CARE RELATIONS OF WOMEN DIAGNOSED WITH CANCER

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ABSTRACT

Objective: to analyze how occur the care relations in the social environment facing the diagnosis and the cancer trajectory, according to the optics of women with cancer. Method: qualitative, exploratory and descriptive study, with women who were at any stage of treatment in the Oncology Center Dr. Muccini, for breast, uterine or ovarian cancer, aged between 20 and 60 years. The production data occurred in August 2011, through semi-structured interview. Data were analyzed using Content Analysis. The research project was approved by the Research Ethics Committee, CAAE No 0044.0.441.000-11. Results: two categories emerged, from the content analysis: 1. Family Care and 2. The female figure as a provider of care. Conclusion: in the middle of family network, emerges a member that constitutes as more directly involved in caring. Therefore, the informal caregiver is a person without professional training that provides care and support to another individual. Descriptors: Oncology; Neoplasms; Women's Health; Nursing Care.

RESUMO

Objetivo: analisar como ocorrem as relações de cuidado no ambiente social frente ao diagnóstico e a trajetória do câncer, segundo a ótica de mulheres com câncer. Método: estudo qualitativo, exploratório e descritivo, com mulheres que estavam em qualquer fase do tratamento no Centro de Oncologia Dr. Muccini, para câncer de mama, útero ou ovário, com idade entre 20 e 60 anos. A produção de dados ocorreu no mês de agosto de 2011, por meio de entrevista semiestruturada. Os dados foram analisados através da Análise de Conteúdo. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE nº 0044.0.441.000-11. Resultados: a partir da análise de conteúdo, emergiram duas categorias: 1. O cuidado familiar e 2. A figura feminina como prestadora do cuidado. Conclusão: em meio à rede familiar, surge um membro que se constitui como mais diretamente envolvido nos cuidados prestados. Portanto, o cuidador informal é um indivíduo sem formação profissional que presta cuidados e apoio a outro indivíduo. Descriptores: Oncologia; Neoplasias; Saúde da Mulher; Cuidados de Enfermagem.

RESUMEN

Objetivo: analizar cómo se producen las relaciones de atención en el ambiente social frente al diagnóstico y la trayectoria del cáncer, desde el punto de vista de las mujeres con cáncer. Método: estudio cualitativo, exploratorio y descriptivo, con mujeres que estaban en cualquier etapa del tratamiento en el Centro de Oncología Dr. Muccini, para cáncer de mama, útero o de ovario, con edades entre 20 y 60 años. La producción de los datos se produjo en agosto de 2011, a través de entrevista semi-estructurada. Los datos fueron analizados mediante el Análisis de Contenido. El proyecto de investigación fue aprobado por el Comité de Ética de Investigación, CAAE No. 0044.0.441.000-11. Resultados: a partir del análisis de contenido, emergieron dos categorías: 1. La atención familiar y 2. La figura femenina como un proveedor de atención. Conclusión: en medio de la red familiar, surge un miembro que se constituye como una participación más directa en los cuidados prestados. Por lo tanto, el cuidador informal es un individuo sin formación profesional que brinda atención y apoyo a otro individuo. Descriptores: Oncología; Neoplasias; Salud de la Mujer; Atención de Enfermería.
INTRODUCTION

When thinking about disease, there is a set of feelings that are directly associated with the organ affected and the effects caused by the disease in the body. Generally, receiving a diagnosis is something decisive in the life of the woman because, from then on, she has the ability to reformulate important aspects of her history. Regarding to the diagnosis of cancer-related consequences, some factors are associated with social aspects, others to psyche, as recurrent thoughts of death, or fear of mutilation and loss of some people close to them.1

It is considered that the manifestation of a disease is the demonstration that other symptoms are present in a person’s life and are not resolvable. There are factors that are associated with the manifestation of cancer, for example, experiences of isolation, stories of difficult relationships, links which were strongly established with people in later life and are broken, inability or difficulty to demonstrate feelings. In the case of female cancer, has been that women who already have a depressive personality, are more likely to develop the disease.2

The human being is not used to make contact with their finitude, so one way of dealing with this is the fact of using the escape. When we have a situation of illness, the most common feeling is anguish, because death is present.

The feeling of anxiety is increasing, as medical consultations will occur, and some patients tend to use unconscious defense mechanisms to deal with the situation. Most cancer patients have psychological reactions such as denial, anger or fear toward the disease and its treatment. Many still have psychiatric order problems, such as anxiety and depression.3 However, each person needs an individual and subjective time, to deal with the consequences of this diagnosis and to establish ways of dealing with this.1

This study has as teaching purpose, the care experiences of women with female cancers, whereas for those receiving the diagnosis and living with female cancer exalt an everyday changes in their way of life, because the chances of death and mutilation remain active, therefore aims to:

- To analyze how care relations occur in the social environment facing the diagnosis and cancer trajectory, according to the optics of women with cancer.

THEORICAL REFERENTIAL

Taking care of the cancer patient involves not only knowledge about the disease, but to deal with the feelings of others as well as with their own emotions before the disease with or without the possibility of healing.4 From this perspective, the family plays an important role with the patient diagnosed with cancer. For this, it is noteworthy that the word family encompasses different and varied meanings for people, being closely correlated to where they live, culture, religion and life philosophy that guide them.5

The family is a system in which combine values, beliefs, knowledge and practices, forming an explanatory model of health and illness, through which the family develops its operating dynamics, promoting health, preventing and treating the disease of its members.6 As a system, the family follows, evaluates and supervises daily, the health status of the components of their group and leads if have problems or changes in health status.

From this perspective, care means providing attention and care to someone, in the execution of something that protect life, which creates responsibilities for the caregiver.7 Thus, the care provided by family caregivers eventually becomes a significant overhead, requiring utmost attention of these. Therefore, the experience of an illness causes many reactions and stressful feelings, because the care being and family will have to adapt to the different stages that the disease imposes. The treatment of a disease involves performing diagnostic tests, a fact that contributes to the exacerbation of feelings of anxiety and distress for the patient. Frequently, it is also observed that the fear that sick exhibit about the prognosis, the possible changes in the body resulting from the disease process and how they will be seen by others.8

In this scenario, a factor that plays an important role in the family context is the physical and emotional health, as family members are interconnected and interdependent on each other. Thus, the occurrence of changes in the health of one of its members, all others are affected and the family as a whole undergoes changes. This fact reveals the undeniable value of this institution in the coping of a disease process, serving as a support base, as well as the sporting intent of caregiver of the sick being. However, despite the technological advances and the resulting media coverage of therapeutic successes of cancer, the
confirmation of cancer and treatment planning for patients also require sensitivity of health professionals, the use of simple language, so that the patient and family know the disease, the treatment, and can trust on the professional staff.9

The cancer causes fear of imminent death, physical and social limitations, pain and loss of self-esteem. It may be hard to believe in healing, in a time of intense change of beliefs, values and cultural stigma. The first feeling that comes is the guilt associated with lifestyle. The truth should never be hidden from the patient, because they need to understand the difference between health and being healthy.10 The relationship between professional and patient has fundamental consequences, both in adherence and in the therapeutic results because exist the need of confidence in the treatment and professional.9

Therefore, Nursing can emerge as a support base for these women and families, by the nursing consultation, which aims to supply the needs of the patient in full at all stages of treatment, as well as favor understanding and adherence to the treatment.11 However, in the care of critically ill patients, the contact between health professionals with the family and patient, it is often formal and depersonalized. The relationship is not easy, and for the team members, the distance can be a defense mechanism, which often occurs in the care of cancer patients.12

Every health professional has the role and responsibility the care of patients with cancer, regardless of the context in which their work is grounded and can develop valuable contributions that make a difference in the lives of patients, families and communities where they operate.9

**METHOD**

To perform this study, a qualitative approach was adopted, with the study of exploratory and descriptive type, considering that the studied object is not susceptible of quantification and qualitative approach gives a better understanding and more accurate analysis of reality.

The study occurred at the Oncology Center Dr. Muccini, in Petrolina-PE. The selected social actors were women who were at any stage of treatment at the Oncology Center Dr. Muccini, for breast, uterine or ovarian cancer, aged between 20 and 60 years, understood as the extremes of the age range in which the disease is more prevalent 13, that agreed to participate in the study by signing the Free Consent Form. These inclusion criteria were selected so that they had a closer relationship about the experiences of care towards the disease.

Subjects who refused to participate in the study were excluded, women who have completed treatment or who have been discharged from treatment, and those with special needs such as deafness, dumbness and psychiatric problems that interfere with communication interviewee-interviewer.

We must mention that the listed exclusion criteria, considering the technical data collection, do not constitute discriminatory character, since intend to only ensure to the researcher a better interaction with the subjects.

As a tool for data collection, we used a semistructured interview. The interviews happened in the second half of 2011, after a previous contact with the study subjects. The registers were performed on recorder, with the consent of the interviewee and then, transcribed. As for orthography and grammar, there was the conference speech, strictly preserving the contents of these. The survey consisted of ten women between 20 and 60 years.

The data processing was through Content Analysis of Bardin14, which consists seeking to know what is behind the words on which leans. Data were analyzed, following the stages of pre-analysis, in which the interviews were propagated for an organization of collected data; the exploitation of the material, which regroups all the material divided into similar groups, always around the context of the study. Finally, the treatment of the results and interpretation were performed, phase in which the obtained data were analyzed and interpreted to be meaningful and valid was.15

Thus, the statements were divided into two categories, according to the approach of the topic, being presented the most significant of the study, namely: family care and the female figure as a provider of care. To guarantee anonymity, the interviewees were identified through the following features names of Nursing: Anna Nery, Martha Rogers, Myra E. Levine, Wanda McDowel, Edith Fraenkel, Florence Nightingale, Peplau, Sister Callista Roy, Elizabeth Orem and Wanda Horta. The choice of these nicknames were given in order to make an allusion to care, which is a focus of this work.

The research project was submitted for analysis from the Federal University of Vale do São Francisco (UNIVASF) Research Ethics...
The informal care relation can be understood as an activity typically provided by family members or close friends of a person who can no longer manage all aspects of daily living and personal care. So, amid the familiar network of individuals in need of care, emerges a member, that usually constitutes as more directly involved in caring. This family member is considered to be the primary caregiver. Therefore, the informal caregiver is a person without professional training that provides care and support to another individual, may be direct family, indirect or friend.

In this scenario, to care covers the activities of personal care, such as help with personal hygiene, feeding, clothing, and/or domestic activities, such as cooking, cleaning the house and doing laundry. In this familiar care process, also emerges an affective or emotional component, which allows a complete understanding of the provision of informal care, being transverse to the generality of relations, purchasing, however, unique in the context of relative caregiver-care receiver, that is fundamentally the caregiver that promotes well-being, quality of life and protection of who cares and who has care is a more passive position, of receiver.

In this category, are gathered the most significant testimonies, that bring out care relations, this was divided into two subcategories listed below.

- **The family care**

Everyone comes from a family that inherited beliefs and values that may facilitate or hinder their adaptation to the disease process. Given the coping of a disease, patience and understanding of the family are essential to occur the adaptive learning process of acceptance and self-care by the patient.

As noted in the statements of the interviewees, family care extends from the preoccupation with domestic chores and the well-being of patients to the financial support for completion of treatment.

*Who takes care of me is my husband and my children, what I can not do at home, they do for me. And also the attention they give me is very important. (Martha Rogers)*

*My family takes care of me. [...] These are issues to support me, bring me to the doctor, I can not get too much sun, I can not pick up dust, so in that sense my family has supported me and also financially. (Florence Nightingale)*

Being the family the first unit of care among its members and in view of its presence in the day-to-day of sick ones, it is essential to consider the need to intensify it in the improvement of their care for the person with cancer. Dealing with the disease process and its mishaps brings a change in the very familiar constitution, which get sick together with the patient, as a consequence of a structural reorganization to meet the demands of the caregiving process.

On this union of care, the family has been going through multiple settings and in these, is the need to develop their capacity for autonomy and independence to take care of older loved parents and their genesis. However, to take care of their being with cancer, the family needs to be enhanced as a caregiver. For that, she needs to be helped, especially with regard to the acquisition of new skills of care relating to treatment after radiotherapy and chemotherapy, diet care, among others. By guiding the family, one must take into account the objective and subjective aspects of care that should be provided in order to fully meet their needs, guaranteeing thus, a better adaptation, quality of life, autonomy and empowerment.

The care to cancer woman requires family involvement for that accountability for the healing to be shared between the desire of the woman to heal, between the host and the technical competence of health professionals involved and between care and family support. In this sense, family and professional staff, especially nurses, having more contact with the patient, must work together with the goal of providing welfare and care, alleviating stress and maintaining emotional balance of the woman facing possible changes that may arise from the treatment.

- **The female figure as a provider of care**

Historically, women always stood out as a foundation of support within the family, especially with regard to the care of their loved ones. The instinctive maternal protection always excelled in the care process, and is considered by historians and anthropologists, as the first form of the human being, in the care of their fellows. Such a case might be associated with the fact that women spend more time and devote more variety of care for dependent elderly, children and sick, compared with men. Therefore, in the reports of women participating in this study, it was possible to verify the presence of the female figure as the primary caregiver.
Who takes care is my daughter, she does everything, mops, clean the house, these cleaning things. (Wanda McDowell)

My daughter takes care of me, always looking for if I want something, if I want a juice, a fruit, looking how I am, talking with me. (Sister Callista Roy)

The fact that the woman is the main provider of informal care can be explained in several ways. A priori, it is known that women have a higher than men's average life expectancy, and they tend to marry younger women, indicating that when they are sick, wives still have health that enables them to care for their husbands. On the other hand, the traditional role of women is seen as caring for those unable to care for themselves, especially in the family circle, as the children and dependent elderly people, considered as an identity characteristic task of women and their lifestyle.

Among informal caregivers, women have a higher level of overhead compared to men. This difference may be related to the type of activity that each gender plays in providing care, while men are more likely to perform instrumental activities of daily living (managing income family, shopping, ensure the use and operation of household appliances among others), while women perform more activities of daily living (personal hygiene care and assistance others to dress, feed, ambulate). However, these latter tasks involve more physical effort and more interruptions in daily activities, which explains the greater overload felt by women.

CONCLUSION

In the performed study, it could be inferred that, the cancer and its treatment methods caused changes in body image, and are seen as a burden of this disease, they make the eyes of society see the individual, in this situation, as something liable to exclusion and prejudice. To this end, the women interviewed sought in family support, the force required to overcome this stigma. Therefore, it is understood also that the family, in the design of the interviewees, is not just a part of their illness but also their struggle to have a healthy life again.

According to reports, the patients maintain an authentic relationship with their family, based in most cases, on the important elements of human existence, such as affection, caring and understanding. Thus, in the care relations, established for the recovery and maintenance of health, the family, to the participants of this study appeared as the main caregiver, with emphasis to the female figure, represented here by daughters, who assume the major responsibility of informal care.

REFERENCES


