FNJN

İSTANBUL UNIVERSITY CERRAHPAŞA

Florence Nightingale Journal of Nursing

DOI: 10.5152/FNJN.2020.19012

Research Article

Experiences of Women After Breast Cancer Surgery

Sabriye Sibel Taze[1], Nevin Kanan[2]

[1]Department of Internal Medicine, Division of Endocrinology and Metabolism, İstanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, İstanbul, Turkey
[2]Department of Surgical Nursing, Haliç University Faculty of Nursing, İstanbul, Turkey

ORCID iDs of the authors: S.S.T. 0000-0002-9652-5498; N.K. 0000-0002-2852-2316.

Cite this article as: Taze, S. S., Kanan, N. (2020). Experiences of women after breast cancer surgery. *Florence Nightingale Journal of Nursing, 28*(2), 174-183.

ABSTRACT

Aim: This study was carried out to determine the experiences women go through after breast cancer surgery.

Method: The research was planned by using qualitative method of phenomenological type The sampling of this study consisted of 20 women with breast cancer who had undergone mastectomy in the general surgery clinic of a university hospital between January 2013 and December 2013. In sampling selection, purposeful sampling method was adopted. Women who were literate, able to communicate, willing to participate in the research, and those who had undergone mastectomy between six months and five years ago with no history of psychiatric illnesses were selected in sampling. Face-to-face interview technique was used to gather research data. The interview data were deciphered by the researcher and content analysis was done by using the N-Vivo7 program.

Results: Women participating in the study had an average age of 41.1±7.3 years, 90% (n=18) were married, 55% (n=11) were primary school graduates, they all have children, 80% (n=16) had their first child between 20 and 30 years of age, they all breastfeed their children (n=20) breastfed their children, 90% (n=18) had their first menstruation between 12 and 14 years of age, 65% (n=13) had regular menstruation cycles, and 70% (n=14) did not use contraceptive pills. In qualitative findings, themes of first reaction regarding diagnosis, deterioration of body image, deterioration of sexual life, fear, and ways to cope with illness were defined.

Conclusion: It was determined that breast cancer affects women substantially psychologically; and therefore, providing psychological support before and after surgeries is advised.

Keywords: Breast cancer, body image, sexuality

INTRODUCTION

Women diagnosed with breast cancer face a long and difficult time in which they may experience a range of problems and issues both physically and psychosocially. Especially the fear concerning loss of life associated with the diagnosis of cancer and the intensive treatment process used in breast cancer give rise to a variety of problems. Treatment procedures such as surgery, radiotherapy, chemotherapy, and hormonal therapy may be combined or used separately for the treatment of breast cancer. Surgical intervention in breast cancer is usually utilized as a primary treatment procedure aiming to reduce the likelihood of cancer recurrence and improve quality of life, particularly in localized cases without distant metastases (Akyolcu, 2008; Karamanoğlu & Özer, 2008; Przezdziecki et al., 2013). The goal of surgical treatment is to prevent the progression of cancer by breast-conserving surgery or mastectomy. However, mastectomy performed as a means of surgical treatment, results in the loss of the "breast", which is of great importance for the identity of a female, leading to adverse effects for the woman psychologically (Cheville & Tchou, 2007; Uçar & Uzun, 2008).

One of the most important responsibilities of nurses after surgical intervention is to provide professional psychosocial support to patients. Comprehensive studies are warranted to identify the problems arising from mastectomy and to plan and implement appropriate interventions in women with breast cancer who experience several biopsychosocial difficulties at varying levels.

The present study aimed to describe the experiences of women with breast cancer who underwent surgical intervention.

Corresponding author: Sabriye Sibel Taze
E-mail: sibeltaze@gmail.com

Date of receipt: 19.04.2019
Date of acceptance: 03.10.2019

This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License

Research Questions

1. What does breast cancer diagnosis mean for women?
2. How does breast surgery affect women's body image?
3. What is the effect of breast surgery on sex life?

METHOD

Study Design

The research was planned by using qualitative method of phenomenological type.

Sample

Population of the study consisted of women with breast cancer who had undergone surgical intervention in an inpatient setting at a university hospital between January 2013 and December 2013. The study sample consisted of 20 women who were able to communicate, read and write, had no history of a psychiatric condition, and volunteered to participate in the study with a duration of at least six months and no more than five years since surgical intervention.

Data Collection

Interviewing participants is the most commonly used data collection tool in qualitative studies. In this study, two interviews were conducted with participants. During the first interview, the necessary information about the study was provided before surgery to determine whether participants could take part in the study. The second interview took place six months after the surgery, with adaptation to the new condition expected to occur during this period.

The second interview was conducted in the form of individual in-depth interviews. The appropriate place and time for the interview were determined with the participants who met the eligibility criteria, agreed to participate in the study, and communicated with the investigator. After providing information about the objective and method of the study, participants were provided with an "Informed Consent Form", which they read and signed. The participants were assured that the records would be kept confidential and would not be used anywhere else. After completing the "Patient Information Form" which included questions about demographics and risk factors for breast cancer, semi-structured interviews were conducted using a "Patient Guide". Interviews lasted for 30 to 60 minutes, during which a recording device was used.

Data Analysis

For data analysis, all interviews and audio recordings collected using a recorder were decoded manually by the investigator. Content analysis was performed using the N-Vivo7 program in this study. The main purpose of content analysis is to obtain the concepts and relationships that can explain the collected data. The basic action of content analysis is to bring together similar data within the framework of certain concepts and themes, and interpret them in a way that the reader can understand. Within the framework of this main goal, a number of steps are followed during content analysis. Qualitative study data are basically analyzed in four steps: Coding of data, identifying themes, organizing codes and themes, and defining and interpreting the findings (Yıldırım & Şimşek, 2008).

Ethical Consideration

Both scientific and universal ethical principles were taken into consideration during the conduct of this study. For this reason, the ethics committee approval was obtained from the ethics committee of the university hospital where the research will be carried out, from the Istanbul University Cerrahpaşa Faculty of Medicine Clinical Research Ethics Evaluation Board, dated 09.11.2011, number 16373.

RESULTS

Table 1 shows the descriptive characteristics of the patients included in the study. The women included in the study had a mean age of 41.1±7.3 years, 90% (n=18) were married, 55% (n=11) were primary school graduates, they all have children and breast-feeding history (n=20), 80% (n=16) had their first child between 20 and 30 years of age, 90% (n=18) had their first menstrual period at the age of 12-14 years, 65% (n=13) had normal menstrual cycle, and 70% (n=14) were not birth-control pill users.

Table 2 shows the data derived from qualitative findings. The first theme was "initial reaction to the diagnosis" with the subthemes identified as "being shocked" and "blaming others" followed by the second and third themes of "deterioration of body image" and "deterioration of sexual life". The fourth theme was "fear" with the subthemes "fear of recurrence" and "fear of death", and finally the fifth theme was "coping with the disease" with the subthemes "communicating with other patients with the same condition," "family support," and "spirituality." Patient opinions concerning the themes are presented below.

Table 1. Descriptive characteristics of the patients

Sociodemographic Characteristics (n=20)		n	%
Age	Mean: 41.1±7.3, (min: 27; max: 52)		
Marital Status	Married	18	90.0
	Single	2	10.0
Education Status	Primary School	11	55.0
	Middle School	3	15.0
	High School	4	20.0
	University	2	10.0
Having Children	Yes	20	100.0
	No	0	0.0
Family Breast Cancer Story	Yes	5	25.0
	No	15	75.0
Age of Having First Child	19 years and under	2	10.0
	20-30 years	16	80.0
	31 years and older	2	10.0
Breastfeeding Status	Yes	20	100.0
	No	0	0.0
Age of First Menstruation	15 years and older	2	10.0
	12-4 years	18	90.0
Menstruation Layout	Regular	13	65.0
	Irregular	7	35.0
Contraceptive Usage Status	Yes	6	30.0
	No	14	70.0

SD: Standard deviation; Min: Minimum; Max: Maximum

Table 2. Themes and subthemes

Theme	Subtheme
Initial reaction to the diagnosis	- Being shocked - Blaming others
Deterioration of body image	
Deterioration of sexual life	- Fear of recurrence
Fear	- Fear of death - Communicating with patients with the same condition
Coping with the disease	- Family support - Spirituality

Initial Reaction to the Diagnosis

For the "initial reaction to the diagnosis" theme, subthemes were identified as being shocked and blaming others. Some of the women stated that they were shocked when they first heard the diagnosis, while others stated that they felt others were guilty in the emergence of their condition.

Being shocked

"When I was first told about the diagnosis, it was such a difficult moment. My life changed in a moment! It turned upside down. I couldn't think of what I would think. I was shocked. I had a crying fit How could something like that happen to me? Why me? Why like this? I said nothing. I did not say anything, I did not oppose Allah, but why is this disease at this age, I am so young." (Participant 1)

"I had no family history of this, not even in my extended family. I couldn't believe it. I was shocked and I might have been in an outrage at that moment. You know, it is said that different doctors say different things, so we went to several hospitals after I was told about cancer." (Participant 20)

Blaming others

"When I first heard the diagnosis, I asked why? I said I married and this happened. Had I known this was to happen, I wouldn't have married. I said I was never allowed to have a single happy day." (Participant 5)

"I blame my husband family about my disease. When my husband went to serve on the ship, his family re-

ally troubled me, and these masses appeared after that. I experienced great sadness and that led to these masses." (Participant 3)

Deterioration of Body Image

"I lost my hair and I wear a bonnet. People stare at me but I often ignore them. I'm not close to anyone. I do not prefer going anywhere and I don't want to talk to anyone until I recover fully because I think talking would make me feel worse. I didn't tell anyone as I thought it would affect me. I only told my family." (Participant 8)

"Of course I cried, it makes you feel really bad. There's a film called 'The Hills Have Eyes', where there are abnormal people exposed to radiation. I felt like them, I felt like a distorted person. An incomplete body, which makes you feel bad." (Participant 9)

"We entered a store, I wore clothes there, but there was no bra on me, I was so angry that I was angry at myself, so everyone seemed to be looking at me for why I was like this, in fact, nobody knew but (crying) I was so bad there, I couldn't fit the outfit to myself." (Participant 19)

Deterioration of Sexual Life

Loss of breast after breast surgery and adverse effects of chemotherapy affect not only body image but also sexuality (Burwell, Case, Kaelin, & Avıs, 2006). The significant impact on sexual life is clearly seen based on the statements of the women included in this study.

"Of course my sexual life is not like what it used to be, it has been effected considerably. We have never been together when we had chemotherapy for 6 months. My husband didn't want to. I mean, he said he didn't need it and all he wanted was for me to be well. It wasn't such a big part of his life and that it's okay without sex, too. As a woman I think differently. I sometimes have a different perception - maybe he no longer likes me. We had sex once after the surgery but it wasn't like what it used to be." (Participant 11)

"We didn't have sex since the surgery, it's been 6 months. My husband had no reactions about it. I don't know what he's thinking. We didn't talk about this. I didn't make any attempts either, I feel bad about this. We didn't have sex since the surgery, I'm receiving chemotherapy, I got over surgery. I mean, maybe he would like to approach me but thinks I'm unwell, and I think he's being like that for the sake of me. Is he not approaching me from his thinness? Did we ever talk?." (Participant 12)

Fear

Subthemes for the "fear" theme were identified as fear of recurrence and fear of death. The fact that cancer raises fear of recurrence and fear of death among women is clearly seen based on the statements of the women included in this study.

Fear of recurrence

"Losing my hair, having my breast removed, or the chemotherapies I received didn't break me, nothing did, until they said it's malignant and has a risk of recurrence. That remains my only concern. I'm fine with everything else but that. I believe I can overcome it all but not recurrence. That's the only thing that had an effect on me." (Participant 13)

"I stuck to positive thoughts, and I told myself that this will pass. We can say it's almost over as I'm going to receive the last radiotherapy. Then I know the process. There will be drugs I'll need to take. Well, I hope it doesn't repeat. That's what keeps my head busy now - the risk of recurrence." (Participant 14)

Fear of death

"The course is getting worse. As time passes, I tell myself I'll die anyway - what difference does it make whether it's one day sooner or one day later. It makes you think of death more often." (Participant 10)

"When I first heard the diagnosis I thought of my children before myself. The only thing you can think of at that moment is death. You say oh God! And I realize we're scared of a cancer diagnosis so much so that I couldn't think of anything else but death at that time. Then my husband said we will defeat it, and he told me to keep calm. But I couldn't even cry, we were so shocked that all I could say was "oh, will I die?" and that sort of stuff." (Participant 2)

Coping with the Disease

For the theme "coping with the disease", the subthemes were identified as communicating with patients with the same condition, family support, and spirituality. While some of the women who had undergone mastectomy said that they were still in contact with other patients suffering from the same problem, some mentioned getting support from their families, and some others expressed that they resorted to their religious beliefs.

Communicating with patients with the same condition

"There are friends who have surgery, I am constantly talking to them. Maybe I am discussing the same things because we are experiencing the same, maybe there are those who come to the hospital for surgery and take medication, there are those whose breasts are removed, talking to them relieves me. I do not like to care about other patients, but I like to share what I have experienced with them because they are living, I am more comfortable.." (Participant 3)

"Of course, there are people I know from my hometown, even those who have finished their treatment, and those who have lost their breast. They came to see me as soon as they heard the news. They told me what they knew at the time, just like now I tell others. Some showed their silicone, the silicone breast I mean, I had their support too. Talking to them makes me feel better, no doubt." (Participant 14)

Family support

"I could not survive without my wife, he was very supportive, he did not think pessimist, always approached with kindness, he said, 'It may not be a breast, it doesn't matter to me', he supported me a lot." (Participant 15)

"I had so much support from my husband throughout this period. My older daughter was also always with me and handled my all stuff. My husband, my daughter... I mean, my family showed me a great support." (Participant 12)

Spirituality

"This comes from God after all. If God draws this path for you, it's going to happen no matter what. In Turkey, we believe in God, and you accept whatever comes from God." (Participant 8)

"When the diagnosis was made, I did not rebel that it would go to the power of God. You know, they say God gives the biggest troubles to those He holds dear, so I accept whatever comes from God, I just hope God doesn't give me troubles without any solution. It could be worse, God forbid." (Participant 15)

DISCUSSION

In this part of the qualitative study investigating the experiences of women with breast cancer after surgical intervention, patient perspectives obtained within the specified themes are discussed in light of the literature.

Initial Reaction to the Diagnosis

Being shocked

In people who receive a diagnosis of cancer, the first reaction is usually to be shock. Once the patient gets out of shock, they often say "No, this cannot be true, there must be a mistake in the lab tests, there has to be a mistake in this diagnosis." They say they are healthy, that they have no complaints, see their doctor every year, and even undergo mammography so they believe they cannot have cancer and think that the diagnosis cannot be correct (Ünal, 2008). In the focus group study by Morgan, Mock, Rose, & Fogel (2004), most of the women stated that when they first heard the diagnosis, they cried, felt shocked, could not believe it, had taken refuge in God to cope with the diagnosis, and want support from family and friends. In the qualitative study by Coyne & Borbasi (2009) in six women diagnosed with breast cancer, all of the women stated that when they first heard the diagnosis, they were shocked and asked the question "Why me?" and suddenly lost hope. The study by Elmir, Jackson, Beale, & Schmied (2009) revealed that 50% of the participating women felt shocked when they first heard the diagnosis.

In the present study, some of the women stated that they were shocked and destroyed when they first heard the diagnosis. When the results from other studies are considered, the results show that the women's reactions are similar and that they mostly get shocked when they hear the diagnosis for the first time, which support the results in the literature as well as previous study results.

Blaming others

After the inevitable ending of the first stage of denial, the person diagnosed with cancer proceeds with the anger phase. The most frequently asked question in this period is, "Why me? What have I done to deserve this?" During this period, the individual starts to look for causes of the disease and may blame herself or someone else for what is happening. For example, she might feel that she has been upset as her husband had been cheating on her and may associate this with her cancer (Çam & Gümüş, 2006; Güleç & Büyükkınacı, 2011; Ünal, 2008).

Seeking the reasons of disease by blaming others or oneself is a normal reaction to the diagnosis of cancer. Considering that one of the key aspects of healthy living is to live a stress-free, happy, and

peaceful life, looking for a criminal upon receiving the cancer diagnosis, especially after the bad experiences, may be considered as a natural and common reaction.

Deterioration of Body Image

One of the factors that adversely affect coping with the disease is the deterioration of body image. Treatment of breast cancer includes various methods, primarily surgical intervention, chemotherapy, and radiotherapy. These treatments have a range of adverse effects which may impact patients both physically and psychologically. In addition to the loss of breast due to mastectomy, hair loss from chemotherapy also has a negative effect on the body image perception of a woman (Akyolcu, 2008; Çam & Gümüş, 2006; Lim, Devi, & Ang, 2011; Przezdziecki et al., 2013; Tünel, Vural, Evlice, & Tamam, 2012).

One of the women interviewed during the study by Taleghani, Yekta, & Nasrabadi (2006) expressed that her hair and body are important for her, which constitute a part of the female identity, and that she suffered from being in this condition. In a study by Ziegler, Sassi, Raffoul, & Delaloye (2010), some of the women stated that they felt a void when their breasts were surgically removed and that it was a very sorrowful experience for them. Coyne & Borbasi (2009) reported in their study that one of the women said, "All of a sudden, I felt like everything giving me my female identity was taken away. I lost my breast. I could no longer have a child. All of my life plans seemed far away in a stroke. The scar of the incision extended from my armpit to my chest, with I have no chance to hide, and it reminded me of breast cancer every time I looked at the mirror." One of the themes included in the study by Silva & Santos (2010) was the change in body image. One of the participants stated that the breast was one of the features of femininity, but that it was now disfigured and looked ugly when wearing clothes. In a study by Arroyo & Lopez (2011), one of the women reported that when she looked at herself, she did not find herself attractive at all and tried to overcome feeling that it was important to her, but she failed to do so while another woman stated that she thought she looked like a circus clown. In Shrestha's (2012) study, 50% of the women stated that they felt like they had lost their femininity and did not want to share their feelings with anyone. One of the themes included in the qualitative study by Koçan & Gürsoy (2016) was deterioration in body image where one of the women stated that a part of her body was no longer there and that she had never thought that she could be like that.

While positive body image contributes positively to an individual's mental health, negative body image may have negative effects in this regard. It may be concluded that the result showing the negative effect of breast loss on body image perception among women participating in the study is a natural and common finding.

Deterioration of Sexual Life

Sexuality encompasses the individual's need for touch related to sexual activity, feelings of competence, and the need for a partner for communication. For women, sexuality covers the notions of being desirable, being able to bear a child, and body image. As for sexual intercourse, it is a broad concept involving emotional, intellectual, and sociocultural components beyond competence (Henson, 2002; Öztürk, 2013).

In addition to the negative effects of mastectomy on body image, anti-estrogenic drugs, such as tamoxifen and raloxifene, used for five years after surgery in women who have undergone surgical intervention for breast cancer may also cause vaginal dryness, contributing to sexual dysfunction. In a study conducted by Kissane, White, Cooper, & Vitetta (2004) in women with mastectomy and their partners, participants emphasized the physical problems caused by surgical intervention and the impact on their sexual lives. Shrestha' (2012) reported in their study that seven women were uncomfortable talking about their sexual life with their spouses, two of them felt uncomfortable due to the gap in their chest, and one reported a decrease in sexual desire. In a study by Aygın & Arslan (2008), 32% of the participants whose relationship with their spouse was affected expressed that they felt physically inadequate. The study by Sertöz, Mete, Noyan, Alper, & Kapkaç (2004) revealed that total mastectomy impaired body image perception, which caused a decrease in sexual satisfaction and lack of harmony between partners, and the most common sexual dysfunction observed in women with breast cancer was sexual avoidance and problems with communication. Avis, Crawford, & Manuel (2004) conducted a study to identify the problems related to breast cancer in women and reported that the most prominent problems included women's discomfort concerning the changes in their body and their relationship with

their partners. In another study, it was observed that the sexual problem score of women under the age of 50 years treated with chemotherapy, radiotherapy, and surgery was higher than that in the period before diagnosis. Although sexual problems decrease over time in young women, it is reported to be higher in the first year compared to the pre-diagnosis period (King, 2007).

In the present study, women stated that their sexual life was affected and was not the same after surgery. The findings supporting the previous study results and the literature show that sexual dysfunction may be considered as a natural result of the loss of breast, which is perceived as a sexual object as well as being an important symbol of being a woman and a mother.

Fear

Fear of recurrence

It has been reported that the most common fear seen among women after the primary treatment in breast cancer is the fear of recurrence and that the reason of this fear is the suspicion that cancer cells are not completely cleared (Oxlad, Wade, Hallsworth, & Koczwara, 2008). One of the themes included in the study by Silva & Santos (2010) was the fear of recurrence and metastasis. The majority of women stated that they were afraid of recurrence and metastasis, while another woman expressed concerns about every visit for mammography. In another study, one patient expressed her concern that the disease may also occur in the other breast and may recur after surgery (Yusuf, Ab-Hadi, Mahamood, Ahmad, & Keng, 2013). While the study by Härtl et al. (2003) reported a considerable rate for fear of recurrence, the participants in the study by Shrestha (2012) expressed fears of recurrence and metastasis as well as anxiety and depression. In a focus group study, Oxlod et al. (2008) reported that women who participated in their study were concerned that the disease would recur after surgical treatment.

It is natural that the fear of recurrence, which is a very common feeling among women with breast cancer, has also been experienced by the women constituting the sample of this study. The result reported herein supports the literature and previous study findings.

Fear of death

Since cancer is a life-threatening disease, it can lead to a range of psychological reactions. The main reason behind these reactions appears to be fear. The fear of death is the primary fear observed in these patients (Çam & Gümüş, 2006).

In a study by Yusuf et al. (2013), one of the patients stated that she considered the diagnosis as an incurable disease when she was first told and that she thought she would die the following day while another patient expressed thinking of her children in the first place when she heard the diagnosis for the first time. Majority of participants in the study by Shrestha (2012) stated experiencing the fear of death, and 71% of the women in the study by Vilhauer (2008) expressed the fear of death.

In the present study, some of the women stated experiencing fear of death. Similar to the findings from the previous study, the fear of death is an inevitable experience in women with cancer, and the present results support the literature as well as other study results.

Coping with the Disease

Communicating with patients with the same condition

Communicating with other women, who underwent the same surgical intervention, and their discussions about shared concerns provide an important means of support for affected women to understand that what they are going through is a natural process (Smeltzer, Bare, Hinkle, & Cheever, 2008). In a study by Taleghani et al. (2006), one of the women stated that when she went to visit her doctor, she saw several patients there, one of whom had undergone surgery many years ago and looked very happy and healthy. The participant mentioned realizing two things after talking to that particular woman; firstly, she was not alone as many other women were going through the same thing, and secondly, those women too were used to living with their disease.

In the present study, the women stated that they remained in touch with the women they had met during their treatment at the hospital. It is understood from the statements that women see other patients with the same condition as their friends of fate and try to cope with the disease by supporting each other. As often emphasized in the literature, the result reflects the fact that communication with patients suffering from the same condition helps patients confront their diagnosis and observe the changes through the course of disease.

Family support

According to the WHO report, the importance of social support from family and friends, which is one of the factors that maintains mental health, has been described in an evidence-based manner. Having a good relationship with the family and the support from family members are important for women to cope with breast cancer (Ardahan & Yeşilbakan, 2010; Terakye, 2011).

In the study by Ardahan & Yeşilbakan (2010), scores of family support were considerably high while all of the women in the study conducted by Elmir et al. (2009) reported getting support from family and friends from the time of diagnosis through the surgery process, and family support was reported in 80% of the participants in the study by Acar (2009). In another study, 77% of the participants mentioned that family support was the mainstay of their cancer treatment (Greenslade, Eliot, & Mandville-Anstey, 2010).

The finding that women constituting the sample of the present study stated getting family support during this difficult period of trying to cope with cancer, which is a highly debilitating experience both in physical and emotional terms, is pleasing and appears consistent with other study results as well as the literature.

Spirituality

The people in our country try to cope with life-threatening health problems with spirituality and faith while also making use of the opportunities of modern medicine. Patients use positive and negative spiritual coping methods to cope with their disease. In relevant studies, it has been observed that coping with the disease by means of spirituality and faith is preferred among women, elderly, and individuals with low socioeconomic level among the patients (Daştan & Buzlu, 2010). In addition, religious belief and spirituality have been shown to contribute significantly to psychosocial adjustment to cancer itself and its treatment. Religious belief provides a source of hope for cancer patients and contributes significantly to an improved quality of life (Weaver & Flannelly, 2004). According to a report by Vallurupalli et al. (2012), 84% of the patients with advanced cancer stated that religious belief and spiritual faith gave them confidence in coping with cancer. Feher & Maly (1999) conducted a study in women with breast cancer, reporting that spirituality improved emotional support in 91% of these patients, improved social support in 70%, and affected the ability to make sense of life with cancer in 64%, helping them to better cope with their condition. In another study, 26 out of the 27 women with breast cancer expressed the importance of spiritual faith for the recovery of cancer patients (Choumanova, Wanat, Barrett, & Kopman, 2006), and the study by Karbani et al. (2011) reported that some of the women stated feeling better with praying and faith in God while Henderson, Gore, Davis, & Condon (2003) reported that the women who participated in their study stated that praying and faith had an important role in coping with their condition at every stage of the disease.

The present study, it was observed that some of the women diagnosed with breast cancer and receiving treatment for their condition accepted it as coming from God and tried to cope in this manner. It may be concluded that the results of this study support other studies and reflect that spiritual faith plays an important role in coping with the disease.

CONCLUSION AND RECOMMENTATIONS

In conclusion, the loss of breast is noted to be a highly traumatic process for women. Care should be taken to ensure that the patient is not alone (but accompanied by family, spouse, children, and relatives or friends) during the first explanation of their breast cancer diagnosis, and when informing patients and family/friends or relatives about the diagnosis, treatment and care interventions, an empathic approach should be adopted, allowing them to express their thoughts and concerns while avoiding words and behavior which may lead to their discomfort. Psychosocial evaluation of these women starting from the initial diagnosis to the postoperative period is important in terms of their adaptation to this process.

Ethics Committee Approval: Ethics committee approval was obtained from the Clinical Research Ethics Evaluation Board of İstanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine (number 0937.2011, number 16373).

Informed Consent: Written consent was obtained from women participating in this study

Peer-review: Externally peer-reviewed.

Author Contributions: Concept – S.S.T.; Design – S.S.T., N.K.; Supervision – S.S.T., N.K.; Resources – S.S.T., N.K.; Materials – S.S.T., N.K.; Data Collection and/or Processing – S.S.T., N.K.;

Analysis and/or Interpretation – S.S.T., N.K.; Literature Search – S.S.T., N.K.; Writing Manuscript – S.S.T., N.K.; Critical Review – S.S.T., N.K.; Other – S.S.T., N.K.

Conflict of Interest: The authors have no conflicts of interest to declare.

Financial Disclosure: The authors declared that this study has received no financial support.

REFERENCES

Acar, A. (2009). Sexual functions of females with breast cancer and affecting factors. (Master's Thesis). Mersin University Institute of Health Sciences Nursing Department, *Mersin*.

Akyolcu, N. (2008). Sexual life after surgery after breast cancer. *Journal of Breast Health, 4*(2), 77-83.

Ardahan, M., & Yeşilbakan, Ö. U. (2010). Perceived family support of women with breast cancer and affecting factors in Turkey. *Asian Pacific Journal of Cancer Prevention, 11*(5), 1425-1429.

Arroyo, J. M. G., & Lopez, M. L. D. (2011). Psychological problems derived from mastectomy: A qualitative study. *International Journal of Surgical Oncology, 8*, 1-8. [Crossref]

Avis, N., E., Crawford S., & Manuel, J. (2004). Psychosocial problems among younger women with breast cancer. *Psycho-Oncology, 13*(5), 295-308. [Crossref]

Aygın, D., & Aslan, F. E. (2008). A study of sexual dysfunction in women with breast cancer. *The Journal of Breast Health*, *4*(2), 105-114.

Burwell, S. R., Case, L. D., Kaelin, C., & Avis, N. E. (2006). Sexual problems in younger women after breast cancer surgery. American *Society of Clinical Oncolog, 24*(18), 2815- 2821.

Cheville, A. L., & Tchou, J. (2007). Barriers to rehabilitation following surgery for primary breast cancer. *Journal of Surgical Oncology*, *95*, 409-418. [Crossref]

Choumanova, I., Wanat, S., Barrett, R., & Kopman, C. (2006). Religion and spirituality in coping with breast cancer: Perspectives of Chilean women. *The Breast Journal, 12*(4), 349-352. [Crossref]

Coyne, E., & Borbasi, S. (2009). Living The experience of breast cancer treatment: The younger women's perspective. *Australian Journal of Advanced Nursing, 26*(4): 1-13.

Çam, O., & Gümüş, A. B. (2006). Emotional support focused nursing interventions for the women with breast cancer. *Journal of Cumhuriyet* University School of Nursing*, 10*(3), 52-60.

Daştan, N. B., & Buzlu, S. (2010). The effects of spirituality in breast cancer patients and spiritual care. *Journal of Maltepe University Nursing Science and Art*, *3*(1), 73-78.

Elmir, R., Jackson, D., Beale, B., & Schmied, V. (2009). Against all odds: Australian women's experiences of recovery from breast Cancer. *Journal of Clinical Nursing*, *19*, 2531-2538. [Crossref]

Feher, S., Maly, & R. C. (1999). Coping with breast cancer in later life: The role of religious faith. *Psycho-Oncology*, *8*(5), 408-416. [Crossref]

Greenslade, M. V., Eliot, B. B., & Mandville-Anstey, S. A. (2010). Same-Day Breast Cancer Surgery: A qualitative study of lived experiences. *Oncology Nursing Forum*, *37*(2), 92-97. [Crossref]

Güleç, G., & Büyükkınacı, A. (2011). Cancer and psychiatric disorders. *Current Approaches in Psychiatry*, *3*(2), 343-367.

Härtl, K., Janni, W., Kästner, R., Sommer, H., Strobl, B., Rack, B., et al. (2003). Impact of medical and demographic factors on long-term quality of life and body image of breast cancer patients. *Annals of Oncology, 14*, 1064-1071. [Crossref]

Henderson, P. D., Gore, S. V., Davis, B. L., & Condon, E. H. (2003). African American women coping with breast Cancer: A Qualitative Analysis. *Oncology Nursing Forum, 30*(4), 641-647. [Crossref]

Henson, H. K. (2002). Breast cancer and sexuality. *Sexuality and Disability, 20*(4), 261-275. [Crossref]

Karamanoğlu, A. Y., & Özer, F. G. (2008). Home car for mastectomy patients. *Journal of Breast Health, 4*(1), 3-8.

Karbani, G., Lim, J.N. W., Hewison, J., Atkin, K., Horgan, K., Lansdown, M., et al. (2011). Culture, attitude and knowledge about breast cancer and preventive measures: A qualitative study of South Asian breast cancer patients in the UK. *Asian Pacific Journal of Cancer Prevention, 12(6),* 1619-1626.

King, C. R. (2007). Young women may experience sexual problems after breast cancer surgery. *Oncology Nursing Forum*, *34*(1), 19.

Kissane, D., White, K., Cooper, K., & Vitetta L. (2004, April). Impact of surgery on sexual function. In *Psychosocial impact in the areas of body image and sexuality for women with breast cancer.* National Breast Cancer Centre incorporating the ovarian cancer program. National Breast Cancer Centre, Sydney, Australia.

Koçan, S., & Gürsoy, A. (2016). Body image of women with breast cancer after mastectomy: A qualitative research. *Breast Health*, *12*: 145-50. [Crossref]

Lim, C. C., Devi, K. M., & Ang, E. (2011). Anxiety in women with breast cancer undergoing treatment: A systematic review. *International Journal of Evidence- Based Healthcare,* 9, 215-235.

Morgan, P. D., Mock, V., Rose, L., & Fogel, J. (2004). African American women's emotional responses to breast cancer. *Women's Health and Urban Life*, *3*(1), 56-73.

Oxlad, M., Wade, T. D., Hallsworth, L., & Koczwara, B. (2008). 'I'm living with a chronic illness, not... dying with cancer': A qualitative study of Australian women's self-identified concerns and needs following primary treatment for breast cancer. *European Journal of Cancer Care, 17*(2), 157-166. [Crossref]

Öztürk, D. (2013). The Effect on breast reconstruction after mastectomy and sexual life. (Master's Thesis). *İstanbul University Faculty of Health Sciences Surgical Nursing, İstanbul.*

Przezdziecki, A., Kerry, A., Sherman K. A., Baillie, A., Taylor, A., Foley, E., et al. (2013). My changed body: Breast cancer, body image, distress, and self-Compassion. *Psycho-Oncology, 22*(8),1872-9. [Crossref]

Sertöz, Ö. Ö., Mete, E. H., Noyan, A., Alper, M., & Kapkaç, M. (2004). Effects of surgery type on body image, sexuality, self-esteem, and marital adjustment in breast cancer: A controlled study. *Turkish Journal of Psychiatry, 15*(4), 264-275.

Shrestha, K. (2012). Psychological impact after mastectomy among Nepalese women: A qualitative study. *Nepal Medical College Journal*, *14*(2), 153-156.

Silva, G., & Santos, M. N. (2010). Stressors in breast cancer post-treatment: A qualitative approach. *Revista Latino-americana de Enfermagem, 18*(4), 688-695. [Crossref]

Smeltzer, S. C., Bare, B. G., Hinkle, J. L., Cheever, K. H. (2008). Assessment and management of patients with breast disorders. In *Brunner & Suddarth's textbook of medical surgical nursing.* (pp.1457-1484). Philadelphia, PA: Lippincott Williams and Wilkins.

Taleghani, F., Yekta, Z. P., & Nasrabadi, A. N. (2006). Coping with breast cancer in newly diagnosed Iranian women. *Journal of Advanced Nursing 54*(3), 265-273. [Crossref]

Terakye, G. (2011). Interaction with the patient and his relatives. *Dokuz Eylül* Üniversitesi *Hemşirelik Fakültesi Elektronik Dergisi*, *4*(2), 78-82.

Tünel, M., Vural, A., Evlice, Y. E., & Tamam, L. (2012). Psychiatric problems in patients with breast cancer. *Archives Medical Review Journal, 21*(3), 189-219.

Uçar, T., & Uzun, Ö. (2008). Examination of effect on body image, self-esteem, and marital adjustment of mastectomy in women with breast cancer. *The Journal of Breast Health, 4*(3): 162-168.

Ünal, H. (2008, March). Surgeon's perspective on patient with breast cancer. In İstanbul University Cerrahpaşa Faculty of Medicine Continuing Medical Education Activities Symposium Series, İstanbul.

Vallurupalli, M., Lauderdale, K., Balboni, M. J., Phelps, A. C., Block, S. D., & Ng, . K., (2012). The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. *The Journal of Supportive Oncology, 10*(2), 81-87. [Crossref]

Vilhauer, P. R. (2008). A qualitative study of the experiences of women with metastatic breast cancer. *Palliative & Supportive Care, 6*, 249-258. [Crossref]

Weaver, A. J., & Flannelly, K. J. (2004). The role of religion/spirituality for cancer patients and their caregivers. *Southern Medial Journal, 97*(12), 1210-1214. [Crossref]

Yıldırım, A., & Şimşek, H. (2008). *Sampling in qualitative research: Qualitative research methods in social sciences*. (pp.104-112). İstanbul: Seçkin Publishing.

Yusuf, A., Ab Hadi, I. S, Mahamood, Z., Ahmad, Z., & Keng, L. K. (2013). Understanding the Breast Cancer Experience: A qualitative study of Malaysian women. *Asian Pacific Journal of Cancer Prevention, 14*(6), *3689-3698.* [Crossref]

Ziegler, C. P., Sassi, M. L., Raffoul, W., Delaloye, J. F. (2010). Mastectomy, body deconstruction, and impact on identity: A qualitative study. *British Journal of Health Psychology, 15*(pt3): 479-510. [Crossref]