REVISTA O MUNDO DA SAÚDE

Health perspectives of women with breast cancer

Rebeca Leite Cardoso*
Patrícia Aparecida Baumgratz de Paula*
Camila Teixeira Vaz*

Abstract

The understanding of the constitutive aspects of health, from the perspective of women with breast cancer, can aid professional decision-making and help develop a therapeutic plan, expanding the fundamental aspects during the care process. The present study aimed to investigate the self-assessment of health and to know the health perceptions of women who participated in the "*Guerreiras*" operating group and attended at the State Center for Specialized Care (CEAE). This cross-sectional, qualitative, and quantitative study was carried out with 15 women who were diagnosed with breast cancer. Data were collected through two questionnaires and the focus group. The participants had a median age of 51 years old, were brown, without a partner, retired, with a high school education, a family income below three minimum wages, and were an average of two years and six months after surgery and three years and seven months post-diagnosis. The categorical analysis of the testimonies collected through the focus group revealed health as: absence of disease, well-being, and spirituality; and the self-rated health showed that most of these women perceive their health condition as moderate. It is concluded that despite the view of health remaining as a counterpoint to the disease and synonymous with well-being, the perspectives on health of the studied group also incorporate the state of overcoming, coping, appreciating life, adaptations, beliefs, values, and self-confidence. Thus, the patient's perception of health has been broadened and not only focuses on the state in which the disease remits.

Keywords: Health. Perception. Diagnostic self-assessment. Breast neoplasm.

INTRODUCTION

Worldwide, breast cancer affects most of the female population when compared to other types of cancer. In Brazil, in 2018, breast cancer led to the death of 17,572 women[1]. Regarding the incidence, there will be an estimated 66,280 new cases of breast cancer, for each year of the 2020 – 2022 triennium, which corresponds to a risk of 61.61 new cases per 100 thousand women, in the country[2].

The treatments for breast cancer, regardless of the therapeutic approach chosen, can impact the health of these patients in terms of functionality, quality of life[3], and psychosocial aspects which can influence self-image, confidence, and the way in which each woman perceives her health[4].

Within this context, there are several views and thoughts on health. Some concepts mention the normal or normative

DOI: 10.15343/0104-7809.202145242249

*Universidade Federal de Juiz de Fora campus Governador Valadares- UFJF. Minas Gerais, Brasil.
E-mail: r.cleitte@gmail.com

state, establishing an insufficient separation between the normal and the abnormal, since the scientific definition of normality seems to be, in fact, inaccessible[5]. Therefore, disease is viewed as an abnormal state in relation to the persistence of life, which plays a normative role in this place[5].

On the other hand, health can be understood as a life that is lived, joining with the subjects and norms of society and everyday life, or rather, health permits living; it is to live according to the exercise related to social normativity[5,6].

With this perspective, the consideration of illness contemplates a state of struggle necessary to continue life. However, disease can refer to the impossibility of moving life forward with society, becoming a particular and concrete obstacle to the historical and social path, delimited by time and space[5,6].

Therefore, there is no single meaning of health and disease, as they depend on the social, political, economic, and cultural context, which are endowed with symbolism. Health and disease also cannot be defined only from an external observation, it is necessary to consider the eyes of those who live it, that is, the experiences, beliefs, and values of the individual.

Additionally, self-rated health is an exclusive and valuable indicator, as it represents the person's globalized perception, integrating subjective aspects of well-being, satisfaction, and control over life[7]. This perception originates from the process in which information from the body and mind is received, selected, reviewed, and summarized[8]. In the population of women with breast cancer, self-rated health represents a valid, reliable, and responsive predictor of survival to changes in the disease stage[7].

Therefore, understanding the constitutive aspects of health, from the perspective of women with breast cancer, can aid health management strategies aimed at the comprehensiveness and specificity of this population, thus, contributing to the creation and effective management of a therapeutic plan that fosters the individualized and participatory view of the patient. This would expand the fundamental aspects in the care process and the decision-making of health professionals beginning from the diagnosis. Hence, the present study aimed to investigate self-evaluated health and learn about the health perceptions of women who were diagnosed with breast cancer. In addition, the demographic and socioeconomic characteristics of the studied group will be presented.

METHODOLOGY

A cross-sectional study was carried out, with a qualitative and quantitative design. The use of these approaches is one of the types of the triangulation method. This method consists of a resource that aims to enrich and complement the data[9]. It manifests itself in different ways and does not mean evaluating or validating the results and/or procedures, it works by systematically expanding and complementing the possibilities of knowledge production[9].

Qualitative research conceives answers to very particular questions and is also concerned with aspects that cannot be quantified[10]. With this in view, the focus group technique was used in this study. This consists of the development of a special type of interview (group interview) in which communication between research participants is evaluated so that data can be produced[11].

The focus group was formed in October

2018, at the State Center for Specialized Care (CEAE), in the municipality of Governador Valadares, MG. 15 women, diagnosed with breast cancer, and were members of the support group: "Guerreiras", participated in the study. This denomination was given by the participants, as a symbol of overcoming and coping with the disease (Guerreiras = warriors).

The meeting lasted approximately 50 minutes and the women were encouraged to talk about health and healthcare. The collected statements were recorded, later transcribed, and examined in the light of Bardin's content analysis[12]. To guarantee the confidentiality of the data, numbers from one to fifteen were assigned to the participants.

For the quantitative approach, two questionnaires were applied. The first, elaborated by the researchers themselves, contained demographic, socioeconomic, and breast cancer treatment issues. The second was the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire Core-30 (EORTC QLQ-C30). This is a specific quality of life questionnaire for people diagnosed with cancer, which was translated and validated for the Brazilian population[13]. The EORTC QLQ-C30 is an instrument composed of 30 items, divided into: functional domains, symptoms, and overall health status[14]. The score for each domain ranges from 0 to 100 points[13]. Self-evaluated health, in this study, was measured through two questions that define the domain of overall health status, and the higher the score, the higher the positive perception of health is[14].

This study was approved by the Research Ethics Committee of Universidade Federal de Juiz de Fora, under the number 2.796.579. All participants read and signed the Informed Consent Form.

RESULTS

The analysis of the quantitative data, obtained by table 1, revealed that the median age of the participants was 51 years. The majority declared themselves brown, without a partner, retired, with high school education, and a family income below three minimum wages. Regarding the time since their surgery to treat breast cancer, women had an average of two years and six months after surgery, and three years and seven months after the time of diagnosis. Regarding treatment, 87% of women participated in chemotherapy treatments, 80% had radiotherapy, and 13% had hormone therapy.

Table 1 below shows the demographic and socioeconomic characteristics of women with breast cancer, attended by the CEAE of Governador Valadares, MG in October 2018.

Table 2 shows the individual self-assessment of health of women with breast cancer attended by the CEAE of Governador Valadares, MG in October 2018.

Regarding the self-rated health of these women, Table 2 shows that 53.3% had a score between 50 and 74 in the domain of general health status of the EORTC QLQ-C30; this means that most of these women perceived their own health as moderate. On the other hand, 40% of women had a score ranging from 75 to 100, which indicates a good perception in relation to their health.

With regard to qualitative data, the testimonies collected, about the health perceptions of these women, revealed the following categories: absence of diseases; welfare; spirituality.

Absence of disease

"[...] health is having to take care of yourself before getting the disease." (participant 3)

"[...] because after you are sick, you have already lost your health. So you have to work to not get to that point, which is the disease [...]"! (participant 8)

Well-being

"[...] for me, health is well-being [...]". (participant 3)

"[...] I need to be well so that I can perform my role [...]". (participant 8)

"[...] health is everything, my friend!" (participant 12)

"[...] How do you manage to [...] live even with some quality after you have had surgery like this? You cannot do it, you are in pain all the time! [...] I imagine that if we had surgery and had no follow-up, wow, we would not be able to do it [...] you would not have any well-being! Because the pain bothers me a lot [...]". (participant 3)

Spirituality

"[...] Thank God I did not feel anything during the whole chemotherapy! I still do chemotherapy [...] and thank God I do not feel anything. I am back to work and even so, I am working very well, thank God [...]". (participant 2)

"[...] Thank God [...] when the doctor spoke to me, at that moment I had that impact, but then [...] put your head on the pillow and talk to God and say, it is not just me, my God, there are more people that go through this situation. So, we grab hold of God and ask for mercy [...]". (participant 9)

Table 1– Demographic and socioeconomic characteristics of women with breast cancer at the State Center for Specialized Care (CEAE), Governador Valadares, MG - October 2018.

Demographic and socioeconomic characteristics					
Participants	**Age**	**Color**	**Marital Status**	**Education**	**Renda familiar**
1	39	Brown	Without partner	High school	< 3 mw†
2	39	White	Without partner	High school	< 3 mw†
3	41	Black	Without partner	University education	< 3 mw†
4	47	Brown	Without partner	University education	≥ 3 mw§
5	49	Brown	Without partner	Elementary School	n/d*
6	50	Black	Without partner	Elementary School	< 3 mw†
7	50	Brown	With partner	Illiterate	≥ 3 mw§
8	52	White	Without partner	University education	< 3 mw†
9	52	Black	With partner	Elementary School	< 3 mw†
10	54	Brown	With partner	High school	< 3 mw†
11	55	White	With partner	High school	≥ 3 mw§
12	57	n/d*	n/d*	n/d*	n/d*
13	58	Brown	Without partner	High school	< 3 mw†
14	61	White	Without partner	High school	< 3 mw†
15	n/d	Black	Without partner	Elementary School	< 3 mw†

Explanatory note: *n/d - not declared; †<3 mw - less than three minimum wages; § ≥ 3 mw - greater than or equal to three minimum wages.

Table 2– Self-assessment of health of women with breast cancer at CEAE, Governador Valadares, MG - October 2018.

Self-assessment of Health	
Participants	EORTC QLQ-C30 Overall health status domain
1	66.7
2	75
3	91.7
4	83.3
5	83.3
6	50
7	66.7
8	83.3
9	66.7
10	41.7
11	66.7
12	66.7
13	66.7
14	100
15	58.3

DISCUSSION

These findings are in line with the results of Gozzo, *et al.*[15] (2019), who identified the profile of women after breast cancer treatment. Their study revealed that the profile of the 235 participants had an average age of 56 years old, an elementary education, unpaid work, and 53% of women lived with a partner; only marital status did not corroborate the characteristics found in this study. It is noteworthy that in our study, the small sample is a limiting factor for comparing the results with other studies.

Another study by De Assis, Barreto & Lima[16] (2019), which assessed the sociodemographic profile based on the age and skin color/ race of women with breast cancer between the years 2013 to 2018, indicated a greater predominance in the age group of 50 to 59 years, with the majority of women having brown skin. Therefore, the findings of this study corroborate the national literature and even add data on marital status, education, family income, and post-surgical time of this investigated group.

Self-evaluated health contributes significantly to elucidating morbidity and mortality, going beyond the most objective measurements of health[8]. Höfelmann[17] (2012) carried out a study in women diagnosed with breast cancer and observed that the disease and low socioeconomic status were associated with negative self-evaluated health in the investigated sample[17].

International studies[18,19,20] suggest that a positive perception of a social support network can help women in the postoperative phase, to better deal with the psychological effects of surgery[18]. Also, they point out that the self-assessment of health and the perception of the impact of cancer is ambiguous. While some women perceive the impact of cancer on health and well-being, highlighting the negative aspects of health, others understand that health and well-being shape the negative impact perceived by cancer[19]. Therefore, in most cases, overcoming the limiting barriers, improving the quality of life, and, mainly, the way in which women with breast cancer see the whole process they go through, becomes of fundamental importance for a positive self-assessment of health[21,22].

In the present study, it was noticed that one of the ways that the participants found to face the disease was the creation of and participation in the support group "Guerreiras", the very name of the group refers to the struggle, to their empowerment in face of the reality perceived by them during the entire process (diagnosis, treatment, and post-treatment), and their health status. In this group, the participants received continuous monitoring and education from various health professionals at the center (doctor, psychologist, physiotherapist, nutritionist) and exchanged experiences through the participants' own reports for encouragement

and coping with the disease. These factors may have influenced the results found in this study, since most women rated their health as moderate to good.

As for the qualitative analysis of the testimonies collected regarding perceptions about health, the presence of the category "absence of disease" indicates that the concept of health and disease has been discussed and modified over time.

For Braun and Clarke[23], this is due to the continuous transformations of the subject in one's society, or community, and is closely related to the historical, political, geographical, social, economic, and cultural context in which one lives. However, the speeches of the participants revealed that the concept of health is the absence of disease, that is, health in opposition to the disease, is still present.

This concept of health as the absence of disease is based on the reductionism proposed by the biomedical model, with a focus on disease and scientific rationality[5]. For Lefèvre and Lefèvre[24], health cannot be reduced only to a mechanical view of the body and the presence or absence of the biological agent in the organism of individuals, which would be considered a nonsensical.

Thus, the concept of health based on this model may have influenced the negative health self-assessment of some women in this study, which may be related to fear, the severity and stigma of the disease, as well as to the functional decline and the set of conditions altered/shaken[22].

Regarding the "well-being" category, one can also perceive the presence of the concept of health proposed by the World Health Organization (WHO), in 1948, as "the state of complete physical, mental, and social well-being and not only the absence of disease"[25].

Thus, the testimonies reaffirm the definition of health proposed by WHO and refer to a "perfect well-being" and a "utopian health status" to be achieved[5,6]. However, for Silva and colleagues[5,6], it is the individual themselves who obtains the legitimacy to assess their well-being or happiness, considering their experiences, beliefs, and values.

Still, it can be noted that the construction of the concept of health, also refers to subjectivism, not subjectivity[6], as it does not comprehend only subjective health issues, but the way the person articulates his/her physical, mental, and social reality[5,6] from a purely personal point of view. Some reports confirmed this idea.

Therefore, the perception of health as well-being, according to the testimonies collected, has a direct relationship with the self-assessment of health, making it possible to understand the importance of the broad and comprehensive aspect of the subject's health in society. This relationship ponders the satisfaction of this individual with life and the conditions that contribute to physical, psychological, social, and spiritual well-being.

As for the spirituality category, some of the statements collected indicate that this dimension is in line with the 1988 recommendations of the World Health Organization. WHO incorporated the spiritual dimension in the definition of health, relating it to beliefs, meanings and purposes for life, to emotions and convictions of a non-material nature[26], and thus, man came to be considered a being in a biopsychosociospiritual dimension, with a more integrated view of health[27].

When understanding that each subject has a complex system of beliefs, values, perceptions, feelings, personal characteristics, and needs[26], the spiritual phenomenon, in addition to being closely related to mental health[26], has a system of beliefs, symbology, rites, and myths that fulfill the individual or group conditions, offering the necessary balance for their overall well-being[26].

In the present study, it is possible to contemplate the recognition of the relationship between spiritual well-being and the experience of strengthening, support, and coping. The search for coping and success from a health perspective is important for improving quality of life[28] and integrates the way these women evaluate, experience, and perceive their health experiences[28].

The statements collected on the health

perspective of women with breast cancer, point to the concept of health as the state of overcoming, resilience, coping, and appreciating life. These are considered fundamental attitudes to reach the "health status", defined by themselves, as the concept of well-being and not focused only on the remission of the disease. Thus, these factors may have influenced the positive self-assessed health in most of these women.

CONCLUSION

The results on self-assessment and health perceptions revealed different interpretations, representations, meanings, and symbolisms about the theme and portrayed the existence of the singularity and subjectivity of the perspectives of this group. However, the perception of health in opposition to the disease remained highlighted as being synonymous with well-being and the context of individual spirituality. On the other hand, their views highlighted a state of overcoming, coping, appreciating life, adapting, valuing beliefs, and recovering self-confidence, which is an expanded concept of health perceived by these women, focusing not only on the state in which there is remission of disease, but on being allowed to live and have the experiences lived by them. These factors may have resulted from the participation of these women in the support group “Guerreiras”, because, in addition to receiving care and continuing education from several health professionals at the center (doctor, psychologist, physiotherapist, nutritionist), they also support and exchange experiences between them, reflecting on the encouragement and coping with the disease. Therefore, these factors may have influenced the results found in this study, since most women rated their health as moderate to good.

The findings of this study cannot be extrapolated to other groups or other women who do not have adequate treatment, nor participate in support groups which support self-care. Thus, it becomes necessary to know the reality of other women diagnosed with breast cancer in other scenarios, in order to broaden the understanding of their self-evaluated health and health perceptions.

REFERENCES

1. Ministério da saúde (Brasil). Departamento de informática do SUS - DATASUS. Informações de Saúde (TABNET). Estatísticas Vitais: Mortalidade geral; 2019. [acesso em 17 de outubro de 2019]. Disponível em: http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sim/cnv/obt10uf.def
2. Ministério da saúde (Brasil). INCA. Estimativa 2020: incidência de câncer no Brasil [livro eletrônico]. Rio de Janeiro: INCA; 2019. Acesso em 18 de outubro de 2019. Disponível em: https://www.inca.gov.br/sites/ufu.sti.inca.local/files/media/document/estimativa-2020-incidencia-de-cancer-no-brasil.pdf
3. Saretto CB, Heller P, Brol AM. Fisioterapia em oncologia: A implantação de um serviço ambulatorial. Seminário De Iniciação Científica E Seminário Integrado De Ensino, Pesquisa E Extensão. 29 ago 2014; Joaçaba – Extensão:239.
4. Amaral J. O impacto da fisioterapia na qualidade de vida de doentes oncológicos internados em cuidados paliativos. Porto (Portugal): Faculdade de Medicina da Universidade do Porto, 2012. Dissertação de Mestrado.
5. Canguilhem, G. O normal e o patológico. Trad. Maria Thereza Redig de Carvalho Barrocas. 7ª ed. Rio de Janeiro: Forense Universitária; 2012.
6. Silva MJS, Schraiber LB, Mota A. O conceito de saúde em Saúde Coletiva: contribuições da crítica social e histórica da produção científica: contribuições da crítica social e histórica da produção científica. Rev. Saúde Colet. UEFS, [revista em Internet] 18 de abril de 2019; [acesso 18 de abril de 2019]; 29(1):1-19. Disponível em: https://www.scielo.br/pdf/physis/v29n1/pt_0103-7331-physis-29-01-e290102.pdf
7. Costa, J M M. Qualidade de Vida na Mulher em Quimioterapia por Cancro da Mama: Estudo de Coorte Prospectivo. Porto: Instituto

de Ciências Biomédicas Abel Salazar da Universidade do Porto, 2010. Dissertação (Mestrado) de Curso de Oncologia.
8. Jylhä, M. O que é a autoavaliação da saúde e por que ela prediz a mortalidade? Rumo a um modelo conceitual unificado. Soc. sci. med. 2009;69(3):307-316.
9. Flick, U. Introdução à pesquisa qualitativa. O desenho da pesquisa qualitativa. 3ª ed. Porto Alegre: Artmed; 2009, p. 20-49.
10. Trad, L. Grupos focais:conceitos, procedimentos e reflexões baseadas em experiências com o uso da técnica em pesquisas de saúde. Rev. Saúde Colet. UEFS. 2009;19(3):777-796.
11. Kitzinger, J. Grupos focais com usuários e profissionais da atenção à saúde (cap. 3). In: Pope, C.; Mays, N. Pesquisa qualitativa na atenção à saúde. 2ª ed. Porto Alegre: Artmed; 2006.
12. Bardin, L. Análise de Conteúdo: A analise categorial. Lisboa, Portugal: Edições 70; 1977.
13. Campos JA, Spexoto MC, Silva WR, Serrano SV, Marôco J. Organização Europeia para Pesquisa e Tratamento do Câncer Questionário Básico 30 de Qualidade de Vida: modelos fatoriais em pacientes brasileiros com câncer. Einstein. 2018;16(1).
14. EORTC. EORTC QLQ-C30 Manual de pontuação: Unidade de Qualidade de Vida do Coordenador do QL. Bélgica. [publicação na web]; 2001 acesso em 20 de abril de 2018. Disponível em: https://www.eortc.org/app/uploads/sites/2/2018/02/SCmanual.pdf
15. Gozzo O.T, Aguado G, Tomadon A, Sanches M, Prado M. Perfil de mulheres com linfedema no pós-tratamento de câncer de mama. Esc. Anna Nery Rev. Enferm, [revista em Internet.] 30 de setembro de 2019; [acesso 8 de julho de 2020]; 23(4):1-7. Disponível em: https://www.scielo.br/pdf/ean/v23n4/pt_1414-8145-ean-23-04-e20190090.pdf
16. De Assis EA, Barreto ML, & Lima KBE. Perfil sociodemográfico do câncer de mama na Bahia nos anos de 2013 a 2018. Textura, [revista em Internet] 20 de agosto de 2019; [acesso 8 de julho de 2020];13(21):104-113. Disponível em: https://textura.famam.com.br/textura/article/view/350
17. Höfelmann DA, dos Anjos JC. Autoavaliação de Saúde e Câncer de Mama em Mulheres de Cidade do Sul do Brasil. Rev. Bras. Cancerol, [revista em Internet] 29 de junho de 2012; [acesso 13 de maio de 2020];58(2):209-22. Disponível em: https://rbc.inca.gov.br/revista/index.php/revista/article/view/621
18. Spatuzzi R, Vespa A, Lorenzi P, Miccinesi G, Ricciuti M, Cifarelli W, Susi M, Fabrizio T, Ferrari M, G, Ottaviani M, Giulietti M, V, Merico F, Aieta M. Avaliação do Suporte Social, Qualidade de Vida e Imagem Corporal em Mulheres com Câncer de Mama. Breast care. 2016;11(1):8-32.
19. Bouskill, K., Kramer, M. O impacto do câncer e da qualidade de vida entre sobreviventes de longo prazo do câncer de mama na Áustria. Support. care cancer. 2016;24:4705–4712.
20. Yanez B., Gibbons M. M., Moreno I. P., Jorge A. & Stanton L. A. Preditores de resultados psicológicos em um estudo longitudinal de sobreviventes de câncer de mama latinas.
Rev. Psicol. Saúde. 2016;31(11):1359-1374.
21. Kagawa-Singer M, Padilla GV, Ashing-Giwa K. Qualidade de vida e cultura relacionadas à saúde. Semin. Oncol. Nurs. 2010;26(1):59–67.
22. Shimizu H.E. et al. A estrutura das representações sociais sobre saúde e doença entre membros de movimentos sociais. Ciênc. Saúde Colet., 2015;20(9):2899-2910.
23. Braun V, Clarke V. Usando análise temática em psicologia. Qual Res Psychol. 2006;3(2):77-101(16).
24. Lefèvre F, Lefèvre AMC. Saúde como negação da negação: uma perspectiva dialética. Rev. Saúde Colet. UEFS, [revista em Internet] janeiro-abril de 2007; [acesso 18 de maio de 2020]; 17(1):15-28. Disponível em: http://www.scielo.br/cgi-bin/wxis.exe/iah
25. Organização Mundial de Saúde (OMS). Constituição da organização mundial da saúde: A emenda a este artigo adotada pela Trigésima primeira Assembleia Mundial da Saúde, 2005 acesso em 17 de outubro de 2018. Disponível em: https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf
26. Alves DG, Assis MR. O desenvolvimento religioso e espiritual e a saúde mental: discutindo alguns de seus significados. Conex. PSI. 2015;3(1):72-100.
27. Marques, LF. A saúde e o bem-estar espiritual em adultos portoalegrenses. Psicol. ciênc. prof., [revista em Internet] 18 de março de 2003; [acesso 7 de julho de 2020];23(2):56-65. Disponível em: http://pepsic.bvsalud.org/pdf/pcp/v23n2/v23n2a09.pdf
28. Höfelmann DA, dos Anjos JC. Autoavaliação de Saúde e Câncer de Mama em Mulheres de Cidade do Sul do Brasil. Rev. Bras. Cancerol, [revista em Internet] 29 de junho de 2012; [acesso 13 de maio de 2020];58(2):209-22. Disponível em: https://rbc.inca.gov.br/revista/index.php/revista/article/view/621

Received in november 2020.
Accepted in april 2021.