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ORIGINAL PAPER

The Doctor is Just a Messenger: Beliefs of Ultraorthodox Jewish Women in Regard to Breast Cancer and Screening

Anat Freund · Miri Cohen · Faisal Azaiza

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Abstract Screenings for the early detection of breast cancer greatly improve survival odds. Studies of minority groups have shown lower attendance of screenings; however, these studies seldom focused on religious minorities. This study examines perceptions of cancer and cancer screening among healthy ultraorthodox women in order to gain insight about ways to promote screening. In this qualitative-phenomenological study of two focus groups, three main themes were found: faith in God; the Rabbi as a guide; one's relationship with the community. The study's findings point to the importance of studying the unique needs of members of certain religious groups.

Keywords Breast cancer · Screening · Ultraorthodox women · Health beliefs

Introduction

Research on cultural factors affecting health behaviors, especially screening for early detection of cancer, usually focuses on specific ethnic groups, such as African-American and Hispanic populations in the United States (e.g., Harmon et al. 1996; Lopez-McKee et al. 2008; Russell et al. 2006; Spurlock and Cullins 2006; Talbert 2008) or Arabs in Israel (Azaiza and Cohen 2006, 2008a, b; Azazia et al. 2010, 2011; Cohen and Azaiza 2005). However, little of the existing research on this topic has addressed health behaviors in extreme religious rather than ethnic minorities, especially segregated ones, such as ultraorthodox (Haredi) Jews.

Studies on ethnic minority groups have shown lower performance of health behaviors (Allison et al. 2012; Cohen and Azaiza 2007), especially lower attendance of screenings for the early detection of breast cancer (Bellizzi et al. 2011; Cohen and Azaiza 2005; Miranda et al. 2012) or colorectal cancer (Azaiza and Cohen 2008b; Bandi et al. 2012; Gonzales et al. 2012) in ethnic minority groups compared to majority groups. Lower

A. Freund (✉) · M. Cohen · F. Azaiza
Faculty of Social Welfare & Health Sciences, School of Social Work, University of Haifa, 31905 Mount Carmel, Haifa, Israel
e-mail: afreund@research.haifa.ac.il

screening attendance has been linked with a wide range of factors, including higher barriers and lower perceived benefits of screening (Azaiza and Cohen 2006; Cohen 2006; Cohen and Azaiza 2005; Finney Rutten and Iannotti 2003; Palmer et al. 2008), higher fatalism (Azaiza et al. 2010, 2011; Spurlock and Cullins 2006; Talbert 2008), lower knowledge regarding screening (Abrai'do-Lanza et al. 2007; Harmon et al. 1996; Perez-Stable et al. 1995) or lower socioeconomic status (Bellizi et al. 2011; Gonzales et al. 2012; Lange and Piette 2006), higher religiosity (Azaiza and Cohen, 2008a; Cohen and Azaiza 2005; 2007), and higher cultural barriers (Azaiza et al. 2010, 2011).

Although ethnic minority groups are more religious than the general population, they undergo constant assimilation and westernization processes that affect their attitudes and behaviors toward health. It is questionable whether findings on the attitudes and behaviors of extreme religious groups are generalizable to segregated religious minorities.

Ultraorthodox Jews differ substantially from the majority of the Jewish population. They are characterized by high religiosity and a strict way of life, and usually live in insular and segregated communities (Coleman 2008; Ribner 2003; Rier et al. 2008). There is a dearth of studies focused on health issues among ultraorthodox Jews, and the extent to which they engage in various screening behaviors is unclear. It is important to study the attitudes of ultraorthodox Jews to cancer and cancer screening, in order to gain insight into ways to promote adherence with regard to screening. Moreover, this knowledge may help identify factors which may inhibit screening or other health behaviors in other strictly religious groups throughout the world.

Eight percent of Israel's Jewish population self-identifies as ultraorthodox, and the percentage is even higher among younger Israeli Jews; in 2009, 14 % of 20–29 years olds identified themselves as ultraorthodox (Israel's Central Bureau of Statistics 2010). Ultraorthodox Jews reside in segregated communities in several cities in Israel, as well as in the USA and some European countries (Schnitzer et al. 2011).

Ultraorthodox Jews follow a deeply religious lifestyle based on the Torah (the Bible), along with a range of Jewish religion literature, commentary, and rulings (*Halacha*) that together cover diverse aspects of life. The performance of the Jewish commandments is the central focus in life. A high value is placed on modesty, exemplified by wearing clothes that are not revealing, the separation between men and women in the public sphere, and conservative attitudes toward sexuality. Its members usually live in tightly knit and highly integrated communities functioning in self-imposed cultural insularity; many features of the secular world (e.g., television, internet, and secular newspapers) are perceived as detracting from God's sanctity and are strictly forbidden or very limited (Coleman 2008; Coleman-Brueckheimer and Dein 2011; Friedman 1991; Rier et al. 2008; Stadler et al. 2008). Ultraorthodox Jews usually marry young, have high fertility rates, a low level of participation in the labor force, and earn a relatively low income (Central Bureau of Statistics 2010; Gurovich and Cohen-Kastro 2004; Stadler et al. 2008). It should be noted that, despite these similarities, different ultraorthodox communities have their own Rabbis (the religious authority of an ultraorthodox community) and practices (Coleman-Brueckheimer and Dein 2011; Goodman and Witztumb 2002).

As previously noted, there have been relatively few studies that focus on health service usage by ultraorthodox Jews. The research that has been conducted indicates that there are distinct patterns of health service utilization among this population. For instance, illnesses that are perceived as stigmatizing may be hidden and treatment options are carefully navigated so as not to harm the matrimonial prospects of one's children (Baron-Epel et al. 2008; Schnitzer et al. 2011). Some measures, such as testing for genetic and medical problems (Mor and Oberle 2009), or prenatal fetal screening (Teman et al. 2011) and

vaccinating young children (Anis et al. 2009), are refused. Ultraorthodox Jews refer to their rabbis for decision-making regarding medical procedures and screenings, so as to act in accordance with religious requirements (Coleman-Brueckheimer et al. 2009).

Research on the performance of cancer screening among ultraorthodox women has yielded inconsistent results. Lower levels of screening have been reported for breast, cervical, and colorectal cancer screening among ultraorthodox Jewish women aged 70 and over in New York, compared to a sample of white New Yorkers of the same age. However, among 50–69-year-old women, differences emerged only for colorectal cancer screening (Albert et al. 2004). Bowen et al. (2003) reported that women with a higher religious identity score were more likely to intend to follow recommendations for mammograms, and suggested that this is likely due to the religious obligation to lead healthy lives, which is a long-standing part of Judaism. In an Israeli study of ultraorthodox and non-Orthodox women, there was less knowledge about breast cancer screenings among the ultraorthodox women, as well as a greater belief in the protective qualities of their religious lifestyle, but no significant differences in screening intentions or performance (Strauss 2007) were found. Baron-Epel et al. (2009) reported that 74.3 % of the ultraorthodox participants in their 2007 study had undergone a mammogram in the two previous years, similar to the figure among non-ultraorthodox Jewish women. However, the response level in their study was low, and they found no association between education and mammography attendance, in contrast to studies, which found that lower education is associated with lower screening attendance in Israel (Azaiza and Cohen 2006, 2008b; Cohen and Azaiza 2005) and in other countries (Katapodi et al. 2004; Pruitt et al. 2009). In addition, Baron-Epel et al. (2008) found that mammography attendance was underreported by ultraorthodox women as compared to medical claim records.

Few studies have examined how ultraorthodox women perceive breast cancer screening. In Pfeffer's (2004) research, conducted among members of different ethnic and religious groups in London, several of the ultraorthodox Jewish women claimed that their religion and religious practices protect them from cancer. These practices included arranged marriages and having kids, dietary (kosher) laws, having only one sex partner, and spiritual welfare. Another study of ultraorthodox breast cancer patients in England indicated that interpretations of their cancer were strongly influenced by religious faith and practices. The women viewed cancer as part of God's predetermined and meaningful plan and considered the disease a form of test or, in some cases, as a punishment (Coleman et al. 2007; Coleman 2008). Baron-Epel (2010) found that ultraorthodox women had higher levels of embarrassment and fatalistic beliefs compared to veteran and immigrant Jewish women in Israel, while subjective norms with regard to mammography use were low. Embarrassment and lack of knowledge about the procedure were linked with less mammography attendance. However, Pfeffer (2004) observed that ultraorthodox Jewish women were prepared to suspend some of the religious principles that govern their everyday lives in order to receive proper medical attention.

The results of the few studies conducted among the ultraorthodox population highlight the importance of studying the attitudes regarding cancer and cancer screening among ultraorthodox women, in order to gain insight about ways to promote adherence with regard to screening. Taken together, there is a paucity of knowledge on ultraorthodox Jewish women's perceptions and attitudes toward screening for breast cancer, and there is no study in Israel that has conducted an in-depth assessment of ultraorthodox women in this regard. Therefore, the present study seeks to address this gap by focusing on perceptions about cancer and cancer screening among healthy ultraorthodox women, using focus groups methods.

Methods

The study used the qualitative-phenomenological approach, which is based on the observation of people's behavior and everyday interactions in order to understand them (Moustakas 1994; Patton 2002). This approach attempts to obtain an in-depth understanding of phenomena by entering the world and experiences of the participants. Thus, in our study, it allows us to "capture" the experiences of the women and their perceptions about health in an optimal way.

Sample and Population

We used a purposeful sample approach (Patton 2002), which focuses on choosing participants who best represent the population from which they are chosen, and who can teach us about the studied phenomenon (Mason 1996). In order to do so, 19 women representing two major ultraorthodox communities in Israel were sampled. All women fit the criteria of being between 25 and 60 years of age and not having had breast cancer. The age of each of the participants is provided in the Results section, except in cases when this information was not made available to the researchers. Table 1 provides more information about the sample.

The majority of the women were married, although three were single and one was divorced. Most had children, with the number of children usually ranging from one to eight. All had at least a high school education with about half having some level of higher education. All were professionals; 13 worked outside the home and 5 worked from home.

Eighty-five percent of the women knew a woman who had had breast cancer, and two women had a first-degree relative who had been ill with breast cancer. Twelve women reported never having performed a breast self-exam, two did so occasionally, and only one reported regular performance. Fourteen of the women did not go to their physicians for a clinical breast exam, while one went annually. Of the four women old enough to begin doing mammograms, one attended regularly, one had gone once several years ago, and two had never undergone a mammogram.

Instrument

The research instrument was a semi-structured, in-depth questionnaire which enabled an understanding of the participants' experiences and the meanings they attach to them. The interviews were conducted via two focus groups. The research questionnaire included four main content categories. The first was familiarity with cancer, for instance—"how does the family, the community deal with cancer? Do they talk about cancer, how are cancer patients treated?" The second category related to the frequency of undergoing early detection screenings; this was represented by questions such as "Have they done tests? Which ones? What led them to undergo the tests? Do they have them regularly?" The third category assessed the ways ultraorthodox society deals with the associations and meaning of early detection tests. Examples of such question are as follows: "What associations are related to the test? What does the test mean?" The final content area dealt with the extent to which it was possible to discuss screenings in ultraorthodox society and how their leadership views such tests, as exemplified by the following items: "Who do you talk with about screenings? Who do you avoid talking about them with? Who recommends that you do the screenings? Who doesn't? Who in the family has screenings? How do you think the religion/religious figures view the screenings?"

Table 1 Description of target population

Participants	Age	Marital status	Children	Years of education	Profession	Works outside home	Economic status	Self-exam	Clinical breast exam	Mammogram
1	55	2	3	12	Mikveh attendant	Yes	2	3	2	1
2	57	2	7	14	Teacher	Yes	3	1	2	2
3	26	2	3	13	Principal	Yes	1	1	1	1
4	25	3	–	12	Salesperson	Yes	3	1	1	1
5	39	2	3	12	Principal	No	3	1	–	–
6	25	2	2	13	Principal	Yes	3	1	1	1
7	26	1	4	15	Teacher	Yes	–	1	1	1
8	25	2	3	15	Teacher	–	3	2	1	1
9	25	2	1	16	Teacher	Yes	2	–	–	–
10	38	2	8	15	Teacher	No	3	1	1	1
11	28	2	4	15	Child care worker	No	3	1	1	1
12	25	2	2	15	Kindergarten teacher	Yes	3	–	–	–
13	27	2	2	15	Kindergarten teacher	No	4	1	1	1
14	32	2	4	19	Kindergarten teacher	Yes	3	2	2	1
15	49	2	5	13	Child care worker	No	3	1	–	3
16	46	2	5	16	Teacher	Yes	3	2	2	1
17	60	2	–	12	Secretary	Yes	2	3	3	3
18	32	1	–	12	Real estate agent	Yes	3	1	1	1
19	25	1	–	12	Cosmetician	Yes	3	1	1	1

Key: Economic status: 1 = very high, 2 = high, 3 = medium, 4 = low

Self breast exam: 1 = never, 2 = once in a while, 3 = every 1–2 months

Clinical breast exam: 1 = never, 2 = once in several years, 3 = once 1–2 years

Mammography: 1 = never, 2 = every few years, 3 = every 1–2 years

Procedure

Interviewers had a Bachelor degree in social work, psychology, or education. They were trained and underwent a reflection process (Finlay and Gough 2003) before beginning the interviewing process. This included references and awareness in several stages: What was their background? Their attitudes and opinions about the subject and relevant topic they would be interviewing about, such as experience with cancer; how they position themselves in relation to the ultraorthodox interviewees; and how they felt this was manifested in their behavior. Following this process, they were able to come to the interviews with heightened awareness, which enabled them to better focus on the participants' experiences (Finlay and Gough 2003). Participants were recruited by direct contact and asked for their consent to participate. The focus groups were conducted in locations chosen by each group of interviewees with consideration for their requirements. At the beginning of each interview, the participants signed an informed consent form which included an explanation of the purpose of the focus group's discussions and what they would be used for. Each interview took about 90 min and was recorded and transcribed.

Data Analysis

Prior to the analysis, we performed a bracketing process (Moustakas 1994) in order to be more aware of our personal opinions as researchers, our involvement in the research subject, and to be available for the data analysis resulting from the study. The analysis included several stages (Smith et al. 2009): The first stage was reading through the interviews and studying them in a thorough manner. During the repeat reading, an open coding procedure was used in which relevant quotes were highlighted. Using categorization, which comprises conceptualization and reorganization of the topics that came up, various statements were joined to common units of meaning. Finally, horizontal coding was performed, in which topics that were repeated in the discussions were identified; from this, we derived the main themes that featured in the data. This gradual process ultimately allowed us to build a concept that was based on the topics and themes that arose in the focus groups.

Validity and Reliability

First, researcher bias and the effect of the meeting between interviewee and interviewer on the study were handled with reflection and framing (Liamputtong 2010). In addition, credibility was strengthened by including interviewees from a variety of backgrounds; nevertheless, the findings show that their experiences also have shared features.

Ethical Considerations

Because the study was conducted in an insular society, special care had to be taken to ensure the confidentiality of the interviewees and make certain that their stories were not made public (Corbin and Morse 2003). The need to maintain confidentiality was especially important in light of the participants' comments about the centrality of hiding certain things in ultraorthodox society. This issue brought up the ambivalence between the value of maintaining strict confidentiality and the value of learning. The conflict was resolved by not revealing identifying information about the participants.

Results

Three main themes were found based on the content analysis of the focus group discussions, relating to the participants' perceptions about health, in general, and cancer, specifically. The themes include issues of responsibility for promoting health and are distributed along three circles that are central to an ultraorthodox woman's life: faith in God and in the religious lifestyle, the Rabbi as a guide and advisor, and one's relationship with the community.

The Physician is Just a Messenger: Faith in God and a Religious Lifestyle

The women who participated in our study believe that their ultraorthodox Jewish faith, and the strictly religious lifestyle associated with it, is beneficial to their health and reduces the risk of grave illnesses and other medical issues. The women stated that there are clear rulings and laws that require religious people to take care of their health:

> …the Rambam[1], who was the greatest of Physicians… writes about how a man should live; if he eats right, if he sleeps on time, if he exercises. He gives a very clear explanation of how a man is supposed to live so that he won't get sick (Shulamit, age 60).

Moreover, the women expressed their belief that living a "proper" (religious) lifestyle protects them from medical conditions that afflict non-religious individuals, believing that the latter were more vulnerable, due to the secular society's "ill" way of life, especially the high stress levels and the pursuit of a material way of life. The following quotes illustrate some of the benefits the women perceive in leading a religious lifestyle, compared to a non-religious lifestyle and values:

> The Haredi public is less exposed to the media, so it accumulates less stress, and anxiety and fear about everything that happens in the world (Yafa, age 49).
> [Secular] people live in a very certain way: they chase money and everything; they run after life and don't look, don't say wait, I want to live well, to live happily, a quality life. That's health (Shifra, age 27).

In addition to the belief that their religious lifestyle is a protective factor, which reduces the need to visit physicians, several of the women suggested that seeking medical attention may be a sign of lesser faith, as well as a form of over-reliance on the medical system. Doing so was described as absolving oneself of responsibility for personal health and transferring the responsibility to the physician:

> I think that people who are not believers don't want to take responsibility; they put the responsibility on the Physician, and the Physician takes no responsibility. He makes her [the patient] sign a paper that says he doesn't commit to anything (Yafa, age 49).
> ….But religious people don't pin all their hopes on the Physician, there's another way (Mali, age 32).

Moreover, the physician is viewed less as an expert in his or her own right and more as a means through which God can bring about healing:

[1] The Rambam is the Hebrew name for Maimonides, a noted medieval Jewish philosopher, religious scholar and physician.

> We should trust in God, because we know that only he is responsible for the result, so we pray that things will turn out well… (Bina, 51).
> I think faith is the most important thing in life, not just in regard to cancer but in regard to everything in life. The Physician is just a messenger; you should pray that he will be a good and faithful messenger, and that's all. You should go to the Physician… yes you should, the Halacha (Jewish religious law) also requires it, but don't be hysterical (Shulamit, age 47).

Not being "hysterical"—avoiding unnecessary tests and the related stress—were recurring sentiments among the women, several of whom suggested that getting tested increases the likelihood of finding something, which might not have happened otherwise:

> Sometimes you shouldn't look into things too much; sometimes it's just more stressful to the person… When you look, you always find something (Hadas).
> If you need to do something then you should do it, but not twice a week, or dreaming about it all the time and having nightmares. (Yafa, age 49).

However, there was also some confusion and ambiguity when the women tried to determine when undergoing the recommended tests represented taking responsibility for one's health, rather than overdoing it, which was perceived as a sign of lesser faith or "being hysterical."

With regard to screening rates among ultraorthodox women in Israel, another recurring suggestion among our study participants was that religious women undergo fewer tests not because they are irresponsible or unaware of their health and the importance of taking care of themselves, but because they are less affected by external sources of pressure:

> We know that it (cancer) exists and that you need to have check-ups; you should be very aware and careful, but we don't get all the brainwashing that people get in many areas (Avital, age 38).
> When you don't hear, your ears are clean, your heart is calm; you know that God is with you (Talia, age 50).

Another possibility that was suggested was that tests were unnecessary because God would not let one become ill:

> I trust in God that He will not put me to this test; that it's far from me, God willing…[By the time I'm older], the Messiah will come and everything will be fine (Bina, age 51).

In addition to less exposure to external messages and fewer related concerns, religious women considered themselves more aware of their bodies and their lives than non-religious women and thus less in need of medical tests. This attitude is most clearly exemplified in the following statement by Shifra:

> I think that secular people do more [check-ups], not because they are more aware – I would interpret the word awareness differently – it's because they are less aware of themselves. That's why they do more. We're more aware of ourselves. If I know how to take care of myself, so that I won't get this sickness, then I don't need the test. They're aware of the test, but not aware of themselves, so they have a greater chance of getting this sickness and they go to do the test. So this awareness really means that they're not aware enough.

Each One has her Rabbi: The Role of the Rabbi in Preserving Personal Health

The participants discussed the process of making the decision of whether to undergo breast cancer examinations and how frequently this should be done. As is the case with other health-related decisions, the women considered their Rabbis to be the main authority they needed to consult. The Rabbi is viewed as a divine authority and, as such, his responses and decisions represent those of God and can be trusted absolutely, as exemplified by Moriah's (age 39) comment:

> This is the power of the faith of the wise; we know that whatever we ask our Rabbi, we can trust him with our eyes closed. I asked – and I know that what he said is like an answer from above.

Rabbis are consulted on a variety of medical matters. The participants agreed that the Rabbi is ultimately the one who makes decisions regarding medical care and treatment, based on the information provided to him and his own religious knowledge: which treatment options are the best and most appropriate, which physicians and specialists should be consulted, and which medical brokers should be approached in order to best navigate the medical system.

The women expressed the need to seek out the Rabbi's opinion not only in regard to medical treatment, but also when deciding whether or not to undergo various types of medical tests, such as a mammography or clinical examination. The Rabbi's role in making decisions regarding medical treatment and testing was not questioned by any of the women; they fully expect to consult with their Rabbis about medical issues and to comply with their decision. In fact, the Rabbi is considered, in some cases, to be a more trustworthy authority than medical physicians.

However, the participants were aware that different Rabbis can reach different decisions regarding the same medical procedure:

> Each one has her own Rabbi, who she asks. I know someone who asked her Rabbi and he told her not to do it (the screening test); and I know someone else who asked another Rabbi and he told her to do it, even though it was just a routine test (Rachel, age 50).

Consequently, when the question of how to promote adherence to screening among ultraorthodox women came up, the participants believed that a substantial change could be accomplished only through engagement with the Rabbis:

> In my opinion, in the Haredi (ultraorthodox) sector, if you want to promote this issue (breast exams) you need to contact the Rabbis. If the Rabbis encourage the women, even if there are modesty concerns because it's the breast, if we receive an order to "watch ourselves"…, I am sure each woman will take this advice seriously and go do the tests. But as long as it comes from the medical profession, then each woman will consult [her Rabbi first] and, once again, all the reasons mentioned earlier – about to dig or not to dig – will come up (Avital).

The People of Israel are a Unified Group: Personal Health in Relation to the Community

The participants indicated that the community plays an important role in the lives of ultraorthodox women; medical issues, both their own and those of others, are affected by

this involvement. Illness is viewed as affecting not only the individual or the family, but also the broader community:

> We treat them [cancer patients] as righteous people who pass away or sick people who atone for the rest; everyone does their reckoning and everyone tries to take something upon themselves, too… I mean, it's not just the person who is responsible for himself and that's it; we're the People of Israel and we are all together, living side by side (Merav, age 46).

Illness of an individual is often perceived as a message from God and an opportunity for each community member to atone and make amends for their own transgressions on behalf of the whole community:

> I think it [cancer] is a message from above to awaken us and our deeds… the people of Israel are one link in a long chain and are linked to one another; I am responsible for you and you are responsible for me… Those who are wise and see things correctly understand that (bad things) are a message to wake us up, so that it won't happen to us. The horrors of this world happen, so that we will wake up and fix our own deeds (Shulamit).

Another aspect of this idea of mutual responsibility is the belief that each individual is responsible for the others members of the community. Thus, perhaps the most frequent activity mentioned for members of the community is praying for people who are ill, whether one knows them personally or not. Jewish people are viewed as being connected to one another and responsible for each other; prayer is an expression of this, as it allows people to take what they perceive as an active role in helping others:

> We just prayed; every day we recited Psalms at my house… (Yocheved, age 39).
> Sometimes, when you're listening to the radio (an ultra-orthodox station) and they ask you to please pray for this or that stranger, you simply drop everything, take a book of Psalms and pray for that person. This is because we care about everyone; every Jew who hurts, you feel his pain yourself, physically… (Shulamit).

In addition to prayer, ultraorthodox communities rally around members in need, offering various kinds of support and help, either individually or through charity organizations. A strong sense of solidarity and connectedness with sick members was stressed by the participants.

> There is so much solidarity, you feel the togetherness. When everyone works together, there is more strength to succeed in overcoming whatever bad things may come (Merav).

The community is clearly viewed as a powerful source of assistance, both religious and practical. In some cases, however, community involvement is not sought; the women noted that some things are kept to one's family, and sometimes only the women in the family, due to privacy concerns. This is especially evident when modesty is an issue, as is the case when it comes to breast cancer exams and treatment. Although the women do not object to sharing this information with some people, they prefer to restrict it to their husbands and perhaps close female relatives:

> Say, my husband comes home from synagogue to tell me about someone who, God forbid, has the illness (cancer is often not referred to by name); then, it's not

appropriate for a man to come and tell me, she has it in her breast… it's not respectful, not appropriate, not nice. They'll leave the details to her family (Moriah).

Discussion

The analysis of the focus groups' discussions revealed three main themes related to promoting and preserving personal health and screening behaviors, which can be seen as three main circles of life central to ultraorthodox women's *Faith in God and the religious way of life*—this includes the perceptions of the religious women regarding breast cancer and their performance of early detection exams. *Guidance of the Rabbi*—who acts as an advisor and instructor and plays a central role in deciding which exams to undergo and how often. *The reciprocal responsibility of the individual and the community as a source of strength*—the women believed that these circles play a protective role regarding women's health, but were uncertain regarding the need for screening and its preferred intensity, and how these relate to the protective factors they perceive to exist in their lives.

Daily life, practices, traditions, the lifestyle followed, and other aspects in the lives of ultraorthodox Jews revolve around the divine law, as expressed in the Torah and religious texts and as interpreted by the Rabbi. The Rabbi, as an expert in religious law and practice, provides guidance and counseling to the members of his community. Ultraorthodox Jews are highly involved in the community that they belong to and know one another well; hence, the community can be a source of support as well as criticism.

Regarding the first circle, that of faith in God, the women expressed a deep belief in the impact of the religious lifestyle and the ways in which it promotes health. In addition, they voiced the opinion that the lifestyle associated with ultraorthodox Judaism could protect them from cancer and other medical problems. They referred to Jewish law and interpretations that clearly illustrate how a person can live the best possible lifestyle, thus promoting better health outcomes. In this, our participants appear to be similar to orthodox Jewish women in the UK, who also claimed that the Jewish religious lifestyle has multiple protective properties (Pfeffer 2004).

These findings support those of several previous studies that showed that ultraorthodox women are guided in their decision-making by their faith, believe that God has a plan for them, and espouse fatalistic beliefs (e.g., Baron-Epel 2010; Coleman 2008; Teman et al. 2011). However, the belief that illness and disease are part of God's plan was not a passive belief; rather, this belief entails the adoption of a more active role in preserving health through the religious lifestyle. Their descriptions of what such a life entailed included avoiding exposure to the media; trying to live a quality life, rather than one based on financial goals and the resulting stress; and eating right.

As for the second circle, the women viewed their Rabbis as important authority figures, whose guidance and opinions ensure that one acts according to God's will. This finding is in line with the literature on the role of the Rabbi in healthcare (e.g., Flannelly et al. 2006; Mor and Oberle 2009). More specifically, it supports Coleman-Brueckheimer et al. (2009) observation that Rabbis are an important resource for ultraorthodox breast cancer patients in the UK, sometimes taking an active role in the decision-making process. Our study indicates that not only can a similar pattern be found among ultraorthodox Israeli women, but also that Rabbis have an important role to play in promoting preventive behaviors as they relate to women's health, namely adherence to breast cancer screenings. Indeed, several participants noted that it would be beneficial for medical professionals and decision

makers to work together with Rabbis in order to better reach the ultraorthodox population and persuade its members of the importance of undergoing such screenings. As members of ultraorthodox society may place more faith in religious rather than medical certainty regarding the benefits of medical practices (e.g., Teman et al. 2011), Rabbis have a considerable degree of power when it comes to promoting various health behaviors.

The participants also noted that Rabbis are not homogenous in their approach and opinions, and different Rabbis may give different advice and direction when presented with the same medical problem. A similar finding was reported by Coleman-Brueckheimer et al. (2009), who suggested that the decision about which Rabbi to consult, and how to frame and present one's concerns and questions, is a religiously and culturally sanctioned method of decision-making that is in line with ultraorthodox women's beliefs (Philip et al. 2010).

The orthodox communities that the women live in are tight knit. This third circle provides advantages, such as a sense of togetherness and the ability to help in times of need; on the other hand, the women also expressed concerns about not wanting medical issues to become widely known. Coleman-Brueckheimer and Dein (2011) point out that many illnesses and health issues are considered stigmatizing in the ultraorthodox community, while Rier et al. (2008) noted that the modesty concerns prevalent in ultraorthodox society are a barrier to sharing. This appears to be the case in our study as well, and discussing breast cancer specifically was perceived as disrespectful and inappropriate outside the woman's family.

An important aspect of the strong relationships between the members of the community can be seen in the sense of solidarity and mutual aid, which characterizes ultraorthodox populations (Berman 2000). This involvement is expressed in the empathy, compassion, caring, and help extended to community members with cancer. One example is the way the community rallies together to pray for an ill member. However, the prayer is not just for the person who is ill; the women expressed their faith that the illness of one member serves to protect the other community members and help them atone for and correct their behaviors, meaning that the community also protects their health in this way.

An interesting finding is that the participants found it difficult to say what degree of need there was to undergo routine screening. On the one hand, the women stated that, as religious Jews, they are required to take care of their health and undergo needed screenings. This is in line with previous research indicating higher intentions to follow mammography screening recommendations among women with a strong Jewish religious identity (Bowen et al. 2003). However, the women also suggested that religious people can undergo fewer tests than non-religious people, for reasons including the protective properties of the religious lifestyle and what they consider to be their greater awareness of their bodies. They stated that one should not become "hysterical" about health matters or do too many tests (unlike non-religious people), while "hysterical" could be defined as undergoing tests according to the medical guidelines. However, their comments on the subject of how many tests to perform were generally vague, and they could not point to any specific guidelines regarding what "fewer tests" or not being "hysterical" actually mean.

It is important to analyze the present results in comparison with studies examining the perception of cancer and screenings in other traditional or religious groups. Some of the perceptions expressed by the women are similar to those found among Arab women in Israel (e.g., Azaiza and Cohen 2008a; Goldblatt et al. 2012), who also had high reported levels of religiosity. These include the fatalistic view that everything is in God's hands, that cancer is an expression of God's will, and is a punishment or a test. The religious responsibility to protect one's health was also expressed by Arab women in relation to undergoing breast cancer screenings (Azaiza and Cohen 2008a). However, differences

between the two populations are also evident: The Arab women expressed barriers to screening that were fatalistic in nature and suggested that once someone has cancer, the result will be death so that early detection is meaningless (Azaiza and Cohen 2008a), while the orthodox women suggested that tests are not really necessary because religious women are more aware of their bodies. Studies conducted among Arab women did not reveal the same advisory/decision-making role of the religious authority that was found among the ultraorthodox participants in our study regarding their Rabbis. In the case of the Arab women, the decision is made by the women or their partners and is often expressed in a lack of decision about whether to do the tests, rather than a conscious decision not to do the tests (Azaiza and Cohen 2008a).

The Arab women also referred to the role of the community and the society in which they live, pointing out the community members' compassion and desire to help. However, they mainly emphasized people's fear of the disease and the many stigmas regarding cancer patients, which result in people distancing themselves from cancer patients, and cancer patients trying to distance themselves from others, in order to hide their illness (Azaiza and Cohen 2008a, Azaiza et al. 2010). Rallying around the ill person through assistance and prayers appears to be unique to the ultraorthodox society. Interestingly, ultraorthodox breast cancer patients from England also reported experiencing stigmatization in their community and feared that there would be implications in regard to their children's matrimonial prospects (Coleman 2008). This may be because members of the Jewish ultraorthodox society in England are a smaller minority in the UK than they are in Israel, leading to different levels of insularity and pressure. Another possibility is that such issues are of greater concern to ultraorthodox women who have actually been diagnosed with breast cancer, as compared with those who have not had any personal experience with the disease.

This study has several limitations that must be acknowledged. First, although the groups included women from various ultraorthodox communities, women who had grown up in ultraorthodox communities and those who embraced religion at a later age, and women of different ages and levels of education, it was still impossible to capture the full diversity of ultraorthodox society. Additional research with a broader scope could enrich the existing knowledge in this regard. A second limitation has to do with the use of focus groups to collect data. Some of the women may have felt more inhibited and might not have shared thoughts or perceptions that differ from those of the other participants in their group, or views that lie outside the consensus within their community.

Despite these limitations, the study provides one of the first views about the perceptions of ultraorthodox women regarding cancer and early detection tests. It presents the manner in which these perceptions are integrated with their religious faith in the broader sense, as well as the religious lifestyle. The study findings can help develop new interventions targeted at increasing attendance at screenings. For instance, contrary to the approach that focuses on increasing physicians' awareness and the idea that they should more strongly recommend the tests, in orthodox society, improving adherence is greatly dependent on the knowledge and awareness of the Rabbis; thus, they should be viewed as a future target for interventions designed to increase awareness. The role of the community in providing support and encouragement allows for the development of interventions aimed at the perception of mutual solidarity and responsibility in the community. In addition, the finding that ultraorthodox women do not have any principled objection to undergoing tests, but do have a somewhat vague perception of the possibility of undergoing fewer tests, suggests that programs should be targeted toward better clarifying these somewhat cloudy issues.

This is the first in-depth study of its kind to be conducted among ultraorthodox women in Israel; as such, it provides an important initial understanding of how they view cancer and early detection tests. Future studies focused on a broader cross section of ultraorthodox society, as well as utilizing other qualitative methods (such as individual interviews), are needed in order to better understand the perceptions and behavior of this population. The study's findings also point to the importance of tailoring research and interventions in this field to the unique needs of members of certain religious groups. Members of different religions and different groups within these religions can have vastly different views, perceptions, and experiences. Understanding how these affect health behaviors, in general, and adherence to early screening procedures, in particular, is of vital importance in order to promote better health outcomes.

References

Abraıdo-Lanza, A. F., Viladrich, A., Fló rez, K. R., Céspedes, A., Aguirre, A. N., & De La Cruz, A. A. (2007). Fatalismo reconsidered: A cautionary note for health-related research and practice with Latino populations. *Ethnicity and Disease, 17*, 153–158.

Albert, S. M., Harlap, S., & Caplan, L. (2004). Cancer screening among older women in a culturally insular community. *Preventive Medicine, 39*(4), 649–656.

Allison, M. A., Jensky, N. E., Marshall, S. J., Bertoni, A. G., & Cushman, M. (2012). Sedentary behavior and adiposity-associated inflammation: The multi-ethnic study of atherosclerosis. *American Journal of Preventive Medicine, 42*(1), 8–13.

Anis, E., Grotto, I., Moerman, L., Warshavsky, B., Slater, P. E., Lev, B., et al. (2009). Measles in a highly vaccinated society: The 2007–2008 outbreak in Israel. *The Journal of Infection, 59*(4), 252–258.

Azaiza, F., & Cohen, M. (2006). Health beliefs and rates of breast cancer screening among Arab women. *Journal of Women's Health, 15*(5), 520–530.

Azaiza, F., & Cohen, M. (2008a). Between traditional and modern perceptions of breast and cervical cancer screenings: A qualitative study of Arab women in Israel. *Psycho-Oncology, 17*, 34–41.

Azaiza, F., & Cohen, M. (2008b). Colorectal cancer screening, intentions, and predictors in Jewish and Arab Israelis: A population-based study. *Health Education & Behavior, 35*(4), 478–493.

Azaiza, F., Cohen, M., Awad, M., & Daoud, F. (2010). Factors associated with low screening for breast cancer in the Palestinian Authority: Relations of availability, barriers fatalism. *Cancer*, *116*, 4646–4655.

Azaiza, F., Cohen, M., Daoud, F., & Awad, M. (2011). Traditional-Westernizing continuum of change in screening behaviors: Comparison between Arab women in Israel and the West Bank. *Breast Cancer Research and Treatment*, *128*, 219–227.

Bandi, P., Cokkinides, V., Smith, R. A., & Jemal, A. (2012). Trends in colorectal cancer screening with home-based fecal occult blood tests in adults ages 50 to 64 years, 2000 to 2008. *Cancer*. doi: 10.1002/cncr.27529.

Baron-Epel, O. (2010). Attitudes and beliefs Associated with mammography in a multiethnic population in Israel. *Health Education & Behavior, 37*(2), 227–242.

Baron-Epel, O., Friedman, N., & Lernau, O. (2008). Validity of self-reported mammography in a multicultural population in Israel. *Preventive Medicine, 46*, 489–491.

Baron-Epel, O., Friedman, N., & Lernau, O. (2009). Reducing disparities in mammography-use in a multicultural population in Israel. *International Journal for Equity in Health*. doi:10.1186/1475-9276-8-19.

Bellizzi, K. M., Breslau, E. S., Burness, A., & Waldron, W. (2011). Prevalence of cancer screening in older, racially diverse adults: Still screening after all these years. *Archives of Internal Medicine, 171*(22), 2031–2037.

Berman, E. (2000). Sect, subsidy, and sacrifice: An economist's view of ultra-orthodox Jews. *The Quarterly Journal of Economics, 115*(3), 905–953.

Bowen, D. J., Singal, R., Eng, E., Crystal, S., & Burke, W. (2003). Jewish identity and intentions to obtain breast cancer screening. *Cultural Diversity & Ethnic Minority Psychology, 9*, 79–87.

Central Bureau of Statistics. (2010). *Social survey 2009—religiosity in Israel—characteristics of different groups*. Jerusalem: Central Bureau of Statistics (in Hebrew).

Central Bureau of Statistics. (2011). *Statistical abstract of Israel 2011*. Jerusalem: Central Bureau of Statistics (in Hebrew).

Cohen, M. (2006). Breast cancer early detection, health beliefs, and cancer worries in randomly selected women with and without a family history of breast cancer. *PsychoOncology, 15*, 873–883.
Cohen, M., & Azaiza, F. (2005). Early breast cancer detection practices, health beliefs and cancer worries in Jewish and Arab women. *Preventive Medicine, 41*, 852–858.
Cohen, M., & Azaiza, F. (2007). Health-promoting behaviors and health locus of control from a multicultural perspective. *Ethnicity and Disease, 17*, 636–642.
Cohen, M., & Azaiza, F. (2010). Increasing breast examinations among Arab women using a tailored culture-based intervention. *Behavioral Medicine, 36*, 92–99.
Coleman, K. (2008). Personal and communal reactions to cancer: An interpretative phenomenological analysis of the beliefs held by charedi Jewish breast cancer patients. In P. L. Twohig & V. Kalitzkus (Eds.), *The Tapestry of Health, Illness and Disease* (pp. 75–94). Amsterdam: Rodopi.
Coleman, K., Koffman, J., & Daniels, C. (2007). Why is this happening to me? Illness beliefs held by haredi Jewish breast cancer patients: An exploratory study. *Spirituality and Health International, 8*, 121–134.
Coleman-Brueckheimer, K., & Dein, S. (2011). Health care behaviours and beliefs in Hasidic Jewish populations: A systematic review of the literature. *Journal of Religion and Health, 50*, 422–436.
Coleman-Brueckheimer, K., Spitzer, J., & Koffman, J. (2009). Involvement of Rabbinic and communal authorities in decision-making by haredi Jews in the UK with breast cancer: An interpretative phenomenological analysis. *Social Science and Medicine, 68*, 323–333.
Corbin, J., & Morse, J. M. (2003). The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics. *Qualitative Inquiry, 9*, 335–354. doi:10.1177/1077800403009003001.
Finlay, L., & Gough, B. (2003). *Reflexivity: A practical guide for researchers in health and social sciences*. Bodmin, Great Britain: Blackwell.
Finney Rutten, L. J., & Iannotti, R. J. (2003). Health beliefs, salience of breast cancer family history, and involvement with breast cancer issues: Adherence to annual mammography screening recommendations. *Cancer Detection and Prevention, 27*, 353–359.
Flannelly, K. J., Stern, S., Costa, K. G., Weaver, A. J., & Koenig, H. G. (2006). Rabbis and health: A half-century review of the mental and physical health care literature: 1950–1999. *Pastoral Psychology, 54*(6), 545–554.
Friedman, M. (1991). *The Haredi ultra-orthodox society: Sources trends and processes*. Jerusalem: The Jerusalem Institute for Israel Studies.
Goldblatt, H., Cohen, M., Azaiza, F., & Manassa, R. (2012). Being within or being between? The cultural context of Arab women's experience of coping with breast cancer in Israel. *Psycho-Oncology*. doi: 10.1002/pon.3078.
Gonzales, M., Nelson, H., Rhyne, R. L., Stone, S. N., & Hoffman, R. M. (2012). Surveillance of colorectal cancer screening in New Mexico Hispanics and non-Hispanic whites. *Journal of Community Health*. doi:10.1007/s10900-012-9568-6.
Goodman, Y., & Witztum, E. (2002). Cross-cultural encounters between care providers: Rabbis' referral letters to a psychiatric clinic in Israel. *Social Science and Medicine, 55*, 1309–1323.
Gurovich, N., & Cohen-Kastro, E. (2004). *Ultra-orthodox Jews geographic distribution and demographic, social and economic characteristics of the ultra-orthodox Jewish population in Israel 1996–2001*. Jerusalem: Central Bureau of Statistics (in Hebrew).
Harmon, M. P., Castro, F. G., & Coe, K. (1996). Acculturation and cervical cancer: Knowledge, beliefs, and behaviors of Hispanic women. *Women and Health, 24*(3), 37–57.
Katapodi, M. C., Lee, K. A., Facione, N. C., & Dodd, M. J. (2004). Predictors of perceived breast cancer risk and the relation between perceived risk and breast cancer screening: A meta-analytic review. *Preventive Medicine, 38*(4), 388–402.
Lange, L. J., & Piette, J. D. (2006). Personal models for diabetes in context and patients' health status. *Journal of Behavioural Medicine, 29*(3), 239–253.
Liamputtong, P. (2010). *Performing qualitative cross-cultural research*. Cambridge, United Kingdom: Cambridge University Press.
Lopez-McKee, G., McNeill, J., Bader, J., & Morales, P. (2008). Comparison of factors affecting repeat mammography screening of low-income Mexican-American women. *Oncology Nursing Forum, 35*(6), 941–946.
Mason, J. (1996). *Qualitative researching*. London: Sage.
Miranda, P. Y., Tarraf, W., González, P., Johnson-Jennings, M., & González, H. M. (2012). Breast cancer screening trends in the United States and ethnicity. *Cancer Epidemiology, Biomarkers and Prevention, 21*(2), 351–357.
Mor, P., & Oberle, K. (2009). Ethical issues related to BRCA gene testing in orthodox Jewish women. *Nursing Ethics, 15*(4), 512–522.
Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Palmer, R. C., Emmons, K. M., Fletcher, R. H., Lobb, R., Miroshnik, I., Kemp, J. A., et al. (2008). Familial risk and colorectal cancer screening health beliefs and attitudes in an insured population. *Preventive Medicine, 45*, 336–341.

Pasick, R. J., & Burke, N. J. (2008). A critical review of theory in breast cancer screening promotion across cultures. *Annual Review of Public Health, 9*, 351–368.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Perez-Stable, E. J., Sabogal, E., & Otero-Sabogal, R. (1995). Use of cancer-screening tests in the San Francisco Bay area: Comparison of Latinos and Anglos. *Journal of the National Cancer Institute Monographs, 18*, 147–153.

Pfeffer, N. (2004). Screening for breast cancer: Candidacy and compliance. *Social Science and Medicine, 58*(1), 151–160.

Philip, E. J., DuHamel, K., & Jandorf, L. (2010). Evaluating the impact of an educational intervention to increase CRC screening rates in the African American community: A preliminary study. *Cancer Causes and Control, 21*(10), 1685–1691.

Pruitt, S., Shim, M., Mullen, P., Vernon, S., & Amick, B. (2009). Association of area socioeconomic status and breast, cervical, and colorectal cancer screening: A systematic review. *Cancer Epidemiology Biomarkers and Prevention, 18*(10), 2579.

Ribner, D. S. (2003). Modifying sensate focus for use with Haredi (Ultra-Orthodox) Jewish couples. *Journal of Sex and Marital Therapy, 29*, 165–171.

Rier, D. A., Schwartzbaum, A., & Heller, C. (2008). Methodological issues in studying an insular, traditional population: A women's health survey among Israeli Haredi (Ultra-orthodox) Jews. *Women and Health, 48*(4), 363–381.

Russell, K. M., Champion, V. L., & Skinner, C. S. (2006). Psychosocial factors related to repeat mammography screening over 5 years in African American women. *Cancer Nursing, 29*, 236–243.

Sanders Thompson, V. L., Lewis, T., & Williams, S. L. (2011). Refining the use of cancer-related cultural constructs among African Americans. *Health Promotion Practice*. doi:10.1177/1524839911399431.

Schnitzer, G., Loots, G., Escudero, V., & Schechter, I. (2011). Negotiating the pathways into care in a globalizing world: Help-seeking behaviour of ultra-orthodox Jewish parents. *International Journal of Social Psychiatry, 57*(2), 153–165.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Los Angeles, CA: Sage.

Spurlock, W. R., & Cullins, L. S. (2006). Cancer fatalism and breast cancer screening in African American women. *The ABNF Journal, 17*(1), 38–43.

Stadler, N., Lomsky-Feder, E., & Ben-Ari, E. (2008). Fundamentalism's encounters with citizenship: The Haredim in Israel. *Citizenship Studies, 12*(3), 215–231.

Strauss, E. (2007). Factors effecting health behavior, related to breast cancer screening, among Jewish Ultra orthodox women in comparison to Jewish non-ultra orthodox women. Doctoral Dissertation, Tel-Aviv University.

Talbert, P. Y. (2008). The relationship of fear and fatalism with breast cancer screening among a selected target population of African American middle class women. *Journal of Social, Behavioral, and Health Sciences, 2*, 96–110.

Teman, E., Ivry, T., & Bernhardt, B. A. (2011). Pregnancy as a proclamation of faith: Ultra-orthodox Jewish women navigating the uncertainty of pregnancy and prenatal diagnosis. *American Journal of Medical Genetics Part A, 155*, 69–80.