Breast Cancer in Malaysia: From Faith to Fragmented Stories Through Franks' Narrative Illness Framework

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ABSTRACT

Illness narratives provide valuable insight into how individuals interpret and make meaning of their disease experiences. Arthur Frank's typology of restitution, chaos, and quest narratives offers a valuable framework for understanding the emotional, cultural, and existential dimensions of illness. This study applies Frank's typology to explore how Malaysian women with breast cancer construct their illness stories, with particular attention to the influence of cultural, social, and spiritual factors. Three participants were purposively selected from a larger cohort of 14 Malaysian women diagnosed with breast cancer. Unstructured, in-depth interviews were conducted, allowing participants to recount their experiences in their own words. Data were analysed using Riessman's narrative analysis, focusing on the structure, content, and imagery of the narratives to uncover meaning-making processes. One participant's account reflected a restitution narrative centred on recovery; another exhibited emotional disorientation characteristic of a chaos narrative; and the third embraced a quest narrative, viewing illness as a transformative journey. The narratives were shaped by interwoven cultural values, religious beliefs, and social expectations, revealing how these dimensions influence women's interpretations of and responses to illness. The findings also demonstrated that narrative types are not fixed; participants frequently shifted between forms within a single account, reflecting the fluid nature of lived experience. In conclusion, Frank's typology offers a culturally sensitive lens for capturing the complex, contextually embedded experiences of Malaysian women with breast cancer. Riessman's narrative analysis further highlights the dynamic and overlapping qualities of illness narratives. These insights have implications for the development of culturally responsive psychosocial care and for advancing understanding of illness meaning-making in non-Western contexts.

Keywords: Chaos, Frank's typology, illness narratives, quest, restitution

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INTRODUCTION

Being diagnosed with breast cancer can be both challenging and devastating for women, as it remains the most common cancer among women globally and the second leading cause of cancer-related deaths among women (Watkins, 2019). According to the National Cancer Registry of Malaysia, breast cancer is the most prevalent cancer across all three major ethnic groups, accounting for 38.9% of all cancers between 2017 and 2021 (Ministry of Health, n.d.). Women with breast cancer face significant physical, social, psychological, economic, and spiritual challenges that may reduce their health-related quality of life (Kagee et al., 2018; Almutairi et al., 2016; Aziato & Clegg-Lamptey, 2015). While breast cancer is a global health concern, women's experiences of illness are shaped by local cultural, social, and spiritual contexts. In Malaysia, these contextual influences play a particularly significant role in how women understand, narrate, and respond to breast cancer. Given these multifaceted impacts, narrative inquiry offers a meaningful approach to exploring how women interpret and make sense of their illness experiences, capturing emotional and cultural dimensions often overlooked in quantitative research. Therefore, the research question for this study is, how do Malaysian women with breast cancer construct and negotiate their illness narratives?

BACKGROUND OF THE STUDY

Narrative research is a qualitative approach situated within the broader field of qualitative inquiry. It shares philosophical foundations with methodologies such as ethnography and phenomenology, particularly in its constructivist ontology, which acknowledges multiple subjective realities rather than a single objective truth (Finlay, 2006). Consistent with many qualitative methods, narrative inquiry typically relies on interviews as the primary data-collection tool. Narrative can be defined as "a personal oral story related to a series of meaningful events, not necessarily following a chronological sequence, and constructed by the teller for a particular audience to convey meaning about the experience under investigation" (Mamat, 2025, p. 17). This approach enables researchers to explore how individuals make sense of their experiences in culturally and socially embedded ways.

Narrative inquiry is recognised for its ability to amplify individual voices by uncovering hidden or marginalised stories that offer nuanced insights into the tellers' lives (Susinos, 2007), as well as into what is considered socially acceptable or unacceptable to disclose. This highlights its value in illuminating how individuals construct and interpret the meaning of their experiences within specific social contexts through storytelling. In this approach, in-depth interviews that invite participants to recount specific experiences are particularly well-suited to exploring how people make sense of their worlds (Ospina & Dodge, 2005). Unlike more structured research designs, narrative inquiry allows participants to shape the direction of the conversation, selectively presenting and framing stories they perceive as most representative of their understanding of the phenomenon under investigation (Mamat, 2025).

Frank (2013) identifies three primary types of illness narratives: restitution, chaos, and quest, each representing a distinct interpretive framework through which individuals understand and respond to illness. Restitution narratives follow a trajectory from health to illness and back to health, emphasising diagnosis, treatment, and cure within a predominantly Western biomedical model that assumes recovery as the norm. While these stories can foster hope, particularly when patients draw inspiration from others who have regained health, they may also be restrictive. As Frank (2013) observes, restitution has become a dominant cultural expectation, operating as a social imperative to return to normalcy, often at the expense of acknowledging the more complex emotional and existential dimensions of illness. In contrast, chaos narratives lack coherent structure or temporal sequencing, reflecting a perception that life will not improve and conveying feelings of "vulnerability, futility, and impotence" (Frank, 2013, p. 97). Despite their fragmented nature, such narratives offer profound insight into the emotional and existential burdens of illness, capturing experiences that resist orderly telling.

The quest narrative reflects a patient's belief that illness can yield meaningful insight or transformation (Frank, 2013). Within this framework, illness is not merely a disruption but a journey imbued with potential for personal growth. As Frank (2013, p. 115) observes, "quest stories meet suffering head on; they accept illness and seek to use it." In this form, the individual assumes an active, agentic role, seeking not simply to return to a prior state of health but to live with the illness and derive value from it. Such narratives often reframe suffering as a catalyst for self-understanding, purpose, or moral insight. Frank (2013) identifies three facets of the quest narrative: memoir, manifesto, and automythology. Memoir intertwines the illness story with other significant life events, offering a holistic self-portrait. Manifesto positions the narrative as a vehicle for social critique or a call to truth. Automythology transforms suffering through metaphor, enabling the illness experience to be mediated, reframed, and communicated to others.

Within the Malaysian context, illness narratives are deeply embedded in cultural norms, religious beliefs, and social expectations that influence how women interpret suffering, treatment, and recovery. These contextual dimensions make narrative inquiry especially relevant for exploring breast cancer experiences in Malaysia. Guided by Frank's typology of illness narratives, this study explores how Malaysian women with breast cancer construct and make meaning of their illness experiences.

METHOD

This paper focuses on the methodological rationale and analytic sensibilities underpinning narrative inquiry rather than on procedural detail alone. Ethical approval was obtained from the Faculty of Health Sciences, University of Southampton (Ethics No: 22983) and the Malaysia Ministry of Health Research and Ethics Committee (NMRR-16-1319-31877). Participants were recruited from two urban hospitals using purposive sampling. The inclusion criteria were: 1) women; 2) diagnosed with primary breast cancer; 3) had undergone their first conventional medical treatment within a year; 4) 18 years old and above; and 5) able to communicate in Malay or English. Women with moderate and severe cognitive impairments, those unable to communicate verbally, and those who were too mentally or physically unwell to participate were excluded from the study.

Of the 29 women who initially agreed to be contacted, 15 subsequently declined or were unable to participate for various reasons. These included deteriorating health, work commitments that prevented rescheduling interviews, relocation overseas due to changes in a spouse's employment, loss of contact because telephone numbers were no longer in service, and changes of mind regarding participation. Sample size was guided by the principle of data saturation, whereby interviews continued until no new information emerged and no additional analytic insights could be identified (Guest et al., 2006). In this study, saturation was reached after 13 interviews. Additional interviews were conducted to confirm saturation. Therefore, 14 women were included in this study.

Data were collected through face-to-face, informal, and unstructured interviews guided by a piloted narrative interview script. Interviews began with a broad, open-ended question, such as "*May I ask you to share with me your story since you first thought that you may have a problem with your breast?*" Follow-up questions and probes were used to encourage elaboration and clarification in response to participants' responses. Most interviews were conducted in participants' homes, in accordance with their preferences, while two were conducted at participants' workplaces. Interview durations ranged from 20 to 90 minutes, with an average of approximately 32 minutes.

DATA ANALYSIS

Data analysis was conducted concurrently with the presentation of findings, with interpretation embedded within each narrative account. This approach aligns with narrative research conventions, in which analysis is inseparable from storytelling and meaning construction. The study employed narrative analysis as outlined by Riessman (1990) to guide data interpretation. While Riessman does not prescribe a rigid, step-by-step analytical procedure, this openness required careful and deliberate engagement with her underlying assumptions, methodological principles, and illustrative examples. These informed the analytic decisions made in interpreting and presenting the narratives. Accordingly, the analytic process was characterised by sustained reflexivity, close attention to narrative form and content, and acknowledgement of the inherently interpretive nature of narrative inquiry.

Riessman (1990) emphasises the importance of attending not only to the content of talk but also to its structure and the imagery it evokes, advocating the analysis of "longer stretches of talk, rather than specific complaints ... to uncover how individuals give meaning to the events that have happened to them" (p. 116). This perspective positions narrative analysis as an engagement with the story in its entirety, rather than with isolated, seemingly relevant fragments. In applying this approach, a deliberate effort was made to read and reflect on each participant's complete narrative, recognising that even passages that appeared tangential to the research questions could hold meaning. Honouring the wholeness of the narrative was both a methodological commitment and an ethical stance, respecting the ways participants constructed and conveyed their lived experiences in their own voices.

TRUSTWORTHINESS

Credibility was established through data triangulation and the integration of multiple data sources. In addition to in-depth interviews with participants, interviews were conducted with a nominated family member for each participant to provide contextual depth and support interpretive triangulation. While the present paper reports exclusively on the women's narratives, family interviews informed analytic interpretation and enhanced confidence in thematic coherence.

Dependability and confirmability were enhanced through the systematic maintenance of an audit trail documenting decisions and changes across all stages of the research process, including data collection, analysis, interpretation, and manuscript preparation (Cypress, 2017). This audit trail was primarily maintained through a research diary, which contained reflexive notes on interactions with participants as well as the researcher's evolving thoughts, emotions, and analytic reflections.

Transparency in analytic decision-making is central to rigour in narrative research, as detailed accounts of how interpretations are produced enable readers to assess trustworthiness (Riessman, 1993). In this study, interpretations were grounded in multiple data sources, including interview transcripts, audio recordings, reflective journals, field notes, ongoing consultation with qualitative research experts, and engagement with relevant literature. Consistent with principles of narrative inquiry, member checking was not treated as a primary criterion for credibility, as interpretive responsibility ultimately resides with the researcher (Riessman, 1993).

REFLEXIVITY

The researcher adopted a reflexive stance throughout the study, recognising that narrative inquiry is inherently interpretive. As a Malaysian researcher with prior experience in qualitative health research, I was aware that my cultural background and professional training could shape how participants' stories were heard, interpreted, and presented. To minimise undue influence, interviews were conducted in a conversational, participant-led manner, allowing women to construct their narratives on their own terms. Reflexive notes were maintained during data collection and analysis to document analytic decisions, emotional responses, and interpretations, and interpretations were continuously revisited to ensure that participants' voices remained central.

As a Malaysian researcher, I may be regarded as having advanced cultural knowledge of the Malaysian community through shared understandings of normative rules, values, belief systems, and traditions. This shared cultural and linguistic background enabled me to attain an emic perspective, defined as an insider's understanding of a culture or society (Given, 2008). Emic researchers seek to understand the meanings and significance of phenomena within specific cultural contexts (Magnusson, 2012). At the same time, my role as a researcher required adopting an *etic* perspective, as I had no personal experience of breast cancer, no prior involvement in breast cancer research, and no close relationship with the participants or recruitment sites. According to Given (2008), an etic perspective refers to the viewpoint of an outsider who has not lived within the particular experience being studied. However, my background as a nurse, although not in oncology, may still have influenced how I approached data collection, framed interview questions, and interpreted cultural meanings. Therefore, ongoing reflexive awareness was necessary, as the process of inquiry and interpretation can be shaped by the researcher's education, ethnicity, and social and cultural identities (Muhammad et al., 2015).

RESULT

The findings are organised according to Frank's (2013) typology of illness narratives: restitution, chaos, and quest. Of the 14 women with breast cancer who participated in the study, three were purposively selected to exemplify each narrative type. Selection was guided by the richness of participants' accounts and their alignment with Frank's identified narrative forms, enabling in-depth illustration of each narrative category. The demographic and contextual characteristics of these participants are presented in Table 1.

Table 1: Demographic characteristics of the participants whose narratives are presented in details

Participant	Age	Marital status	Race	Occupation	Stage of breast cancer	Family history	Treatment
Participant 5	46	Married	Malay	Teacher	IV	No	Chemotherapy
Participant 6	35	Married	Malay	Clerk	III	Yes	Chemotherapy
Participant 7	28	Married	Indian	Housekeeper	III	Yes	Chemotherapy

Restitution narratives

Restitution narratives emerged as the most desired storyline among participants, reflecting a strong aspiration to regain health. In this study, Participant 7's account closely aligned with Frank's (2013) restitution narrative, both in the way she articulated her own experience and in how she drew upon her late mother's illness journey. Her understanding of breast cancer and its treatment was deeply shaped by personal and intergenerational experience, as her mother had also been diagnosed with a similar disease. She vividly recalled her mother's advice, which reinforced the belief that chemotherapy was the only effective means of overcoming cancer.

> *Yeah, I still remember how my mother fought her breast cancer. Although she suffered because of the side effects of chemotherapy, she acted as though the treatment was no big deal. She was so calm and positive; I learned from her. My late mother told me that only chemotherapy could kill cancer—no other medicine. ... I still want to do many things with my husband. And if I don't get the treatment, my cancer will get worse. And I don't want that happening to me. After I was diagnosed [with breast cancer], my main goal was to get healthy again. I told myself, "The quicker I get better, the better it will be."*

While this quotation was previously cited in a publication on early decision-making in breast cancer treatment (Mamat et al., 2023), it is reinterpreted here through the lens of Frank's restitution narrative. In recounting her mother's calmness and strength, Participant 7 revealed how emotional memory informed her understanding of illness across generations. The maternal example framed chemotherapy not merely as a clinical necessity, but as a moral imperative, an essential, unquestionable step towards recovery. Her story exemplifies the restorative logic of restitution narratives, in which suffering is framed as temporary, treatment as decisive, and recovery as both expected and attainable. This account illustrates how biomedical authority, cultural expectation, and personal conviction converge to produce a resilient, future-oriented outlook.

Participant 7's future-oriented perspective further anchored her story within the restitution narrative. She reflected,

> *"I still want to do many things with my husband. And if I don't get the treatment, my cancer will get worse. And I don't want that happening to me." For her, treatment was not solely a medical decision but a deeply relational one, rooted in the desire to preserve a shared life with her spouse. As with many individuals who align with the restitution narrative, her aim was not transformation but restoration, specifically a return to her previous way of life. She displayed a clear awareness of the potential consequences of delayed treatment, recognising that life could no longer be taken for granted. Her decision to pursue early intervention reflected both a pragmatic understanding of illness progression and an underlying hope that treatment would enable her to maintain her role as a wife and to continue engaging in everyday activities. This conviction that recovery is not only possible but essential lies at the core of the restitution narrative, where illness is confronted with urgency, discipline, and an expectation of renewed normalcy."*

Another participant, Participant 5, also exemplifies the restitution narrative, although her path to accepting biomedical treatment was notably delayed by an initial reliance on traditional healing practices. Despite receiving a medical recommendation for surgery, she declined and instead pursued alternative approaches, including dietary supplements and consultations with multiple traditional healers for two years. During the interview, it became clear that, despite her prolonged delay, her account ultimately aligned with key elements of Frank's (2013) restitution narrative. In conversation with her doctor, she acknowledged her illness while expressing confidence in her capacity to recover, thereby embodying the restitution logic *"Today I am ill, but tomorrow I will be well again."* Her eventual decision to undergo chemotherapy, despite earlier hesitation, reflected a belief that medical intervention could restore her health.

Significantly, her initial reliance on traditional healing did not signal a rejection of treatment, but rather a culturally grounded attempt at recovery. When these methods failed to halt the progression of her symptoms, she turned to Western biomedicine, marking a narrative shift from avoidance to active pursuit of a cure. Participant 5's story illustrates that restitution narratives do not always emerge at the onset of illness; they may surface only when the illness intensifies, and the urgency to reclaim one's former life becomes undeniable. The following quotation captures her perspective after beginning chemotherapy.

> *Doctor W told me, "When I saw you, I knew that you were healthy." It means that he said that chemotherapy was appropriate for me. "That's right, doctor, all these", I said, "It's already fated that chemotherapy is appropriate for me. Moreover, the supplements that I took previously might also have helped.", I said. "Moreover, it's not the time for me to die yet. Like this doctor, when the time comes, we still die. If not the time yet, we get healthy."*
>
> *Then, Doctor W said, "Usually, the patient has a loss of appetite. But I saw you are healthy." "Yeah. I feel that I am healthy." I said. "Because my appetite was okay, I always eat. Alhamdulillah (All praises to God), till today. I didn't want to think about cancer that had already spread. I don't want to think about that. I said, "Let it be. If that is my fate, I accept it. I don't want to think, I don't want to get a headache, I don't want."*

As I listened to Participant 5's account, it became clear that her understanding of illness was deeply embedded in religious faith, cultural norms, and social expectations. When she stated, *"It's already fated that chemotherapy is appropriate for me,"* I interpreted this as an expression of her belief in divine will and destiny (*Qada' and Qadar*). In Islam, both favourable and unfavourable outcomes are viewed as part of God's divine plan and ultimate control (Khan, 2015). For her, chemotherapy was not merely a biomedical intervention but a treatment divinely ordained. This convergence of spiritual surrender and medical trust appeared to provide her with a profound sense of peace and acceptance.

Later in the conversation, she reflected, *"It's not the time for me to die yet… when the time comes, we still die. If not the time yet, we get healthy."* This reinforced her deep spiritual surrender to divine will, framing mortality not as something to fear but as a predetermined reality beyond human control. Yet this acceptance was not defeatist. Instead, it appeared to empower her decision to proceed with treatment, grounded in the belief that if it was not yet her time to die, recovery was still possible. Her perspective illustrates how spiritual belief can function as a source of resilience, not by diminishing the seriousness of illness, but by situating it within a broader, faith-based understanding of life's purpose and trajectory. Although previous research has identified cancer fatalism -defined as the belief that a cancer diagnosis inevitably results in death - as a barrier to screening and treatment adherence (Powe & Finnie, 2003), the present findings indicate a more nuanced dynamic. In this case, fatalistic language coexisted with proactive treatment-seeking behaviour, suggesting that culturally embedded spiritual beliefs may not uniformly discourage medical engagement.

As I listened to this part of the interview, I was struck by the participant's repeated use of the phrase *"I don't want."* The reiteration "*I don't want to think, I don't want to get a headache, I don't want*" appeared to function as an emotional coping mechanism, creating a psychological boundary between herself and the overwhelming reality of her diagnosis. This was not simply an avoidance of thought; rather, the act of thinking itself seemed to represent a source of distress and potential psychological harm. In narrative terms, this form of expression resonates with Frank's (2013) description of the chaos narrative, in which experiences become emotionally uncontainable and attempts at rational sequencing or reflective interpretation are too painful to sustain. Her fragmented speech vividly captured the turbulence of her inner state, offering a raw, unfiltered glimpse into the disorientation that illness can provoke.

When the doctor remarked, "*Usually the patient has a loss of appetite. But I saw you are healthy,"* I interpreted this not merely as a clinical observation, but also as a culturally resonant form of reassurance, affirming that she appeared to be coping well both physically and emotionally. For the participant, maintaining her appetite seemed to serve as evidence of her ability to manage the illness. In many Malaysian contexts, appetite carries symbolic meaning, often linked to well-being, strength, resilience, and the restoration of inner balance. In this light, food becomes more than physical sustenance; it operates as a visible and socially recognisable marker of health. This interpretation aligns with research indicating that adherence to culturally endorsed emotional and behavioural norms is associated with more positive experiences and enhanced well-being (De et al., 2014; Fulmer et al., 2010).

Taken together, her expressions of spiritual surrender, emotional regulation, and culturally embedded indicators of wellness suggest a complex narrative dynamic. While her speech reflected elements of chaos in its fragmentation and emotional immediacy, these were interwoven with aspects of restitution, in which illness was not seen as a terminal point but as a divinely guided disruption on the path toward recovery and restored equilibrium.

Chaos narratives

While Participant 5's narrative was previously discussed in relation to restitution, a closer reading reveals the presence of chaos elements. Subtle indications of emotional disorientation surfaced earlier in her account, but the following excerpt makes these features more explicit, capturing her heightened uncertainty and fragmented expression—hallmarks of Frank's (2013) chaos narrative.

> *"When I went back home, I thought a lot until I lost 10kg. Hurm, 10kg lost from 55kg. My weight turned to 45kg. I kept thinking. I rarely ate. I was worried. Abstained too. I didn't eat oily foods. I ate grilled fish. I avoided cold vegetables such as long beans, pumpkin, and fern leaves. Fruits such as bananas, duku, and langsat. All these foods can swell the nerves and make the lump get bigger. Moreover, if we take out the cancer, it will grow back on the other breast. It will get more and more. Because that thing was alive. It had a root. It can spread. That made me feel afraid."*

While part of this participant's quotation was cited in a prior publication on early decision-making in breast cancer treatment (Mamat et al., 2023), it is reinterpreted here through the conceptual lens of Frank's (2013) chaos narrative. What stood out during the interview was the emotionally fragmented and disjointed nature of her storytelling. Her account moved abruptly between subtopics, beginning with her return home after receiving the diagnosis, shifting to weight loss and diminished appetite, then to emotional reactions and culturally informed food taboos, and finally circling back to her fears about surgery and cancer recurrence. This absence of linear progression reflected the emotional intensity of her experience. As Riessman (2008) observes, narratives rooted in emotionally charged events are often told in a non-chronological manner, with individuals shifting between themes as they attempt to make sense of complex realities.

Although her meaning was generally comprehensible, certain statements appeared contextually disconnected. For example, her remark, "*I think a lot until I lost 10 kg,"* was emotionally charged yet syntactically detached from the surrounding narrative. This lack of coherence signalled a psychological state marked by anxiety and overwhelm, highlighting the profound impact breast cancer had on both her physical body and her sense of self. The fragmented delivery, characterised by movement between themes and repeated returns to core emotions, suggested that she was still actively processing her experience. It was not a story told with reflective distance or resolution, but one unfolding in real time, a hallmark of chaos narratives, in which the emotional weight of illness disrupts chronological structuring and produces accounts that are, as Frank (2013) observes, "*difficult to hear.*" They are not difficult because they lack value, but because they vividly convey emotional disorientation.

An added layer of complexity in her narrative was the integration of culturally grounded beliefs about food and illness. She perceived certain foods as potentially harmful to her condition, believing that some vegetables and fruits were "*hazardous*" and could worsen breast cancer by "*swelling the nerves*" or "*stimulating cancer growth*." Guided by this cultural framework, she avoided foods deemed risky and modified her dietary practices for fear they might contribute to recurrence or metastasis.

In the Malaysian context, food occupies a central role in shaping illness perceptions, including those related to cancer. While such beliefs may not directly delay treatment, they can influence dietary behaviours during illness. Across various cultural traditions - including those of the Islamic world, the Indian subcontinent, Latin America, and China - food is often categorised into symbolic types of "hot" and "cold" (Helman, 2007). These classifications do not refer to physical temperature, spiciness, or cooking method, but to the food's reputed physiological effects (Manderson, 1981) and the symbolic meanings ascribed to foods, herbs, medicines, emotional states, illnesses, and even supernatural forces (Ariff & Beng, 2006). Illness is often conceptualised as a disruption of internal balance, with health restored by dietary adjustments that re-establish equilibrium (Ariff & Beng, 2006). In the context of breast cancer, research indicates that patients frequently modify their diets to reduce the perceived risk of recurrence or metastasis (Beagan & Chapman, 2004), partly due to the belief that dietary factors may contribute to disease onset or progression (Zainuddin et al., 2017).

Quest narrative

This narrative structure is illustrated in Participant 6's account, whose description of her emotional response and her situating of her illness within her personal and familial background reflects key elements of the quest narrative. In particular, her story highlights efforts to derive meaning from the illness and to reframe it as part of a broader journey of self-discovery and resilience.

> *"I was sad, but I accepted the fact that I had a family history. So, the chances of me getting breast cancer were high. I knew that. Breast cancer is a really scary word. One of my sisters passed away from cancer last year. She had been fighting it for ten years, but in front of us, she always looked strong, like nothing was wrong. You would never know she was sick just by looking at her. So, I did not cry when the doctor said that I had breast cancer. The breast cancer was already there, so there was no point in regret. The rice has become porridge, but I am still alive. So, I just accept whatever treatment suits my breast cancer. I felt that my life had just begun. Now, I really appreciate what I had. My life, my work, my husband. Everything seemed important to me. I wanted to enjoy my life before I closed my eyes."*

In this deeply personal account, the memoir unfolds as described by Frank (2013), with Participant 6 interweaving her breast cancer journey and her family's shared history, particularly her sister's prolonged battle with cancer. Her reflections merge personal and familial illness narratives, enriching her story with historical context and emotional resonance. She navigates a quiet tension between sadness and acceptance: while acknowledging that a family history of breast cancer had mentally prepared her for the diagnosis, her statement that "*breast cancer is a really scary word*" reveals that fear persisted beneath the surface. Her tone reflects resignation tempered by emotional depth, illustrating that even anticipated illness can evoke profound psychological responses.

This emotional composure is further conveyed through her remark, "*I did not cry when the doctor said that I had breast cancer,*" signalling a moment of calm where many might have reacted with distress. Drawing strength from her sister's example of resilience, described as someone who "*always looked strong, like nothing was wrong and whose illness was not apparent to others*", she adopted a similar stance. Her sister's illness served not only as an emotional reference point but also as a form of cultural inheritance, shaping how she encountered and interpreted her own diagnosis.

Listening to Participant 6's account, I recognised a strong alignment with Frank's (2013) quest narrative. Her story extended beyond the medical pursuit of a cure; it became a journey of meaning-making. She spoke with calm acceptance, positioning herself not as a passive sufferer but as someone continuing a legacy of quiet resilience. The emotional complexity of her account, marked by fear, acceptance, and a search for meaning, epitomises the quest narrative, in which illness is reframed as a pathway to personal transformation and connection to a broader narrative of strength and endurance.

Her account also functions as a manifesto, conveying a broader message of resilience and acceptance. A pivotal moment occurs when she reflects, "*The rice has become porridge*," a Malay proverb akin to the English idiom "*There's no use crying over spilled milk*." This metaphor, rich in cultural resonance, symbolises the irrevocability of her condition and a pragmatic acceptance that what has happened cannot be undone. By invoking this familiar phrase, she situates her cancer experience within a shared cultural framework, marking a transition from despair to purposeful action and renewed appreciation for life. Through such metaphorical framing, she also engages in auto-mythology, casting her illness as fate or destiny while recalling the lessons embodied in her sister's life.

Her indirect quest narrative conveys that although she has not yet experienced restitution, she has developed a heightened appreciation for life. She declares, "I felt that my life had just begun," reframing her illness as a catalyst for self-awakening and growth. This renewed perspective includes gratitude for her "*life, work, and husband"* and a conscious resolve to "*Enjoy my life before I close my eyes*." The latter, a culturally nuanced Malay euphemism for death, reflects her preference for dignity and subtlety in discussing mortality.

Participant 6's journey demonstrates the intertwining of memoir, manifesto, and auto-mythology, illustrating how illness narratives can serve as deeply personal accounts and vehicles for societal messages and transformative meaning. Her story positions cancer not as an end, but as a catalyst for self-discovery, resilience, and reconnection with the beauty of daily life. In doing so, it encapsulates the essence of the quest narrative, in which illness becomes a meaningful journey that fosters self-awareness, emotional growth, and a deeper appreciation for life's ordinary moments.

DISCUSSION

Narrative analysis encompasses diverse approaches across disciplines, each grounded in distinct theoretical perspectives. In this study, Frank's (2013) typology of illness narratives, namely restitution, chaos, and quest, was employed as an analytic lens to interpret Malaysian women's breast cancer stories, illustrating how personal, cultural, and social factors interweave to shape the telling and meaning of illness experiences. A central methodological principle was to engage with participants' stories in their entirety rather than in fragmented excerpts. This holistic approach honours the participants' deliberate narrative constructions and preserves the integrity of their meaning-making processes. Thus, it distinguishes narrative analysis from other qualitative methods that risk decontextualising data.

By maintaining the integrity of whole narratives, the analysis preserved emotional depth and complexity, revealing illness stories as layered constructs of identity, resilience, and transformation. This perspective emphasises how individuals negotiate and communicate suffering within specific sociocultural contexts, moving beyond surface-level thematic coding. Framing participants' accounts through Frank's typology enabled exploration of how women make sense of breast cancer not only in biomedical terms but also through cultural memory, spiritual beliefs, and intergenerational narratives. Their accounts were deeply influenced by religious traditions, social expectations, and linguistic expressions, reflecting the reality that illness is always experienced within a culturally embedded context.

The narrative approach also facilitated the holistic presentation of stories, embracing their experiential richness (Bell, 2002). As Riessman (1993) observes, storytelling enables individuals to create order and meaning within social and cultural frameworks. This approach was particularly effective in capturing how participants constructed and reconstructed their experiences over time, aligning with Webster and Mertova's (2007) view that personal stories often centre on life's most significant events. Importantly, participants frequently shifted between narrative forms, moving from restitution to chaos and back again, reflecting Radley's (1996) observation that perspectives on health change profoundly during illness. Similarly, Riessman (2008) notes that emotionally charged accounts are often consequential yet non-chronological, enabling multiple narratives to co-exist within a single story and revealing dimensions that might otherwise remain hidden.

Attending to narrative and linguistic devices such as imagery, metaphor, idioms, repetition, and proverbs proved essential to analysis. These devices were not treated as stylistic embellishments, but as interpretive tools through which participants made sense of complex realities and engaged the listener (Jensen, 2006). In this study, such devices drew the researcher into vivid depictions of settings, characters, and emotional states, preserving symbolic language and nonlinear reasoning, elements that are often overlooked in conventional qualitative analysis. They also allowed participants to maintain narrative control and foster a relational connection with the researcher, positioning the latter as a co-constructive witness rather than a detached observer. As Hydén (1997) affirms, narrative serves not only as a vehicle for expressing suffering but also as a framework for situating illness within broader life events and cultural understandings.

Cultural context was central in shaping illness narratives. In Malaysia, Islamic beliefs strongly influenced expressions of acceptance, resilience, and meaning-making. Phrases such as *Alhamdulillah* and references to divine fate reflected a spiritual framing of illness, often aligning with quest narratives that conceptualise cancer as a test or opportunity for personal growth. Malay proverbs such as "The rice has become porridge" functioned as culturally resonant metaphors for acceptance and pragmatic adaptation. Social expectations for women to remain strong and fulfill caregiving roles contributed to the predominance of restitution narratives, while chaos narratives often emerged more subtly, intertwined with concerns about family responsibilities and social stigma. These patterns highlight that illness experiences cannot be fully understood outside of their spiritual, cultural, and relational contexts, particularly in collectivist societies.

Narrative research also demands attention to the influence of context on how stories are told. Lieblich et al. (1998) emphasise that narratives are shaped by factors such as the teller's motivation, audience, relational dynamics, and emotional state. In this study, while participants received a patient information sheet outlining the research topic and aims; however, interviews were conducted conversationally to foster a relaxed atmosphere. Sessions were scheduled according to participants' preferences, acknowledging their readiness to share their stories.

Finally, reflexivity was critical in addressing the inherent power dynamics between researcher and participant. As Alvermann (2002) notes, researchers exercise interpretive authority in selecting which stories are told, how they are presented, and how much of the narrator's voice is preserved. In this study, although excerpts were chosen to illustrate key findings, care was taken to retain participants' own words and constructions of meaning. By balancing interpretive analysis with faithful representation, the study sought to honour participants' voices while offering a culturally and methodologically grounded interpretation of their illness narratives. This reflexive stance enhances the trustworthiness, ethical integrity, and depth of narrative inquiry in qualitative health research.

CONCLUSION

In conclusion, this study demonstrates the value of Frank's typology of restitution, chaos, and quest narratives as a culturally sensitive framework for understanding how Malaysian women with breast cancer construct meaning from their experiences. Through narrative inquiry, the findings reveal a dynamic interplay of biomedical realities, spiritual beliefs, cultural values, and intergenerational memories that shape women's responses to illness. By embracing narrative complexity and attending to symbolic language, cultural metaphors, and local idioms, this research highlights the importance of holistic, patient-centred care that honours the multifaceted nature of suffering and healing within specific sociocultural contexts. Recognising and engaging with varied narrative forms facilitates empathetic communication and enables more tailored support strategies, thereby enhancing the quality of care and social assistance available to patients throughout their illness trajectory. Ultimately, integrating patients' narrative perspectives into healthcare practice and policy is essential for fostering resilience, dignity, and holistic well-being among women living with breast cancer.

LIMITATION OF STUDY

This study explored the alignment of Frank's illness narrative typology with Malaysian women's breast cancer stories, using a limited sample to represent each narrative type. While this purposive approach facilitated in-depth analysis, it may have constrained the diversity of illness narratives captured. The narrative interview method generated rich qualitative data but is inherently shaped by participants' articulation and the researcher's interpretive lens, introducing potential subjectivity and bias. While the findings are not intended to be statistically generalisable, transferability is supported by rich contextual detail on participants' sociocultural backgrounds and illness experiences. This allows readers to assess the relevance of the findings to other settings or populations with similar cultural, religious, or healthcare contexts. Nonetheless, caution should be exercised when applying these findings beyond comparable contexts.

RECOMMENDATIONS OF THE STUDY

Given the methodological focus, future research should prioritise refining narrative analytic techniques to enhance reflexivity, transparency, and systematic interpretation. Incorporating strategies such as participant validation and data triangulation is recommended to strengthen credibility and trustworthiness. Moreover, culturally sensitive adaptations of narrative methods are essential for authentically representing diverse illness experiences and ensuring methodological rigour across varied sociocultural contexts.

IMPLICATIONS OF THE STUDY

This study highlights the importance of integrating patients' personal narratives shaped by biomedical realities, cultural values, religious beliefs, and social expectations into breast cancer care in Malaysia. Recognising that women may shift between restitution, chaos, and quest narratives enables healthcare providers to adapt communication and psychosocial support to patients' evolving needs. For example, women expressing restitution narratives may benefit from clear, treatment-focused information and reassurance about recovery, whereas those conveying chaos narratives may require emotional containment, active listening, and reassurance before detailed information is introduced. Patients whose accounts align with quest narratives may benefit from opportunities to reflect on meaning, spirituality, and personal growth, such as through counselling or support groups that acknowledge these dimensions. Attending to culturally embedded expressions of faith, metaphor, and family roles can further enhance the sensitivity and effectiveness of psychosocial care. Building narrative competence among healthcare professionals can strengthen trust, enhance patient engagement, and ensure that care addresses both medical and emotional dimensions. Applying these insights in cancer support programmes and policy development can promote culturally attuned services that foster resilience, dignity, and holistic wellbeing among women living with breast cancer.

AUTHOR CONTRIBUTION

WHWM was responsible for data collection, analysis, and drafting the manuscript. SL contributed by reviewing, checking, and verifying the analysis and manuscript content. Both authors reviewed and approved the final version of the article.

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CONFLICT OF INTEREST STATEMENT

We declare no conflict of interest. All co-authors have reviewed and approved the manuscript, and there are no financial interests to disclose.

DECLARATION OF STATEMENT

The authors confirm that this study provides an honest, accurate, and transparent account of the reported study. No crucial aspects of the study have been omitted and nor are there any discrepancies from the original plan.

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