beyond that period and Margaret remains single, although supported by her close-knit family. She describes her neighborhood as quiet, where everyone minds their own business and she feels very safe. This is exemplified by her describing how she goes out late at night and alone. She is thrifty as she takes a taxi to town to purchase foods and always finds the best price. She shares the cost of electricity, food, rent, and other necessities with her family. They also share the responsibility of two family dogs, who give her much comfort. Everyone gives special attention to their mother (who is 57 years of age and does not work but takes care of their home). Her mother is the person from whom people seek advice, although sometimes Margaret seeks out her friends who live on the other side of town.

Margaret explains that she does not experience stressful social relationships. Her family supports one another and there are rarely disagreements. In fact, Margaret's life is embedded in her family's moments. She wakes early to help her nieces get ready for school before she gets ready and leaves for town. She sells sweets until around 7 pm and comes home to make dinner and go to sleep. Margaret rarely eats breakfast and often puts a peanut butter sandwich in her pocket for lunch. She often has milk, bread, and spinach for dinner, but rarely meat because of the cost. She reports that everyone sacrifices for the family.

Margaret said that she tries to let go of negative emotions because they are bad for her health. When she does think too much, especially about how she would like a nicer life, she reminds herself to accept what she has. She reflects on her miscarriage, but described not focusing on it too seriously because what happens will happen. This form of acceptance of life's troubles was a common form of resilience and exemplified how people swore off negative thoughts. When Margaret begins to think too much, she often turns on Jozi FM, or Kozi, two of her favorite radio stations. She also drinks rooibos tea with lemon, gets lost in a television program, or relaxes and sleeps.

Margaret defines healthy as not feeling sick and as having good results at the clinic. She stated that a little sickness is okay so your body can release things. Health is measured in how you walk, how your face looks, and if you can do things like walk and wash your laundry. She does not worry about being HIV positive because she simply takes treatment and doesn't feel sick at all, although she says that some people fear HIV and others

accept it. Moreover, you cannot tell that someone has HIV because they look fat; Margaret claims that 90% of the people have HIV. She doesn't "take things to heart" and is "not down" about her HIV. She describes this strength as coming from a supportive clinical team, a WhatsApp support group, and her meetings with different counselors at Bara, the public hospital where she seeks treatment.

Margaret's first reaction to her cancer diagnosis was fear that she was going to die. She described most people with cancer as being unhappy because they have no courage and think they will die in the cancer clinic. She first found a lump, it was confirmed at Bara with a mammogram in 2015, then she had a lumpectomy (where they removed the lump), followed by chemotherapy and radiation. Now she takes pills that cause her to have hot flashes and feel dizzy and tired. Although she felt alone and surprised by her cancer diagnosis as she has no family history of cancer, she completed the most difficult aspect of treatment.

Margaret describes meeting with a local healer in addition to her HIV and cancer treatments at Bara. She describes this healer as providing help for social problems or foreseeing the future, but not HIV or cancer because they are "in your blood." Margaret's healer gives her muthi, a treatment that is often plant-based, which is understood to provide spiritual wellness. But the doctors advised her not to mix treatments so Margaret rarely takes it. Margaret also goes to church and says that faith can heal you if you put yourself in God's hands.

Margaret only goes to the public clinic because private healthcare is too expensive. She places a great deal of trust in her clinical community because she has received extensive counseling for HIV. She also has received informative one-on-one HIV counseling from NGOs, and Margaret believes counseling should be provided for people with cancer, too. She observed a number of differences between care for HIV and cancer, in addition to the lack of cancer counseling. People need more information about cancer – there is stigma and misinformation that many people hold simply because little is known about the disease. They need more opportunities to build community among others with cancer, such as through support groups, opportunities to speak with survivors, and better medication (she says Tamoxifen is the worst). Margaret is very open about her cancer, although she says that people rarely share their stories; she doesn't fear stigma and says that people only feel sorry about your challenges, but don't treat you differently. Compared to other diseases, though, Margaret believes cancer is the worst. Margaret believes that you can't just sleep and get depressed about your cancer; instead, you need to eat healthy, let go of self-pity, and go to the hospital and take your treatment seriously.

Panel 2:

Thomas

Thomas is a 71-year-old man who resides with his family in Soweto. He was born in Pimville, one of the townships of Soweto, and lost his father when he was three years old. His mother raised him and they moved around from family to family most of his childhood because they could not afford a place of their own. Thomas remembers that the families treated them poorly, and this on top of the constant moving made it difficult to study. Thomas and his brother were persuaded to join "gangs" in their youth, although they maintained close relationships with their mother and siblings. He earned a junior certificate and began his first job when he was around 20 years of age. Six years later he began his career of doing clerical work for auditors, from which he had only recently retired. He and his wife have a close relationship, although they faced extraordinary stress losing a child to meningitis at six months old and recently losing one to HIV.

Now that Thomas is retired, he wishes he could continue to help the family financially. Before he was hospitalized in February for his prostate cancer (which was six months before the interview was conducted), he was active and would shop for groceries and participate in family life. Although his wife took care of most of the household chores and the children, they shared almost everything and talked through their problems, and provided advice to one another. Thomas describes this process of sharing of emotions and troubles as a central part of staying healthy; he tries to unburden himself from his stressors by sharing them with his wife, stating, "You keep something in your brain and your heart and it turns into something, this and that, so I avoid being stressed." For example, Thomas's most stressful experience was losing his mother, which was something so difficult that he sought professional help. Thomas described seeking care from a psychiatrist who provided tablets and talk therapy. The psychiatrist listened to him and encouraged him to talk through his feelings with his family, which Thomas believed helped a great deal. This was a similar tactic he took when he lost his child to AIDS and his grandchildren lost their mother. He believes he was stronger through this grief because, "If you are under a doctor, you are getting good help."

Thomas feels safe in his home and in his neighborhood. He does not venture outside his home after dark, usually around 7 pm, in order to avoid any trouble. He often reads a book, listens to the radio, or watches television to relax. He indicates that he often suggests that others who feel stress or have experienced some form of traumatic experiences do the same.

Both his psychiatrist and Thomas described losing his mother as a trauma. Thomas explained that a trauma "is something that goes right deep into your heart because you think when is your next meal going to come from? But when you're stressed, you think someone's passing came really unexpected. The minute you get help, you forget about that because the stress is over." He went on to state that as soon as you get help, you can get better. Importantly, Thomas argued that trauma forces you to seek help because you will "end up being mad" until you have it taken out of your system. Talking through his problems is the central way in which Thomas has again and again unburdened himself.

Thomas describes good health as having no pains in your body, eating well, exercising, and giving yourself time to rest. Thomas described himself in good health because he receives positive messages from his doctor, who told him that if he maintains his results then he will be fine. Thomas stated that his health did not bother him because he is active and speaks with many people. This helps him address any problems with others, and also provides many solutions.

Thomas was diagnosed with prostate cancer about six months before the interview according to the cohort data we had for him. But he explained that he has never been diagnosed with cancer (although he said he recently had his pancreas removed). Thomas does not have many words to describe cancer and indicates that he knows about cancer from what he has learned on the television or what patients in the waiting room tell him. He believes people develop cancer when they are negligent, which he describes as eating and drinking too much. After his pancreas was removed four months before the interview, Thomas said he had difficulty walking long distances and depended upon his wife for support. He explains that he does not know why he had the prostate exam and is most fearful of cancer, HIV, and smallpox (a disease that has been eradicated for decades) because they could disrupt his family emotionally as well as their day-to-day activities. Thomas does not believe in seeking care from traditional healers (sangomas) because he does not believe they have the best treatments or fully understand the diseases.

When Thomas feels pain, he prays to God and asks God to deal with his pain. Afterwards, he feels relieved and sometimes he feels that his pain has diminished. Some of this pain comes from his hypertension, which was diagnosed in 2013 and prevents him from jogging and causes him to feel tired. It also stems from his daughter's death; she thinks she got HIV from her boyfriend who was sleeping around. He is also stressed because he has difficulty getting erections, although he says that this wife is understanding because of his medical condition. Thomas conveys that he cannot connect his erections to his prostate because his doctor has not provided more information about his condition. He attributed most of his health concerns to the recent surgery to remove his pancreas.

Table 1.

Sociodemographic characteristics of sample.

	Women (n = 50)		Men (n = 30)		Total (N = 80)	
	Mean	SD	Mean	SD	Mean	SD
Age	49.1	±11.1	67.6	±7.81	56.0	±13.4
Income	2971.1	±2101.9	2614	±1822.4	2824.8	±1984.2
CES-D (Mean±SD)	10.2	±6.3	11.3	±4.60	10.6	±5.76
	n	%	n	%	N	%
Education (n, %)						
No school	2	4	3	10	5	6
Less than matric (12 years)	40	80	29	97	69	86
Completed 12+ years or more	10	20	1	3	11	14
Pension or less (R1600)	13	26	11	37	24	30
More than pension	23	46	14	47	37	46
Total comorbidities	30	60	21	70	51	64
Cancer only	20	40	9	30	29	36
Comorbid hypertension	15	30	13	43	28	35
Comorbid HIV	15	30	8	27	23	29

Table 2.

Major forms of resilience expressed in interviews.

	Women (n = 50)		Men (n = 30)		Total (N = 80)	
	n	**%**	**N**	**%**	**n**	**%**
Personal dimensions						
Acceptance	25	50	15	50	40	50
Social dimensions						
Relatives	42	84	21	70	63	79
Religion	29	58	18	60	47	59
Socializing	18	36	11	37	29	36
Role model	14	28	0	0	14	18
Counseling	14	28	6	20	20	25
Medical care	37	74	24	80	61	76