

Experienced concept of breast cancer survivors: directions for nursing and health care



Conceito vivido de sobrevivente ao câncer de mama: direcionamentos para cuidados de enfermagem e saúde

Concepto vivido de sobreviviente de cáncer de mama: orientaciones para la enfermería y la atención en salud

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ABSTRACT

Objective: To unveil the existential movement of being a woman survivor of breast cancer.

Method: Qualitative, phenomenological, with Heideggerian analytics from 15 interviews, between October 2020 and January 2021 in a teaching hospital in Minas Gerais. The construction of seven Meaning Units was followed by comprehensive methodical moments.

Results: The being-there-woman-survivor-of-breast-cancer showed itself in the ways of being of everyday life, occupied in manuality of tasks inside and outside the home, moved by impersonality and impropriety. The fear of death, gossip, curiosity and ambiguity were revealed that led to decadence, experienced in the world of treatment and follow-up, enabling being-with. The anguish that announced itself fleetingly was followed by the decadence that most of the time the presence remains.

Conclusion: The need to structure a specialized and interdisciplinary line of care is reinforced, in which care centered on active and qualified listening encompasses multidimensionality, envisioning women in aspects that permeate cancer survival.

Keywords: Breast neoplasms. Cancer survivors. Qualitative research. Nursing.

RESUMO

Objetivo: Desvelar o movimento existencial do ser mulher sobrevivente ao câncer de mama.

Métodos: Qualitativo, fenomenológico, com analítica heideggeriana a partir de 15 entrevistas, entre outubro de 2020 e janeiro de 2021, em um hospital de ensino mineiro. À construção das Unidades de Significação, seguiram-se momentos metódicos compreensivos.

Resultados: O ser-aí-mulher-sobrevivente-ao-câncer-de-mama se mostrou na cotidianidade, ocupada na manualidade dos afazeres dentro e fora de casa, movida pela impessoalidade e impropriedade. Desvelou-se o temor da morte, falatório, curiosidade e ambiguidade que a conduziram à decadência, vivenciada no mundo do tratamento e do seguimento, possibilitando ser-com. À angústia que se anunciou fugaz, seguiu-se a decadência que na maior parte das vezes a presença se mantém.

Conclusões: Reforça-se a necessária estruturação de linha de cuidados especializada e interdisciplinar, em que o cuidado centrado na escuta ativa e qualificada abarque a multidimensionalidade, vislumbrando a mulher nos aspectos que permeiam a sobrevivência ao câncer.

Palavras-chave: Neoplasias da mama. Sobreviventes de câncer. Pesquisa qualitativa. Enfermagem.

RESUMEN

Objetivo: Develar el movimiento existencial de ser mujer sobreviviente de cáncer de mama.

Métodos: Cualitativa, fenomenológica, con analítica heideggeriana a partir de las entrevistas de 15 mujeres, entre Octubre/2020 a Enero/2021 en un hospital de Minas Gerais. A la construcción de las siete Unidades de Significado le siguieron momentos comprensivos.

Resultados: El ser-ahí-mulher-sobreviviente-de-câncer-de-mama se manifestó en los modos de ser de la vida cotidiana, ocupada en la manualidad, de que hacer dentro y fuera del hogar, impulsados por la impersonalidad y la impropiedad. Se revelaron el miedo a la muerte, las habladurías, la curiosidad y la ambigüedad que la llevaron a la decadencia, experimentada en el mundo del tratamiento y seguimiento, posibilitando el estar-con. A la angustia que se anunciaba fugazmente le siguió la decadencia que la mayor parte del tiempo permanece la presencia.

Conclusiones: Se refuerza la necesidad de estructurar una línea de atención especializada e interdisciplinaria, en la que la atención centrada en la escucha activa y calificada abarque la multidimensionalidad, vislumbrando a la mujer en los aspectos que permean la supervivencia al cáncer.

Palabras clave: Neoplasias de la mama. Supervivientes de cáncer. Investigación cualitativa. Enfermería.

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■ INTRODUCTION

In Brazil, 625,000 new cases of cancer are expected to occur for each year of the triennium 2020–2022. Among these, 66,280 are breast cancer, representing 29.7% of oncological diseases in women, that is, the one with the highest incidence in this gender, not counting the non-melanoma skin type⁽¹⁾.

The overall survival of people with breast cancer ranges from 65% to 87% in five years, with changes in different regions, often related to socioeconomic conditions. More developed regions, despite higher incidences, tend to have better survival rates⁽²⁾.

Survival from breast cancer depends on the stage of the disease and possibly on the interval for the beginning of treatment, the quality of the treatment instituted and the patient's adherence to the follow-up, which is susceptible to social factors such as education level, family income, access to information and health services⁽³⁾.

The definition of the terms “cancer survivor” and “cancer survival” has been the subject of extensive debates. The concept of survival emerged from the medical literature as a synonym with emphasis on survival time, relating to that person who, having his/her life at risk, is alive five years after diagnosis. The survival state, and therefore the survivor status, begins at the moment of diagnosis, when people begin to adjust to what will be not only their immediate existence, but also their future. In this sense, being a survivor is more than a binary question, for which it is not possible to set boundaries⁽⁴⁾.

Thus, the repercussions of breast cancer are not limited to the moment of diagnosis and treatment, becoming part of the woman's daily life from the suspicion of a recurrence, lasting for all life⁽⁵⁾. Although the survivor “label” is part of their backstory, a cure cannot be considered, allowing feelings of uncertainty and fear about recurrence.

Oncology is an area that demands high complexity care throughout the therapeutic, follow-up and monitoring process, requiring from health professionals, especially nurses, extreme relational and affective abilities, considering the needs and specificities of users⁽⁶⁾, this is consistent with the expanded concept of survivor, envisioning the individual in a biopsychosocial-spiritual context.

From this, it becomes important to rethink what is necessary for better care for those who survive this disease. Only immediate treatment is not enough, as the woman will have to deal with late effects and complications, in addition to experiencing psychosocial issues intrinsic to the condition of survival. With regard to comprehensive care in the situation

of illness from breast cancer, it is believed that Nursing can move towards an assistance that transcends technical and protocol guidelines and reflects on the subjective and essential aspects that involve women, as their life story, the meaning of survival and how this implies their daily lives⁽⁷⁾.

In this plan, daily coexistence in clinical practice with women who survived cancer and who expressed the fear of recurrence, uncertainties about the future and the deleterious effects of an invasive treatment aroused concerns and questions about what it is like for the woman to experience the condition of a breast cancer survivor, with the aim of unveiling the existential movement of being a woman who has survived breast cancer.

The phenomenology in Martin Heidegger's thinking emerged as a possibility of theoretical, philosophical and methodological research framework, since it is in the factual experience of breast cancer survival — in the experienced world⁽⁸⁾ — that there is a possibility of understanding for better care from the perspective of integrality of health actions.

■ METHOD

This is a qualitative, descriptive and interpretive research with a phenomenological approach based on Martin Heidegger that made it possible for the breast cancer survivor to show herself as a being in herself, in the search for understanding the sides of the phenomenon from those who experience it⁽⁸⁾. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guide was considered for the scientific writing of this investigation.

The research was developed with women who survived breast cancer under follow-up at an Oncology and Mastology Surgery outpatient clinic of a teaching hospital, from October 2020 to January 2021, in Minas Gerais. To gather the participants, convenience sampling was used through the weekly scheduling of patients for consultations through the electronic and technology system developed for the hospital in question, and a survey was carried out in the electronic medical record of all patients scheduled from March to December 2020.

The following inclusion criteria were met: being over 18 years of age; having finished the treatment for breast cancer; and being monitored at the hospital's outpatient clinic, and those that were excluded from having mental disorders; having a history of other type(s) of cancer; and being in palliative care. Then, telephone contact was made with 38 possible participants in order to introduce the researcher, explain the objectives of the study and, in view of their acceptance and availability, schedule the interview for choice of date

and place. From these, 19 did not answer the phone, or the number called did not exist, two refused to participate in the study due to emotional fragility in reporting the subject, and two had a recurrence of the disease and were undergoing treatment at the time of contact.

It is highlighted that the researcher responsible for conducting the interviews had previous experience of data collection using this technique, because the development of previous research at graduation and residency. In addition, she was familiar with the research setting, as she worked as a nurse in the hospital institution. However, no previous relationship was established between the interviewer and the participants in the role of nurse and patient, since nursing consultations were not being conducted in the period that comprised the inclusion criteria.

Thus, 15 women participated in the research, who were interviewed by the nurse, master's student and first author of this article based on a previous setting in the scenario as a researcher. After signing the Free and Informed Consent Form, the statements occurred mostly in the research setting (10), followed by the residence (4) and, finally, in their own workplace (1).

The phenomenological interview, with an average duration of 15 minutes, pervaded by empathy and intersubjectivity between researcher and deponent, was the data collection technique used with the support of a guiding instrument that had questions for knowledge of historiography (participants' characterization), open questions for free expression of the phenomenon of interest (How is your daily life since you were diagnosed with breast cancer? What are the meanings of this experience for you?) and a space for field diary records.

In this investigation, sensitization interviews were not performed. However, at each meeting with the participants, the researcher resorted to the research team for the necessary conduction adjustments to meet the investigation objective.

To protect the identity of the participants, it was used the identification through an alphanumeric code represented by the letter "W" (initial of the word "woman"), followed by a number that corresponds to the chronological order of the meetings. The statements were recorded in electronic media and later transcribed.

The analytical stage began after each interview, when listening and repeated readings were conducted, intending to immerse into the lived and the experience of each woman. The field diary allowed the emergence of historicity that, in Heidegger, reveals the way of being of those who tell about themselves, allowing the ontic-ontological bridge to be safely established⁽⁸⁻⁹⁾.

From the statements, the essential structures were highlighted, responsive to the research objective. The approximation of meanings allowed the construction of Meaning Units (MU) with sufficient expressions until considering the end of the field stage, which, in phenomenology, implies reach of the phenomenon under study, in which the approximations of the expressed meanings and understood allow revealing meanings of the experience⁽⁸⁾ of the woman survivor of breast cancer.

Thus, as exposed by Heidegger, at first methodical moment, the vague and average understanding was developed, which remains in the ontic instance, which is that of the facts. The elaboration of the concept of being as a guiding thread for the ontological dimension started the second methodical moment, constituting the interpretive or hermeneutic understanding, in the phenomenal instance. It is emphasized that the concepts of the Heideggerian framework were operationalized from the work *Being and Time*⁽⁸⁾.

It is emphasized the following of the ethical precepts recommended throughout the development of the research, with the approval of the Ethics Committee granted under CAAE No. 25992619,6,0000,5133 and approval opinion No.3,759,279.

■ RESULTS AND DISCUSSION

The 15 participants were aged between 40 and 80 years, and the year of diagnosis ranged from 2009 to 2018. Most declared themselves to be married (10) and with a child (8). Eleven women were not working at the moment of the interview.

The analysis of the existential movement of women allowed the synthesis of the understanding expressed by the participants, composing the Meaning Units and resulting in the expression of the experienced concept of being-there-survivor-of-breast-cancer as: **To take life normally, working and doing things at home, but not being able to do more because the arm hurts... Not being able to look at yourself in the mirror, feeling ugly, having your self-esteem down there and worrying about your clothes... Doing tests, being sad and afraid of dying when knowing about the diagnosis, but accepting and facing it... thinking that the cancer may come back, always being careful and going to the physician. Doing the treatment, having side effects and continuing with the follow-up... Having support, help and strength from family and friends... Having faith in God and clinging to prayers to win and improve...**

Feeling changes, living the today, learn to value and enjoy life more... understand that you can overcome the disease and feel stronger.

In view of this, in its existential movement, the being-there showed itself from the facticity that the condition of survival imposed on the ways of being of everyday life in which it is occupied in the manuality of tasks inside and outside home, aiming **to take life normally, working and doing things at home, but not being able to do more because the arm hurts:**

[...] I created a routine for myself, [...] I started to work to help other people, to record video, to send messages of hope [...] I have almost no time. That I go to church in the morning, 7 am, I get up at the time I got up to go to work, I help there, I sing the Psalms. Then I go up to my house, prepare my lunch, do you know how the hours go by really fast? [...]. (W01)

It's still normal, I haven't changed anything in my life. I continued cooking, washing, ironing, taking the daughter to school. (W07)

The woman survivor of breast cancer takes care of things, being-in-the-world from the significance of things and people that belong to her surroundings, through her significant references (the church, the house, the children's school, husband's work), since "it is from the world that the manual is at hand"⁽⁸⁾.

Since being-in-the-world is being-of-possibilities, the being-there-woman cannot occupy in certain activities without feeling pain in her arm — which brings to mind the cancer — and makes her upset for not being able to do everything she once did:

Even I try [to take care of the house], but the day I abuse a little, in this case, wring clothes, scrub the floor, like I did, I can't do it anymore. Like, there are days when I take it and do it, at night I already feel the difference. Then the pain increases. (W05)

Yeah... I don't do things like I used to, housework, I don't have that freedom anymore, how can I say? It is not about freedom. Ability. One moment the body is bad, another moment I start doing it, and my arm starts to hurt. I'm not left-handed, I keep trying to do it with my left hand when I think not, I'm with my right. [...] I avoid thinking, but it reminds me [cancer], when my arm hurts [laughs]. (W11)
Ah, the only thing that has changed is my arm, which I can't use it anymore like I used to, carrying a bag because

it hurts [...] It's very uncomfortable [...] Another day I was in pain and I could barely hold a plate. I was upset, that I couldn't do the things I used to do [cry]. (W14)

It is by reference to the existential condition of daily life that the deprivation of the potentiality of being of Dasein must be analyzed ontologically as a deprivation of healthy-being and ontically, as ailment. In ailment, the man compares himself and with others in his potential of being⁽¹⁰⁾. Thus, being-there appears to be more restricted in the sense of being able to respond to the demands of daily occupation and coexistence due to the limitation of the arm, and the restrictions on their freedom 'take' the modes of impotence, which could be prevented, alleviated and treated by health professionals. In the present investigation, the participants did not mention previous approaches by professionals regarding the prevention of lymphedema.

It is known that both surgical treatment with an axillary approach and radiotherapy with irradiation in this region may cause blockage in the lymphatic vessels or compression by fibrosis. This complication causes a feeling of heaviness in the arm of same side to the affected breast, followed by changes in the mechanical properties of the skin, increased limb volume, sensory changes, predisposition to infections, stiffness and decreased range of motion, which determines a decrease in function of the upper limb⁽⁹⁾.

Linked to lymphedema, there are also other signs and symptoms that can persist in the post-treatment period, such as pain, insomnia, depression, anxiety and other causes of functional impairment⁽¹¹⁾. Breast cancer survivors normalize their pain in many ways, such as a necessary step on the pathway to recovery, proof of the effectiveness of treatment, or even as a permanent condition that one must learn to live with. In all of them, however, there is a clear need for these women to be better informed, assisted and listened to in their complaints and reports, since symptoms such as chronic pain can compromise their quality of life⁽¹²⁾.

When examining the effects of nursing interventions based on the Health Belief Model (HBM) on home visits in 72 women who received radiotherapy after breast surgery, there were positive changes in lymphedema prevention behavior, improvement in upper limb functions, reduction of side effects, frequency of lymphedema and costs. In addition, the interventions provided relief from arm-breast symptoms and increased quality of life and self-efficacy⁽¹³⁾.

Similarly, an evidence-based nursing program focused on progressive functional exercise demonstrated how the care strategy can effectively reduce lymphedema in patients

after breast cancer surgery, improve postoperative upper limb function, and promote quality of life and nursing satisfaction⁽¹⁴⁾.

Being-woman-survivor who underwent mastectomy as part of the treatment for breast cancer, the woman meant **not being able to look in the mirror, feeling ugly, having her self-esteem down there and bothering with clothes**, unveiling in the ways of being of inauthenticity, impersonality and impropriety for not considering oneself as a being of possibilities.

The woman as a presence as a result of the mastectomy suffers a shock in the relationship she established with her own body. The mutilation negatively altered her self-perception, influencing her way of being in daily life. The void left by the removal of the breast was a situation recurrently reported in the statements, expressed in a tone of deep sadness. In this sense, body image and self-esteem lead women to a feeling of strangeness when viewing their body in the mirror.

I can't look at myself in the mirror [cry]. Is very hard. [...] and your life, you start losing. And that... ah, but it's just the breast, but for a woman it's very hard. [...] The cancer was very bad, it devastated me. [...] my hair didn't fall out. But hair grows, the breast does not grow. I didn't touch with my hand [...]. (W04)

But... you know that you will lose all your hair, this all messes a lot with the woman. Self-esteem goes down there. My nails turned very black. (W09)

In an attempt to rescue self-esteem and improve the woman's relationship with herself and with others, breast reconstruction appears as a possibility covered with a new meaning, in publicity in which all women raise their self-esteem with preserved breasts. In this context, breast reconstruction allowed women to accept themselves and feel better.

After the cancer it became hard, because when we were going to get intimate, putting hands, it gave me something like that, and I would take it away. I currently have the expander. I don't know if I'll be able to put the prosthesis on, because it was rejected the first time [...]. (W11)

Ah, with the body it was a little hard because the part I like the most are my breasts. [...] So, I got a little down, yes. And I accepted myself now because I'm implanted and that's where I like it even more. (W10)

Likewise, body image disorders have been found to be a major issue of survival status after breast cancer, often associated with a variety of other emotional, physical, and interpersonal concerns that impact women's personal relationships and sexuality of survivors⁽¹⁵⁾.

Although women have conquered their space in society, their representation is still linked to body image, generating constant concern and frustration for not meeting culturally imposed standards. With this, the possibility of breast removal and the effects of the treatment on the self-image can be experienced in a traumatic way, as it is related to femininity, sexuality, sensuality and the maternal role⁽¹⁶⁾.

Unlike the present study, it was pointed out that concerns about body image are prevalent among younger women, and, according to the type of treatment, they experienced increased levels of physical and emotional symptoms, often unresolved at follow-up, both because of their stage of life and the treatments associated with the most aggressive cancers that affect this public⁽¹⁷⁾.

Nurses who provide care for women survivors of breast cancer already in the process of diagnosis and treatment are at an opportune moment to carry out an assessment focused on issues of body image and concerns related to sexuality, anticipating future problems in the relational scope and developing actions of health promotion, aiming at improving their sexuality experience⁽¹⁰⁾.

Women expect that nurses or physicians start this subject through a private conversation when they are alone or with their partners in appointments. This bond can ease dialogue on these issues and provide professionals with resources to help survivors with regard to a better understanding of the therapeutic process⁽¹⁷⁾.

In doing tests, being sad and afraid of dying when knowing the diagnosis but accepting and facing it... thinking that the cancer may come back, always being careful and going to the physician, the woman was scared and worried about experiencing a daily life permeated with uncertainties about work, children, success of treatment and cure, allowing to unveil the meaning of fear.

In this movement, the woman's daily life is permeated by feelings such as fear of cancer, fear of dying from cancer and fear of having cancer again. Getting ill from breast cancer is permeated with preconceived information associated with the disease, such as pain, mutilation, physical and emotional suffering, in addition to a prognosis that can point to cancer recurrence.

I am an oncological person for the rest of my life, so I will always be careful. [...] I couldn't even imagine that my cancer was an aggressive cancer, subject to metastasis to the whole body. (W01)

[...] from the moment we receive the diagnosis, there is that fear of death, I did the test, did an ultrasound scanning, where I really discovered that it was an aggressive cancer [...]. (W03)

And, when I found out about my cancer, I had seven months since I had buried my mother who also died with cancer. [...] my question was actually 'what do I need to do to stay alive?'. That was my goal: to stay alive. (W07)

[...] But, I don't feel calm. Everything that happens to me I already think it's cancer again. This time, in today's appointment, I'm bringing an MRI that the doctor asked to do a follow-up on the right breast, because there was anything until then, then came a kind of strange result. I said that I don't have peace on life anymore and I don't think I will, there's no way. (W13)

And this breast gave me a lot of work, there were almost 28 surgeries in total, back and forth. [...] Emptying the armpit gives you a limitation. Removing the latissimus dorsi gives you a limitation of arm movement, I did both sides. So, I do follow-up every six months and it will be for the rest of my life. (W07)

And now I had a blood test recently, the doctor suspects that I have a syndrome that I can't tell you the name, it develops after cancer treatment. The treatment made me very sick, it is very aggressive [...] Just like I said, we go to the doctor, I do the control, I think now I only have it next year. (W09)

[...] There were 5 sessions and then Herceptin too [...] Now, one thing I had a reaction to in chemotherapy was allergy to anti-allergic, this was also discovered during chemotherapy. When I put Phenergan on, I was little red, my throat was clogged, and I needed help quickly. (W13)

I always go to the mastologist. I go to the physician and nothing. (W15)

In the research, it was understood that living and thriving as a survivor demands continuous challenges that patients must face. In parallel, it is pointed out that the fear of cancer recurrence is one of the greatest unmet needs in breast cancer. From the identification of this feeling, it is necessary to develop a care plan that considers potential interventions to manage fear, such as being attentive, managing uncertainty, having more effective patient-professional communication and dealing with stress through counseling⁽¹⁸⁾.

In **doing the treatment, having side effects and continuing with the follow-up**, the woman unveiled herself in the way of being of the talk, as a prior understanding of what things are — an understanding that gives the illusion that everything is already determined⁽⁸⁾.

As long as being-in-the-world as a survivor, this woman, "in her decay, has already fallen from herself. But it did not fall into something ontic that she encountered in the course of her being, but into the world that, in itself, belongs to the being of presence", that is, the world of treatment and follow-up for breast cancer⁽⁸⁾:

[...] I took the medication correctly, Tamoxifen. I only took it, and I went to the control, did all the tests to take it, I also examined it, to see if it was in the other one or in the same place. (W06)

In view of the extracted texts from the statements, there is a need for educational and multidisciplinary health support for these women to understand the state of illness, to assist them overcome adversities (economic, social, family) and enable them to meet self-care demands at all phases, from diagnosis to follow-up, in chronic or disease-free conditions.

Apparently, the first two years of follow-up are seen as the most precarious in terms of information and care. In this sense, it is essential to establish systematically designed, implemented and evaluated programs for the entire population that encompass and articulate information on the stages of cancer disease and that generate decision-making abilities, with a consequent improvement in quality of life and reaching of well-being⁽¹⁰⁾.

In **having support, help and strength from people, family and friends**, the being-with was unveiled. After receiving the diagnosis of a remarkable and complex disease, as well as experiencing a long treatment, the being-woman-survivor-of-breast-cancer seeks, in family, friends, physicians and groups, support for the challenges faced in their daily lives. According to Heidegger's thought, the experience of being-with-the-other allowed to cope with the disease with more strength, leading the being-there-woman not to feel alone in the situation of being-thrown into the world with cancer.

My husband accompanied me in everything. He was a friend, he was a companion, we really need the family's help. He bought scarves, said I was beautiful. I had a lot of encouragement from the family, a lot. (W01)

I used to talk to many sisters from the church, that brings tranquility to us, words of comfort, from friends. That will help you a lot. (W02)

But you start talking to friends, family, it gives you a lot of strength, my boss gave me a lot of strength too. Wow! A blessing in my life. God first, then my boss and my family. (W05)

Research has shown that women with partners had a higher index of hope. Sharing their fears and experiences brought them closer to their partner and showed to be an important factor in coping with and overcome adversity. However, the decrease in self-esteem with cancer and its treatment can directly affect marital relationships. Thus, for better results, it is essential to include the partner in the nursing care plan. One should invest in health education and support aimed at family members and patients, with the caregiver-patient considered as a unit of care and assistance^(16,19).

Furthermore, support groups have emerged as a resource for overcoming suffering, promoting well-being and differentiated care. They are considered a way of knowing, accepting and understanding the disease, facilitating the socialization of emotions, ideas and experiences during the hard journey of coping with the disease⁽²⁰⁾.

From the perspective of this research, comprehensive care for being-woman should have focused on meeting social needs and emotional weaknesses, when the family did not have the resources to meet them. It is necessary to highlight that this recommendation is valid mainly for women who are socially less favored and who are more vulnerable to depression. Thus, it is evident that nursing professionals need to be aware of the emotional suffering experienced by these women, which can last even a few years after the diagnosis of breast neoplasms⁽²⁰⁾.

On the other hand, being-woman-survivor-of-breast-cancer was understood in being-alone, as a deficient way of being-with. In this way of being, presence had relationships affected by the facticity of the diagnosis of breast cancer.

After the surgery I had no help. No one to help me, do things around at home, I always had to do for myself. When I found out, soon after came the divorce. So, it was a fight that I had to win alone, practically. (W10)

Personal life was not easy, the marriage ended. (W11)

It is necessary to pay attention to the specificities of the condition of survival to breast cancer, understanding the impacts on the lives of women, who are mothers and grandmothers and who need to face their partners, family and society, or even young people who see their relationship aspirations and family constitution put in doubt by their new health condition⁽¹⁹⁾.

In its existential movement, the facticity of the disease is projected as a threat to the existence of being-woman, who seeks in God strength to improve and achieve healing. Sometimes, transferring the responsibility for the recovery to the divinity, **having faith in God and clinging to prayers to win and improve**, revealing impersonality, in "not being as the closest way to presence, the way in which, in most of the time, it remains"⁽⁸⁾.

[...] I know there are medicines, God left that. Did I need to use? I needed it, but spirituality helps a lot for those who are going through this moment. It's an inner strength. [...] Because you have where to hold onto. [...] (W01)

So, in addition to traditional medicine, I'm looking to treat myself spiritually. I do bars, reiki, whatever is good, that brings out these positive things. (W03)

Even the priest went to my house, for you to have an idea. Many people helped me, prayed, sent prayers, requests. I think any, well, positive thinking, I think it helps a lot. At least it helps you get up. To give you comfort. (W04)

Thank God, I have to thank a lot for having gone through this [...] because I think that, if God sent it to me, it's because I had to improve something. (W05)

[...] but we see that you can overcome all this with faith. First you must have faith. Faith that you will get out of this situation and that you will be okay. (W09)

The being-woman-survivor-of-breast-cancer valued the prayers she did alone and the prayers that prayer groups performed. In her understanding, spirituality and any positive thinking help to lift mind and provide spiritual comfort. The priest's visit, spiritual treatment and faith in God helped to overcome and improve.

Spirituality/religiosity can mediate comfort and improve hope, being a positive strategy for the person undergoing cancer treatment. In ailment, faith motivates women to develop coping mechanisms that allow feelings of peace and acceptance. Patients who perform spiritual and religious practices may present strengthening of the psychic and social dimensions, minimizing symptoms of anxiety, depression, anguish, among others^(11,21).

Examining the effectiveness of mindfulness-based cognitive therapy for anxiety and depression, fear of cancer recurrence, fatigue, spiritual well-being, and quality of life in Japanese outpatients with stage I-III breast cancer, showed significant improvement in psychological suffering and spiritual well-being lasting up to four weeks after the intervention⁽¹⁸⁾.

In **feeling changes, living the today, learn to value and enjoy life more... understand that you can overcome the disease and feel stronger**, the anguish announced itself fleetingly in the being-in-the-world as a survivor of breast cancer that values life and looks more at itself, that is, opens itself to being-there in search of meaning in existence, being “properly itself in the original singularity of the silent decision ready to anguish”⁽⁸⁾.

So, anything I feel, that sometimes I get a shock, sometimes a pain, like, 'this is nothing, everything will be fine and I'll be fine. I won one and I will win the other part.' (W02)

[...] now I'm calmer. [...] now I've relaxed more. I feel the difference that I changed a lot later. Even in my way of being with people, [...] It was to improve everything [...]. (W05)

So, I'm alive, I'm here, so that's what matters. Less materialism. I'm less stressed, less sulky, I'm more grateful. I appreciate human contact. (W07)

I think each of us has to enjoy every moment of life, because everything goes. Now we're here, and I don't know where I'll be in half an hour. (W15)

However, it de-cay in everyday life in which, most of the time, the presence is maintained:

[...] At the beginning, when you discover, when you are in the middle of the treatment, we start to give a lot of value to everything, to things in life, to pleasures, to joys, everything has a much greater intensity. To find everything essential. The sun rises in the morning is beautiful, or it's raining is also a blessing, the sky is blue, it's beautiful, but if there's a cloud, it's also great. Then, suddenly, you don't notice it anymore. This happened at the end of 2016, so, let's say that, from 2019 onwards, it seems that life is getting back on track again, you go back, like, to what it was, you don't continue to value it so much. Looks like it's falling into the same again. (W13)

Corroborating the importance of socioeconomic findings regarding the impact of cancer, women with greater economic and educational vulnerability showed a lower degree of concern with health, adding to a negative view of the ailment experience. These data reinforce the importance of educational measures regarding these risk factors in the period following the end of treatment, a phase in which these women acquire new risk behaviors, such as obesity, sedentary lifestyle and smoking⁽¹⁰⁾.

In this context, resilience as the human capacity to face and respond positively to situations with increased risk to health is considered the most important factor that must be evaluated at the time of diagnosis of breast cancer, which allows for the early identification of patients who may need more psychological support⁽²²⁾. In this sense, it was pointed out that ways of coping, perceived social support and resilience were predictors of health-related quality of life, and that resilience was a significant mediator between coping styles, perceived social support and quality of life. Thus, it is stated that intervention programs aimed towards resilience should be developed that focus on improving the positive effect of coping styles and perceived social support in women with breast cancer⁽²³⁾.

Based on this broadened understanding, non-pharmacological interventions such as music therapy, compresses and rhythmic massages were associated with increased resilience and internal coherence, reinforcing the importance of multimodal treatment⁽²⁴⁾.

A possible limitation for the present study is the number of women participating and the unique setting. However, in view of the investigative intention and the supporting framework, the intended understanding was achieved, constituting a relevant finding for allowing the promotion of health care from the being-there, considering the methodical marks and the scientific contribution of the analysis towards the integrality of health care for women survivors of breast cancer.

■ FINAL CONSIDERATIONS

The experienced concept of breast cancer survival allowed us to envision the being-there-woman in its essence, from a phenomenological point of view, and to point out directions for health and nursing care. Hermeneutics revealed that the woman showed herself in the ways of being of the daily life in which she is involved in the manuality of tasks inside and

outside home, moved by impersonality and impropriety for not considering herself as a being of possibilities. The fear of death after the diagnosis was unveiled. The talk, curiosity, and ambiguity with which moved being-in-the-world as a survivor led to the decay of the monitoring of the health condition, allowing the approximation of other entities in the concern of being-with. The anguish announced itself fleetingly in the can-being-in-the-world as a breast cancer survivor who values life and looks more at herself, however, with the passage of time, it de-cays in the daily life in which, most of the times, the presence remains.

The analytical understanding allowed us to allude that, although the deponents are no longer undergoing treatment for breast cancer, their behaviors are grounded on memories that refer to the trajectory of the disease, understood by the fear that was veiled in the being-woman as a way of disposition.

Thus, the study reinforces the need to structure a specialized and interdisciplinary line of care, at primary, secondary and tertiary levels, curative and palliative, grounded on early identification, treatment and rehabilitation of chronic pain. Humanized care in cancer survival must be centered on active and qualified listening to these narratives. Caring for and treating these survivors requires not only strictly biological or only psychic considerations. Emotional, family, sociocultural and economic issues must also be considered in an integrated manner.

Despite technological advances and the fact that the therapeutic protocols for breast cancer are increasingly improved and well-established, the treatment needs to be followed by elements that individualize care through the appreciation of feelings and respect to the uniqueness in which each woman faces the problem.

As nurses are the professionals that provide care directly to the woman throughout the treatment, it becomes of great relevance to identify possible impacts in the biopsychosocial-spiritual scope. The look of this professional must transcend the moment of treatment, envisioning this woman in all aspects that permeate cancer survival.

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