



Perceptions of women with breast cancer about treatments

Percepções de mulheres com câncer de mama acerca dos tratamentos

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ABSTRACT

The objective of this study was to understand the perception of women with breast cancer about treatments. This is a qualitative, descriptive, cross-sectional study, involving 40 women undergoing chemotherapy for the treatment of breast cancer in a hospital specialized in oncology. The instrument used for data collection was a semi-structured interview. Data was analyzed using Bardin's Content Analysis and categorized according to the Health Belief Model. Four categories emerged: "Perceived susceptibility: cancer and COVID-19", "Perception of severity in view of treatments impact", "Challenges and barriers in treatments" and "Perceived benefits in cancer treatment". It is concluded that there are different factors that resonate in women's perception of treatments and that generate repercussions in the way of facing them. Knowledge of these factors by healthcare professionals can help in providing better assistance to women in facing the disease.

Keywords: Breast Neoplasms. Women's Health. Health Belief Model.

RESUMO:

O objetivo deste estudo foi compreender a percepção das mulheres com câncer de mama acerca dos tratamentos. Trata-se de um estudo qualitativo, descritivo, transversal, no qual participaram 40 mulheres em quimioterapia para tratamento do câncer mamário em um hospital especializado em oncologia. O instrumento utilizado para coleta de dados foi uma entrevista semiestruturada. Os dados foram analisados mediante Análise de Conteúdo de Bardin e categorizados conforme o Modelo de Crenças em Saúde. Originaram-se quatro categorias: "Suscetibilidade percebida: câncer e COVID-19", "Percepção da gravidade em face do impacto dos tratamentos", "Desafios e barreiras nos tratamentos" e "Benefícios percebidos no tratamento do câncer". Conclui-se que existem diferentes fatores que ressoam na percepção que a mulher tem sobre os tratamentos e que geram repercussões na forma de enfrentá-los. O conhecimento desses fatores pelos profissionais de saúde pode auxiliar na assistência às mulheres para melhor enfrentamento da doença.

Palavras-chave: Modelo de Crenças em Saúde. Neoplasia mamária. Saúde da mulher.

INTRODUCTION

Breast cancer is the neoplasm with the highest incidence among women in the world, with 2.3 million new cases. In Brazil, it is also considered the most common type of cancer¹. In Minas Gerais, it is the leading cause of death among women. Due to the high impact, it has become a public health problem². Treatment includes surgery, which can remove all or part of the breast; chemotherapy, which can be before (neoadjuvance) or after surgery; radiation therapy; hormone therapy; and targeted therapies, among others³. The adverse effects of treatments are many and greatly impact women's lives. Feelings of fear, anxiety, and depression can be triggered by the repercussions of treatments, fear of prejudice towards cancer, and fear of death or the return of the disease deeply⁴⁻⁵⁻⁶.

The study of the subject's perception about the treatments against breast cancer is relevant to evaluate how they will face the treatment for their recovery. A person's behavior is generated by his perception, i.e., thoughts and beliefs about a given situation will drive their actions⁷⁻⁸. Personal, cultural, and religious beliefs and previous information about the disease influence the perception⁸⁻⁹⁻¹⁰. The health beliefs model (HBM), developed by social psychologists, has been used to explain the role of psychosocial processes and variables (perceptions of susceptibility and severity; and perceptions of barriers and benefits) that interfere with health behaviors and psychological adjustment to situations such as illness or physical limitation⁷⁻⁸⁻¹¹. The HBM is efficient in understanding the acceptance of healthcare recommendations⁸⁻¹¹.

Regarding breast cancer, several studies point out how these variables may be associated with the behaviors adopted throughout the health-disease process, ranging from disease prevention to treatments⁶⁻⁸⁻¹¹. Thus, aspects such as delays in seeking health services for the investigation and screening of the disease¹⁰ and the way the woman faces the diagnosis and therapies⁸ are influenced by these variables.

Women with breast cancer face many difficulties, such as fear, insecurity about the future, low self-esteem, and sexuality issues. Therefore, in addition to the physical effects of the disease, women experience many psychological effects that place them at a risk group for the development of psychological disorders. The health team must treat the woman as a biopsychosocial being, evaluating not only the physical state but considering the emotional, social, and cultural aspects that involve the illness, emphasizing the need for a multi-professional work¹².

The knowledge of each woman about the problem, as well as the repercussions of the

adverse effects of treatments, the perception of changes in the body itself, and beliefs about cancer can influence the perception of susceptibility to present the disease and the perception of its severity. Throughout the treatment, several factors can act as facilitators or obstacles in the process of coping and controlling the disease⁸. These factors can help in the perception of the benefits of adherence and identification of barriers to carrying out therapeutic actions⁸⁻¹¹. Thus, it is relevant to consider the women's perception about treatments so that health professionals can understand their behaviors, helping them in their health-disease process. From this perspective, the present study aimed to know the different perceptions and beliefs of women with breast cancer regarding therapies and their adverse effects.

METHODOLOGY

This is a descriptive exploratory, cross-sectional study with a qualitative approach, which took place in the chemotherapy sector of a hospital specialized in oncology in the city of Juiz de Fora. This hospital serves several municipalities in the Zona da Mata of Minas Gerais. Data collection was conducted from January 2020 to February 2021, with a break from March to October 2020 because of the Covid-19 pandemic. The study followed the guidelines of the qualitative research reports guide, the Consolidated criteria for reporting qualitative research COREQ, to compose this report¹³.

SAMPLE PROFILE AND SELECTION OF PARTICIPANTS

The selection of the sample was for convenience, consisting of 40 women with breast cancer undergoing chemotherapy treatment, attended via the Unified Health System (SUS) and in the aforementioned hospital. Inclusion criteria were: age over 18 years, undergoing adjuvant or neoadjuvant chemotherapy, with or without breast surgery. The study did not include women with metastasis or local recurrence, time of surgery over 18 months, bilateral breast surgery, education less than 4th grade of elementary school, or cognitive impairment that prevented the understanding of the questions in the interview script.

The selection of participants by convenience was based on the indication of the nurse in charge of the chemotherapy sector of the hospital since the researcher had no previous contact with the patients. The women were approached during chemotherapy directly and individually. The researcher invited those who met the inclusion criteria to participate and explained them about the research and its objectives. Then, she introduced herself and started the interview

process. Data collection was performed only by the principal investigator. Of the 80 women approached, only 40 met the criteria. The other patients were not included for the following reasons: metastasis (n = 24), low education (n = 3), time of surgery for over 18 months (n = 4), bilateral breast surgery (n = 2), non-acceptance to participate (n = 3) or cognitive impairment (n = 4).

INSTRUMENT AND DATA COLLECTION

For data collection, the researcher used a semi-structured interview. The script was prepared based on studies related to the theme after the screening of health professionals and was tested with a small group of women in a situation similar to that of the sample. It included sociodemographic and clinical data, with breast cancer, its treatments, and self-care as the main themes. The researcher conducted a pilot study to determine the feasibility of answering the survey questions.

After the researcher and the presentation of his credentials, she read and clarified the objectives and intentions of the study. In case of acceptance of the invitation, the interviewee signed the printed Informed Consent Form (ICF), and the interview began. The script encouraged reporting on the discovery of the disease, the treatments and their impacts, the guidance received, and self-care actions. The interviews had an average time of 24 minutes. They were recorded on an electronic device and transcribed in full. At the end of the interview, the researcher sought medical records to complement the sociodemographic or clinical data. The interviewer observed the saturation criteria to end the partial collection of the survey, answering some specific objectives of another investigation that is still ongoing.

DATA ANALYSIS

For the qualitative data, the research used the content analysis in the thematic conception¹⁴. The material used was the transcripts of interviews and field notes conducted during data collection. The main researcher manually performed the systematization of the procedures, using the steps proposed by Bardin¹⁴: pre-analysis, exploration of the material, and treatment of the results. The first, pre-analysis, served to organize the available material and perform immersion and floating reading, aiming to build the corpus of the study. The exploration of the material allowed the grouping and creation of the codes, as well as its categorization according to the recurrence of the ideas, which gave rise to the thematic axes.

The last stage provided the formulation of a report with the defined categories and elaboration of the interpretation of the results through inference. The variables presented in the sociodemographic and clinical data were analyzed using the Statistical Package for the Social Sciences (SPSS), version 21.0, and presented as the absolute and relative frequency.

The research used the HBM as a theoretical framework to guide the analysis of the interviews. This model is composed of four types of beliefs, two related to illness, susceptibility, and severity; and two related to health behaviors to prevent or treat a disease, the barriers and benefits⁷⁻¹¹. Perceived susceptibility clarifies how much the person perceives the risk of contracting or developing a specific disease. Perceived severity denotes the perception of the severity or seriousness of the disease, which can be observed by emotions when thinking about the illness or treatments. The perceived benefits, on the other hand, point out how much the person believes that the actions adopted by them are effective in improving health; and the perceived barriers indicate the person's understanding of the cost-benefit of their actions, that is, how much the effort is worth in the face of obstacles that present themselves to behavior change⁷⁻¹¹. The research used some quotes from the participants whose names were replaced by the letter E, followed by a number indicating the order of the interviews to confer confidentiality to the identities and exemplify the categories listed.

ETHICAL STANDARDS

The study respected the ethical and regulatory aspects of research involving human beings, following resolution n° 466, of December 12, 2012, of the National Health Council/Ministry of Health. The Research Ethics Committee of the Federal University of Juiz de Fora (Opinion No. 3,649,430, of 10/18/2019) approved the project. This article is a cross-section of doctoral research in the final phase conducted by the main author.

RESULTS AND ANALYSIS OF INTERVIEWS

SOCIODEMOGRAPHIC PROFILE OF THE PARTICIPANTS

Brown color/race was predominant (42.5%), with an age range from 31 to 77 years (mean age of 53.5). Regarding schooling, incomplete elementary school (35%) and complete high school (35%) prevailed. A portion (37.5%) of the women were married. Half of them (50%) were on sick leave, and most (85%) had a family income of one to three minimum wages.

The Catholic religion predominated (72.5%), with 80% of women saying they practiced it. More than half (57.5%) of the participants were from Juiz de Fora (Table 1).

Table 1. Sociodemographic characteristics of participants (n = 40)

Variable	N (%)
Age	
< 50 years	10 (25.0)
≥ 50 years	30 (75.0)
Skin color	
White	15 (37.5)
Brown	17 (42.5)
Black	8 (20.0)
Marital status	
Single	7 (17.5)
Married	15 (37.5)
Divorced	5 (12.5)
Widow	6 (15.0)
Stable union or companion	7 (17.5)
Occupation	
Maid	4 (10.0)
Autonomous	2 (5.0)
Retired	11 (27.5)
On health leave	20 (50.0)
Housewife	3 (7.5)
Family income	
1-3 minimum wages	34 (85.0)
>3-5 minimum wages	6 (15.0)
Schooling	
Complete elementary school	2 (5.0)
Incomplete elementary school	14 (35.0)
Full high school	14 (35.0)
Incomplete high school	6 (15.0)
Complete higher education	3 (7.5)
Incomplete higher education	1 (2.5)
Religion	
Catholic	29 (72.5)
Evangelical	7 (17.5)
Other	4 (10.0)
Religious practice	
Practitioner	32 (80.0)
Non-practitioner	2 (5.0)
Not regularly active	6 (15.0)
City	
Juiz de Fora	23 (57.5)
Other	17 (42.5)

Source: survey data.

CLINICAL PROFILE OF PARTICIPANTS

Most interviewees were non-smokers (62.5%) and non-drinkers (70%). Regarding locoregional treatments, the majority had undergone breast-conserving surgery (65%) and had not undergone radiotherapy (62.5%) until the interview. Regarding systemic therapies, 40% of

the participants were only undergoing chemotherapy, with 25% in a neoadjuvant situation. In addition to chemotherapy, 45% were also undergoing targeted therapy, and 10% were also undergoing hormone therapy (Table 2).

Table 2. Clinical characteristics of participants (n = 40)

Variable	N (%)
Comorbidities	
Yes	24 (60)
No	16 (40)
Smoking	
Yes	6 (15.0)
No	25 (62.5)
Former smoker	9 (22.5)
Ethylism	
Yes	2 (5.00)
No	28 (70.0)
Socially/Sporadically	10 (25.0)
Surgery	
Mastectomy (radical)	4 (10.0)
Sectorectomy (conservative)	26 (65.0)
Not applicable	10 (25.0)
Radiotherapy	
Yes	5 (12.5)
No	25 (62.5)
Not applicable	10 (25.0)
Systemic therapies	
Chemotherapy	16 (40.0)
Target therapy	0
Hormone therapy	0
Chemotherapy + Hormone Therapy	2 (5.0)
Chemotherapy + targeted therapy	18 (45.0)
Chemotherapy + hormone therapy + target therapy	4 (10.0)
Neoadjuvance	
Yes	10 (25.0)
No	30 (75.0)

Source: survey data.

Regarding the identification of the neoplasm, 50% of the interviewees visualized a breast alteration and sought the health service before the pandemic. A part (37.5%) of the women went through the investigation and diagnosis during the health crisis, and 12.5% noticed the breast alteration before the pandemic, but, throughout it, they had the definitive diagnosis.

ADVERSE EFFECTS

Adverse reactions can affect numerous regions, organs, or systems of the body, depending on the therapy implemented. Among the most prevalent adverse effects, the following stood out: hair loss, called alopecia (70%); general malaise (45%) and fatigue (45%);

nausea (60%) and vomiting (42.5%); diarrhea (30%); pain in the body (35%) and legs (22.5%); sleep disturbances (25%); and neutropenia (25%), which leads to an increased risk of developing infections. Also mentioned were: altered sensitivity in the region of surgery and/or arm (27.5%), limitation in the range of motion of the upper limb (12.5%), hot flashes (25%), and radiodermatitis (5%), which are skin lesions resulting from radiotherapy. In addition to physical issues, participants mentioned several emotional implications, such as anguish, fear, concern about treatments, discouragement, emotional lability, fear of death, and anxiety.

Several authors report similar findings in their research regarding the effects of treatments. Among the reactions triggered by chemotherapy, there were: pain, tiredness, weakness, stiffness in the joints, nausea and vomiting, trouble sleeping, stomach upset, weight loss¹⁵⁻¹⁶, dizziness, headache, shortness of breath¹⁶, changes in the menstrual cycle, skin changes, alopecia⁴⁻¹⁵. According to Iddrisu, Aziato, and Dedey¹⁵, surgery leaves a scar, radiotherapy can still cause skin burns, and hormone therapy can trigger hot flashes, cramps, joint pain, loss of libido, fear of intimacy, reduction and frequency of sexual intercourse, leading to infertility. In this way, the repercussions of the disease and treatments can affect femininity, self-image, and self-esteem, triggering feelings of anxiety and depression resulting from affliction with prejudice towards cancer and fear of death or the return of the disease⁴⁻⁵⁻⁶. Ferreira e Lemos⁴ clarify that these repercussions may vary according to the therapies used, among which chemotherapy stands out since each treatment has its adverse effects.

ANALYSIS OF INTERVIEWS

The reading and exploration of the transcripts of the interviews allowed the researchers to capture the perception of the participants about the beliefs that involve the “treatments,” becoming a thematic axis in which the highlighted registration units were outlined based on the theoretical framework of the HBM. In the analysis, four categories emerged: “perceived susceptibility: cancer and covid-19,” “perception of severity in the face of the impact of treatments,” “challenges and barriers in treatments,” and “perceived benefits in cancer treatment.”

Perceived Susceptibility: Cancer and COVID-19

During treatments against neoplasia, the prospect of alteration of the immune system because of chemotherapy fosters susceptibility to the disease. Concomitantly with this picture of deficient immunity caused by cancer therapies, the situation of the covid-19 pandemic has

awakened the need for better care regarding the prevention of contamination by any form of infection, given a high perception of susceptibility and the severity of coronavirus infection.

I think that every person who is treating cancer should never stop wearing a mask [because of the pandemic]. We have to take care. My immunity, I think it's normal (...). (E21)

Perception of Severity in the Face of the Impact of Treatments

Reactions to each treatment may vary according to the experiences and perceptions of each person affected by cancer. Side effects influence the perception of the severity of cancer. The more serious the perceived consequences of radiotherapy, chemotherapy, or other therapies, the more this can affect women's adherence to treatments. Concomitantly, the more positive the interpretation of the benefits of the therapies, the higher the adherence.

Radiation [radiotherapy] is a danger, isn't it? My chest is getting lighter now, but it was quite dark. It made a wound under the breast too. (E3)

I have to say it's for my good, even if it's bad. Because [chemotherapy] blow us up. (E12)

It seems that there are people who do not get along with the treatment, then the person becomes weak, debilitated. (E14)

Through the reports, the research found that women realized the impact on themselves because of hair loss. Alopecia exposed the participants' illness because it is considered a critical illness and permeates the idea of the finitude of life. The observed reaction of pity to the suffering of others showed that the adverse repercussions of chemotherapy generated, in the interviewees, a clearer perception of the severity of the cancer.

The worst is the 'outside' for us. You walk into the supermarket queue; they scan you from top to bottom. You go to the cashier, and he says, "Oh, are you sick?" So, it's all like that, very strong pressure. (E5)

When it fell [hair], (...). I put on the wig, but to walk with it on the street, the feeling I had was that people looked, seeing that I was wearing something [cancer]. (E37)

The symbology of hair as part of the female image was highlighted in the reports. In this sense, alopecia caused by chemotherapy was cited by most of the study participants as one of the most impactful effects, which deeply shakes the women's self-image. Consequently, this problem caused feelings of sadness, suffering, and anxiety, which may bring insecurity about future perspectives on treatments, reinforcing the conception of the severity of the disease.

And, also, I suffered a lot from the issue of losing my hair, I did not accept it. (E26)

For me, the difficulty was a little vanity, which is the hair has fallen out. (E20)

Some days it's not easy, like today. Yesterday I did not sleep at all, because of anxiety, worried about how it will be from now on, and how I will react when my hair starts to fall out. (E31)

When it fell [hair] I was very sad, I was very down, I cried a lot. (E37)

Challenges and Barriers in Treatment

The interviewees' reports showed that doubts about treatments are not always resolved with the health team. Perceptions about therapeutic procedures for cancer can be influenced by the way the health professional approaches the therapeutic options to be implemented, instilling courage or generating insecurity and interfering positively or negatively in adherence to treatments. In long-term therapeutic actions, such as hormone therapy, uncertainties about reactions can be a factor that hinders adherence, becoming a barrier to completing treatments.

Then I came home even more confused. I thought: "but, take it away, like that, out of nowhere"...she [doctor] said "you come here, we take it away." [the tumor]; and on the same day, you leave. Same day. It's a simple thing." Then I got scared, I could feel it, it was big. (E26)

As I understand it, the doctor said that for this type of cancer that came out in me, it was not hormonal. But I believe that some medication should continue, I do not understand much of it. (...) I don't know how it will be from now on. (E26)

In addition to the lack of knowledge or difficulty in understanding the side effects of treatments, the impact of these can generate feelings such as anxiety and fear. Thus, the iatrogenic effects of the treatment itself may typify a barrier to the acceptance of therapies.

I forget to take medicine [tamoxifen]. Once I skipped three days without taking it because I started to feel strange things. (E3)

At first, I didn't want to undergo [chemotherapy] not at all. The day I come here; it gives me even trauma to enter this street. (...), I decided to do the treatment. But it is being very difficult! (E27)

Furthermore, the pandemic has interposed as a barrier to health care and cancer treatment, generating insecurity in the decision regarding surgery due to the possibility of being infected with another disease also considered serious such as covid-19.

Then, the pandemic came and affected it; I could have been operated on since March, so I was scared. A lot [anxiety]. I thought: "My God, if I go to operate and get this disease? What if I run out of surgery and this [cancer] gets worse?" It messed with my head a lot. (...) Then we concluded undergo chemotherapy. (E20)

Another barrier faced is the progress of treatments. Starting with surgery or chemotherapy, women must undergo several frequent examinations, undergo adjuvant therapies, and face possible repercussions. This trajectory is tiring, exhausting, demands time, and is often shrouded in questions and insecurities about healing.

I do it every week, mainly a complete [examination] blood count and creatinine. There are some others, I don't know how to tell you now, I don't remember. Regardless of doing chemotherapy, I have to do the tests. I will be referred for radiotherapist evaluation. (...), finishing chemotherapy, I already start radiotherapy. (...) you have to ask for release from SUS, because it takes 15 to 20 days. There is a number of exams that I probably have to do again. (E26)

After everything I've been through, I had another mammogram to see how it was. It presented a lump on the right side, but it will be accompanied, nothing scary. (...). As well as the use of Herceptin, which is accompanied every three months, for the heart. (E37)

In early February, I had another appointment with her [mastologist]. I see her every six months now for control. (E5)

Perceived Benefits in Cancer Treatment

Through technology, the ease of access to information about cancer and forms of treatment allows the understanding of the possibilities of recovery from the disease. Understanding the advancement of techniques and the curative potential of therapeutic actions eased the perception of the severity of cancer and collaborated in the perspective that treatments, although aggressive, are necessary for the duel against cancer.

Today, (...) I am starting chemotherapy; and, for her [grandmother], it's not being easy. (...) it's not as normal as it is for us. (...) Today we have technology in our hands; in her time, she did not have it. (E31)

Despite the impact of adverse reactions of treatments, especially chemotherapy, women did not passively accept the disease label evidenced by alopecia. On the contrary, they questioned and sought to break the paradigms created in the popular imagination, facing the disease to overcome the barriers of side effects to achieve the benefits of the possibility of a cure.

It wasn't easy [face hair loss] because, as I did not adapt to the headscarf, these things, I looked at myself in the mirror and felt sicker. It was hard, but I'm there. I won that stage too. (E37)

In my opinion, they could speak more openly and break this taboo that a woman has to wear a scarf. She has to walk bald, or the way she wants, with a headscarf, with a wig. (...) In the first month of chemotherapy, I said: "No! I'll take on my bald head." It was the best thing I ever did. (E5)

Despite facing many challenges and barriers, women saw the results of the fight against the disease. They did not allow themselves to be overwhelmed by the condition of illness, even though they initially felt the impact and implications of the treatments. They sought to combat the idea that the person affected by a neoplasm must necessarily be with the appearance of suffering.

The doctor [oncologist] said: "I have never seen anyone who is undergoing cancer treatment go to the pool and the beach." "I'm feeling good!" "But the medicines are strong, cannot sunbathe, or you'll get stains." I was like, "Oh my god!" I thought about that blouse, the amount of protector, because I want to take my daughter to get some air, get some sun. (E2)

[After surgery] My roommate said, "I'm dumb to see, you just had surgery and it doesn't look like it, you're normal, you're fine." I said we have to live like this. (E18)

From the moment we accept the problem (...), we do not kill ourselves, raise our heads to move forward, take the opportunity to undergo treatment. (E34)

According to some interviewees' beliefs, the reactions caused by chemotherapy drugs can be attenuated by adopting a positive thought. Understanding the benefits of treatments as an opportunity for disease remission helps women to face the aggressiveness of adverse reactions to cancer therapies. Even if they have to face these reactions to achieve a cure, the perceived benefits outweigh the side effects of the treatments, giving them the strength to persevere in the continuity of therapeutic actions.

I think it's the psychological as well. Because medications interfere with the body. (...) I was feeling sick, (...) I relaxed, and the sickness passed. I really believe that the head commands the body. (E7)

If the person is thinking only the worst, the immune system falls, and it is a path for the cells to become weaker. I try to be happy, and it's much better. (E21)

They gave me the guidance so that I wouldn't miss the treatments, because the more we go for the treatment sessions, the more chances of being cured. I pray to God because I know I am being healed. Thanking and asking God. (E11)

What has changed for me is that I really want to live. I want to take care of myself, whatever it takes, get treatment. Even if they tell me I'm going to lose my hair, no problem, my hair will grow again. (E14)

DISCUSSION

The category "Perceived susceptibility: cancer and covid-19" included reports that indicate the perception of the risks of treatments and the feeling of vulnerability in the face of one's health status. In this context, the feeling of fear about the possibility of contracting the coronavirus erupted due to the low immunity caused by chemotherapy.

According to Massicotte¹⁷ and March and Vaz¹⁸, the pandemic context caused great stress, putting individuals in a vulnerable position. The forms of treatments needed to be readjusted due to the measures required to control the spread of covid-19. The use of chemotherapy is a risk factor since it causes secondary immunosuppression; therefore, people undergoing cancer treatment are at greater risk of contracting the coronavirus, so greater attention is needed in care¹⁹.

The category “Perception of severity in the face of the impact of the treatments” included the perception of the severity of the disease, highlighting the discomforts resulting from the treatments. This category addressed the unwanted reactions of radiotherapy, chemotherapy, and hormone therapy, which triggered prostration and weakness, culminating in alopecia.

Concerning unwanted reactions, Fugita and Gualda⁸ and Bea et al.⁹ report that side effects, such as fatigue, weakness, and pain, negatively impact women’s lives and are considered barriers to persistence in consultations and engagement in therapeutic behaviors, as they generate conflicts in decision-making. Most women do not have adequate follow-up and counseling both at the time of diagnosis and during treatments, which can trigger more negative reactions to the disease, accentuating the perception of the severity of the disease¹⁵.

In the research, alopecia was cited as the most impactful adverse effect since it had repercussions on body image and the perception of the condition of a disease considered serious. Only four participants underwent mastectomy; the others had undergone conservative surgery, which preserves much of the breast. However, all of them were undergoing chemotherapy, i.e., they were experiencing or had already experienced alopecia at some point.

Several authors consider the breast an essential symbolic part in the woman’s body, representing the motherhood, femininity and sexuality⁴⁻¹⁵⁻²⁰. Although the surgical removal of the breast — partial or total — disturbs this symbology, it can be hidden by clothing. Alopecia, on the other hand, is patent and opens up the disease due to cancer, which is a disease that comes accompanied with taboos²⁰.

In the study, the impact of alopecia was evident in interpersonal relationships and self-esteem: it affected body image and self-esteem, showing that the adverse effects of chemotherapy generated a better perception of the severity of cancer. The negative consequences of chemotherapy treatment on body image are widely reported in the literature, as the representation of hair in the female image is highlighted in the reports of women who have undergone chemotherapy treatment⁴⁻⁵⁻¹⁵⁻²⁰. Ferreira e Lemos⁴ point out that body image is

negatively affected, as well as self-esteem and feelings of femininity, causing symptoms of anxiety and depression.

Body image is a synthesis of emotional experiences and is related to the subjectivity and history of the individual, being unique to each one. It is the image of a body imbued with meanings, forged by everyday experiences and perceived in its lived context⁴⁻²⁰. The body modifications generated by the treatment are more evident when in relationships with other people.

In the condition of a person affected by cancer, marked by the stigma of suffering and predestined to death, they perceive the gaze of the other as one of pity⁴. In the imagination of women, there is the expectation that, in the gaze of the other, the idea of misfortune and proximity to death occurs in the face of signs of oncological disease. In this sense, the fear of rejection is present, even if it does not occur explicitly⁵.

In contrast to these changes in body image and representations of femininity, Ferreira and Lemos⁴ highlight that the commitment of the participants in their study to the treatment remained unshaken. The authors reinforce the importance of spiritual and family support in this period of fragility, which provides strength and motivation for women to face the consequences of aggressive treatments such as those to combat cancer. According to Lopes, Camargo, and Maia¹², the loss of hair and body hair is an overwhelming difficulty faced by patients, but they cling to the premise that it is a “necessary evil” aimed at a “greater good”.

The category “Challenges and barriers in treatments” covered the points of difficulty in trying to adhere to breast cancer treatments, such as doubts about therapeutic actions, the impact of side effects, the context of the pandemic, and the course of the treatment itself. In the study, despite the efforts of the health team in clarifying and orienting, doubts arose about the treatments, which caused a feeling of insecurity in the women assisted.

In long-term therapeutic actions, the lack of understanding of the importance of the medicine created a barrier to acceptance or completion of complete treatment. Tesfaw, Alebachew, and Tiruneh¹⁰ emphasize that the lack of confidence in the care and the fear of invasive procedures can set up barriers in the immediate search for medical treatment, in addition to the belief that cancer is incurable and that, therefore, medical treatments would not be effective.

Research has shown that the impact of treatments’ side effects can generate anxiety and insecurity, becoming a barrier to adherence to therapies against breast cancer. Brier et al.²¹ report that premature interruption of treatment with hormone therapy happens to many women

due to some perceived barriers, such as the side reactions of this therapy and the duration of treatment, which can vary from five to ten years.

According to the assumptions of Azriful et al.²², feelings such as sadness, fear, confusion, and stress may emerge in the diagnosis and treatment of cancer. However, in the desire to recover, individuals seek to overcome obstacles, face this treatment process, and deal with stress.

The repercussion of the pandemic was clear in the reports, demonstrating the delay in treatments because of the fear of contamination by covid-19. According to Brivio et al.²³, cancer treatments were hampered by the pandemic, as hospitals had to prioritize covid cases due to the severity of this disease.

Many screening and treatment programs have been delayed for fear of exposure to the virus since cancer patients are at risk. Some studies point out that the pause in oncological services triggered feelings of vulnerability and anxious and depressive symptoms¹⁷⁻²⁴. For Gonçalves et al.²⁵, the delay in scheduling appointments and exams and the difficulty in obtaining their results were considered barriers to accessibility.

Regarding the course of cancer treatments, the research observed that the sequence of examinations and treatments and the expectation of each result are exhaustive and painful. Alencar et al.²⁶ show that, for the treatment sequence, women are left with a full schedule of consultations with different professionals, the need to perform specialized examinations and follow-up of therapeutic actions.

This process of comings and goings demands time and exclusive dedication to treatment, which generates physical and emotional wear due to the displacement to fulfill the health care agenda (related to treatments) and anguish in waiting for results. However, the authors emphasize that they try, with faith and calm, to manage this process and face this indispensable process to recovery gradually since they glimpse the cure for the disease²⁶.

The category “Perceived benefits in cancer treatment” encompassed the perception of the effectiveness of specific actions to reduce the threat of the disease. In this category, the benefits of facilitated access to information, coping with the repercussion of treatments, the situation of illness due to cancer as a moment of great suffering, the process of acceptance and effort not to collapse in the face of the situation, and the focus on the chances of curing the disease were highlighted.

In this study, access to information allowed the demystification of cancer as a disease linked to the finitude of life. It also clarifies the therapeutic possibilities and prospects of a prognosis with a positive outcome. Ferreira and Lemos⁴, state that keeping women informed

about their health status and each stage of treatment, clarifying possible doubts, favors their perception of their participation in decisions, making them active subjects in health care and the therapeutic process.

Regarding the impact of the treatments, in this study, the women broke paradigms regarding the use of the headscarf to hide hair loss. It differed, in part, from the findings of Iddrisu, Aziato, and Dedey¹⁵, which report women's reliance on synthetic wigs or wigs made from human hair to hide baldness caused by chemotherapy toxicity.

As for coping with cancer illness as suffering, even with so many challenges, women did not accept the pathology as sorrow and did not allow themselves to be shaken. Focusing on the chances of curing the disease, they faced the iatrogenic effects and continued the treatments. According to Oliveira et al.²⁰, women create strategies to learn to live with this new condition of illness and with the impact of treatments.

In a dynamic process, they seek ways of coping to overcome the challenges of adverse effects, accepting and confronting treatments positively to make the journey smoother and more bearable. Consonant Borges, Angels, and Fields⁶, strategies such as belief in God, religiosity, and social support contributed to women facing difficult treatment situations and seeing the condition from a different perspective, providing hope for healing and reducing anxiety during treatment.

The reports showed the presence of stigma experiences that negatively affect women's perception of their illness, and paradigms still need to be broken. Therefore, they need to build knowledge that contributes to a better perception of belonging and acceptance. Thus, the process of acceptance and overcoming the disease should be strengthened, observing the comprehensiveness of care and conditions for adherence to a healthy lifestyle and exercise of autonomy.

Strengths and Limitations Of The Study

The qualitative methodology used in this study presents as limitation the impossibility of defining the case studied with greater consistency and amplitude due to the limited number of participants. Despite this, the research carried out can enable health professionals to reflect on the importance of validating the narrative of women who are undergoing treatment for breast cancer so that there is recognition of how they perceive and experience treatment for the disease.

As it is part of an ongoing study, the cutout generated 40 interviews, above the average of several qualitative studies, reflecting the density of the results presented. The research

provided greater freedom for the participants to express their feelings and perceptions on the subject due to the fact that data collection was conducted by a female researcher who has experience in research in the area of women's health.

It is necessary to highlight the practical implications of this study for the population and the practice of prevention and health promotion in oncology. The study contributes to one of the challenges of health care promotion, helping services to overcome the fragmentation of care towards comprehensive care²⁷.

The study observed some gaps related to the health service based on the perception of women, such as difficulty in accessing information, doubts about treatments and their side effects, and an exhaustive routine of examinations and procedures. It showed that these points deserve attention in the provision of the service, especially for the potential they have to influence treatment adherence.

Furthermore, the use of the Health Beliefs Model, which is widely used in research related to breast cancer prevention, can also benefit the understanding of how women perceive the disease, even when they are already undergoing cancer treatment. In this sense, it enables health professionals to use interventions that are more appropriate to the needs of women undergoing treatment.

The present study aims to provide subsidies for health professionals to consider new possibilities for understanding emotional and behavioral aspects; and incorporate into their practices a comprehensive care model, favoring greater adherence to treatment.

CONCLUSION

The study concluded that the therapies used for the remission of breast cancer arouse in women undergoing treatment different perceptions about themselves, about the disease, and about therapeutic interventions, which can facilitate or hinder the process of treatment adherence; and can attenuate or maximize the perception of severity and seriousness of the disease. As for health professionals, it is essential to recognize, through narratives, how women perceive and experience cancer therapies to provide them with better resources that increase a coping process in search of a cure for the disease.

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