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FROM SYMPTOM TO DIAGNOSIS AND TREATMENT: ENVIRONMENT AND HEALTH PERCEIVED BY THE ONCOLOGICAL PATIENT

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ABSTRACT

A study that aimed to get to know the aspects of an oncological patient's health and its environment, in the time interval between the symptom, its diagnosis and its treatment. Field research, quali-qualitative approach, exploratory and longitudinal character. Thirty-four cancer patients took part in it. Participants were selected by accessibility. Data collection used semi-structured interview script. Based on the Content Analysis technique, four categories were created: (a) Symptom; (b) Diagnosis; (c) Environments and Relationships; and, (d) Coping Strategies. Transcripts were submitted to MAXQDA12 Software for quantitative analysis of qualitative data. It was verified that the patients recognize as symptoms only those associated with pain, relativizing the others. Diagnosis is the hardest time to experience, since it is accompanied by the need (desires) of certainties, and at the same time by fears (dread) towards it. Significant changes in the social, familiar and work environments are inevitable, which contributes to a patient's ability to recompose and reorganize. Anxiety, fear, insecurity, uncertainty, strangeness, perception of mutilation, bitterness, rancor, stress, anguish, apprehension, resentment, although common to most oncological patients, attest to the importance of specialized professional care in order to contribute to the adoption of healthy coping strategies to deal with the disease.

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INTRODUCTION

Health is considered an indispensable asset by a large part of the population. People's life is organized and processed based on their interactions with the most diverse contexts, situations and environments; therefore, being healthy is an imperative condition. As an evolving concept, in 2010 report, the World Health Organization - WHO emphasized the determinants of health: "The circumstances in which people grow, live, work, and age strongly influence the way people live and die" (WHO, 2010, p. xi). From the diseases' perspective, it is pertinent to observe that the ones that threaten life are necessarily transformative (Siegel, 1997). Moreover, one of the diseases that does not yet have a prospect of eradication is cancer, the "backdrop" of this study.

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It is pertinent to consider that cancer patients also represent a population that presents suffering from that condition. It seems to be natural, then, that these patients become fragile on their psychological aspects, with consequences on their behavioral aspects and even health itself. In addition to the growing fragility of the patient due to his physical illness, emotional sequelae is often observed: the threat of imminent death, the emotional shock at the time of diagnosis, the fatigue from treatment and the decrease of the support network by the long treatment process, are examples of these. Thus, in the periods: discovery of the symptom (the one in which the patient feels/notices something different in its body), the diagnosis through examinations/medical consultation and treatment, what transformations occur in people's lives? What mechanisms are triggered internally for coping with this period? Do the elements that come from the family or social environment contribute? These and other questions are provocations that come from the interest in producing knowledge about emotional aspects that undergo important

transformations that accrue from the hypothesis of the existence of a serious disease like cancer. This study's main goal was to get to know the perception of cancer patients about their health and the environment they are inserted, in the time interval between the symptom, its diagnosis and its treatment.

Methodological course: Exploratory, descriptive and longitudinal field research. The method used to achieve its results was the deductive method. Regarding the approach, the research assumed predominantly the qualitative characteristic. Some data were quantitatively treated, however, its analysis was qualitative. The study was comprised of thirty-four oncological patients who started treatment from July 2016 on. Their selection was by accessibility. In order to establish a certain parity among the participants and avoid gender or cultural biases, 17 men and 17 women were selected to compose the sample. Interviews were conducted between August and December 2017. Oncological patients were encouraged to discuss their perception of their health and the environment in which they were inserted, in the period between symptom detection, diagnosis confirmation and treatment. In order to do so, the researcher used a semi-structured interview script created from an extensive review of articles published in periodicals produced by Brazilian and foreign authors. To validate the interview script, a pilot test was performed with five cancer patients. Interviews were audio recorded and transcribed. Based upon the Content Analysis technique (Bardin, 2004) the initial categories were created, and later on so were the intermediate and final categories. From this analysis, four categories that brought together important elements to understand the object of study this emerged: (a) Symptom; (b) Diagnosis; (c) Environments and Relationships; (d) Coping strategies; Finally, transcripts were also submitted to the German MAXQDA12 Software for quantitative analysis of qualitative data. The study was approved by the Research Ethics Committee-CEP.

Analysis and Discussion

Attending to what was defined in the method that guided the search for results, half of the participants were male (17) and half were female (17). The majority of the participants (21) are within the 56 years old and above age group. This is in line with what the National Cancer Institute (INCA) points out, which refers to aging as a risk factor, meaning cancer is a disease that affects a greater number of people of the highest age groups, according to this study. Regarding marital status, it was observed that the majority (25) of the participants are married. As for schooling, primary education prevailed among them (19). It is interesting to notice that the majority of women are in the upper range of schooling compared to men, where six disclosed having higher education, while amongst them, there are four postgraduates. Regarding men, three have attended higher education and two of them have a postgraduate degree. It should also be noted that among all, one man reported having a technical course degree. A higher number of male individuals have attended secondary and fundamental education (13) than women (12).

Category Analysis: The attention regarding the procedures determined by this methodology has allowed a compilation of four major categories: symptom; diagnosis; environments and relationships; coping strategies.

Symptom Category: Symptom Category came as a result from the subjects' statements about the presence or occurrence of something in their body that felt foreign to it and the

consequences thereof. Some participants, at that time, did not necessarily associate the fact with a symptom of disease. It was acknowledged that in some cases the perception of something outside of normality or oddity felt from what was happening was not identified or related by the participant as something threatening to his health. The absence of pain seems to be an aspect that has contributed to relativize their concern and insecurity. It was gathered from the patients' speeches how unclear it was to them that even some small sign of alteration within their organism could be a 'symptom' already related to the appearing of cancer. It seems that even during treatment, there are cancer patients who still do not recognize that certain strange sensations or physical changes can actually be manifestations of disease. There are still those who use a coping strategy the denial of the disease. There are others who are sure of the malignancy of the symptom and who seek only its confirmation among doctors.

The insistent search for help, in this case represents a strategy to face adversity. However, decision-making regarding cancer alarm symptoms is always complex. The recognition of cancer risk motivates the search for help in a higher proportion than paralysis for fear of cancer (Whitaker *et al.*, 2015). Still regarding the symptom, when subjects were asked about which period they considered the hardest, symptom or diagnosis, it was observed that going through the period of identification of the symptom is considered a delicate moment. Patients do not always consider their diagnosis as the most difficult time in the process of illness, in spite of its impact. For some, the contact with the diagnosis is joined by hopes for their medical treatment. In this regard, Hopman and Rijken (2015) report that patients' perceptions of cancer's chronicity vary, but they strongly believe that cancer treatment is effective. In a general way, the identification of the symptom is an event that naturally raises doubts and uncertainties - a fact that is considered potentially threatening. Thus, the subject's manifestations compiled in the Symptom Category make it possible to perceive that some people relate the symptom to something relatively negative, such as pain, little or not at all considering other changes in their body and health. Such an understanding meets Lione (2008), when he says that oncological pain is one of the most feared aspects by people, not uncommonly described by them as an unbearable sensation. To the author, many patients express their fear of experiencing pain when they are diagnosed. Others sought medical help early in identifying the first sign ('symptom').

It was also possible to realize that some patients, even in the face of the non-identification of their cancer by the attending physician, went on to look for new exams and other medical opinion until they found the diagnosis that they intuitively knew. Silva (2001) identifies this behavior as the opposite, since the patient, instead of denying, points out its own diagnosis. Some interviewees consider that the experiencing of the symptom has represented a more difficult period than the experience of the diagnosis, for though it is, to an extension, gloomy, it brings along with it the possibility of treatment and the hope for a cure. Silva (2001) reports that when the patient begins to feel for the first time the symptom of a disease that can result in a diagnosis such as cancer, its life trajectory usually takes one of two possible routes: the first one leads it to seek a doctor immediately so it can assess and determine the start of the disease's treatment. Alternatively, the other path, which leads it to think that it may be a neoplasm, and due to consternation postpone the search for medical care.

It is pertinent to consider that in spite of the advances in the medical field and the technologies in the service of cancer, it still carries stigmas in itself, and denying it represents a way of coping, as Röss (2017) points out. This author confirms that denial, or at least denying part of the process, is used by almost all patients, either in the early stages of the disease or shortly after its detection. Therefore, it is noticeable that some cancer patients usually seek help at the first sign, while others deny any factors that make them get in touch with such a serious disease as cancer. There are still those who even upon a doctor's release do not feel at ease enough and seek new opinions, as well as insist on new exams.

Diagnosis category: feelings, sensations, reactions and changes: Patients were questioned about how they felt at the time of the confirmation of their cancer diagnosis and whether transformations or changes occurred in their lives or in their way of perceiving the world as a result of the disease. It is understood from the participants' statements that at the time of their cancer diagnosis confirmation the news generated surprise and caused great impact. It is interesting, however, to observe that all of the subjects already had the contact/identification of the symptom, and it could give them indications of a certain probability of its confirmation; in these terms, the news should not come as such a surprise, as it was reported by the patients. What might explain this fact, according to Röss (2017), is that from a psychiatric perspective it is common for people to repel death, and in that sense a disease such as cancer is often associated with dreading death. It is thus possible that this fact explains the extent of the shock reported by the participants upon their diagnosis confirmation. Some participants have even reported that, at the time of diagnosis, they felt as if their lives were about to end, as if upon the news of their diagnosis of the disease, there was a feeling of impending death.

Despite their reactions, subjects were encouraged to talk about what they felt at the time of the confirmation of their diagnosis and how they responded to it. The reactions investigated were defined by the researchers due to the fact that they are common reactions regarding people in stress situations (WHO, 2004). It was verified that the main reactions reported among all participants when they were diagnosed were: appetite change (24), sleep disturbance (24), sadness (22), inability to relax (20), decrease in work productivity (20), isolation (18), libido alterations (18), difficulty concentrating (18), crying (17), agitation (15), weariness (14), apathy (14). A single person said it did not identify with any of the pointed reactions. Upon analyzing the differences between the subjects' genders, the most commonly experienced aspects for male patients were: sleep disturbance (13), sadness (11), isolation (11), inability to relax (11), change in appetite (11) and apathy (10). On the female patients: change in appetite (13), sadness (11), decrease in work productivity (11), libido alterations (10), sleep disturbance (11), difficulty concentrating (10) and crying (10). One of the female subjects said she still had not had any contact with any of the feelings investigated. It is interesting to stress that among all participants, between men and women, the feeling of sadness (11), cynicism (3) and irritation (7) were equated. In addition, the feeling of apathy prevailed more among male subjects (10) than among female subjects (4), as well as the feelings of aggressivity that were mentioned twice more by men (6) than by women (3). Male subjects have also reported crying less (7) and isolating themselves more (11), while women made the opposite move,

cried more (10) and perhaps as a result of it, isolated themselves less (7). Such results find some agreement with an article by Rabasquinho and Pereira (2007) that deals with the issue of gender and mental health as through an epidemiological approach. The authors reveal that women have a higher index of mood disturbances (72.9%) than men (27.1%). The study has also found that women (73.5%) presented a higher rate of life problems than men (26.5%), reiterating that they cause psychological discomfort. Data displays the disparity of reactions between genders, confirming that it is common for women and men to have different reactions to similar situations, such as reacting through crying and isolation. Otherwise, sadness (11), cynicism (3) and irritation (7) between men and women are equated. Other aspects investigated within the subjects were their sensations and feelings experienced upon diagnosis confirmation. The negative feelings/sensations investigated establish a set of feelings common to people under stressful situations (WHO, 2004). The positives were included from the reports from the pilot test. Subjects could respond to more than one possibility. Therefore, it was possible to observe that the feelings and sensations experienced in the period between the symptom and diagnosis and its confirmation, were: hope (33), calm (26), anxiety (25), impatience (14), feeling of impotence (14), frustration (13), feeling of loneliness (12), alienation (10), affective distancing from colleagues, friends and family (10). It appears that both male and female subjects felt equally alone/ powerless – experiencing feelings of loneliness and impotence between the symptom and the diagnosis. In addition to these feelings, one of the male interviewees added feeling very scared. All men (17) reported feeling hopeful in this period; one of the female participants reported that at this time she did not feel any hope. It is interesting to notice also that hope, calm and tranquility, the only positive aspects within the 15 presented, represented about 40% of all manifestations.

In consonance to that, a study by Mendonça *et al* (2017) sought to clarify which psychological factors are present in the progress of the disease and treatment of cancer, as well as to verify which feelings were experienced within this period by the patient. The authors concluded that each patient reacts in an unique way, either during the time of the discovery of the condition as in rehabilitation, making it evident that all subjects are in their way fragilized and in this sense there are those that make use of a process of denial, of hope or of religiosity in order to overcome the disease. There were also reports of concern regarding the subject's family members in the diagnosis' consultation, and of apprehension related to what their companions were feeling at that moment. That is to say, even facing the possibility of difficult news ahead, they put themselves in the background in an attempt to avoid the suffering of their relatives. This result is dissonant against those found by Silva (2005), since the author reports that patients surveyed on her study said they felt the need for a relative next to themselves at that moment, stressing that being alone upon receive diagnosis confirmation is exceedingly distressing. Still regarding the moment of diagnosis confirmation and the way subjects felt, some participants reported that this was the most critical moment regarding the unveiling of negative feelings, such as fear, shock, apprehension and mutilation. Others still have established a direct correlation between diagnosis and impending death. Regarding changes that occurred in their lives and their environments (work, social and family) since diagnosis, 24 participants reported changes in at least one of these spheres

and 10 said they did not observe any changes. Some of these modifications are associated with a subject's way of thinking and acting, changes in their body/physical and emotional state, as well as changes in their routines. Dealing with and going through changes as part of a chronic illness are particularly important aspects (Hartmann, 2007). Through the subjects' narratives, it can be observed that the diagnosis brings along with it a period of changes in physical and emotional dimensions, but mainly in a subject's way of facing life and living. It is interesting to evaluate that because of the inclusion criteria in this study all respondents should have identified a symptom. In spite of that, it seems that the shock upon hearing their diagnosis confirmation does not diminish or minimize its impact on their lives. Rather, it makes them consider it in a remarkably different way from what they used to. When people face chronic diseases or diseases that are perceived as fatal as cancer, their attitudes towards life may change and this is reflected in the manifestations of this study's subjects. Changes in their living habits and religious practices are often part of coping with the anxiety of cancer patients (Turhal *et al.*, 2018).

Emotions such as stress associated to physical symptoms show the importance of professional care to the patient, in order to face changes that will not only be physical. A psycho-oncology professional with conditions and interdisciplinary knowledge regarding the interface between these two areas will enable the necessary care, follow-up or referral, preserving the specificities that each patient carries. Endorsing this understanding are Silva *et al.* (2017), who assert that the approach to an oncological patient should be complete, recognizing it as a subject derived from not only organic but also social and emotional needs, as well as the other individuals who are experiencing compromises regarding their health. It should be noted that in the Diagnosis Category it was also possible to observe how the interviewees dealt with the news of the disease, what were their cares and concerns regarding this moment, as well as the ways they have found to deal with and face this period that many times bears a close relation to death. It seems undeniable that, under such context, intense feelings are experienced, triggering either positive or negative adjustment reactions, such as those reported by this study's participants.

As highlighted above, several kinds of difficulties were present on the participants' speeches and were described in their experiences at their different environmental *loci*: of adjustment, regarding their own body (mutilation), regarding their friends and family, and regarding work/retirement. That is something that can be verified within a study about living with cancer by Batista *et al.* (2015), when they report that diagnosis and treatment lead a patient to experience several different predicaments. The authors assert that the suspicion that something was not right within their body is the beginning of a long journey of discovery, some of those bearing an emancipatory potential, while others bear a destructive potential. It contributes to support the finding about the changes and difficulties experienced by the participants, the study by Fonseca *et al.* (2017) regarding the perceptions and confrontations of women with breast cancer; the feelings perceived by the researchers upon discovery and diagnostic confirmation were: anxiety, fear and indifference, as well as despair upon finding the nodule, uncertainty regarding the future of the disease, bitterness, strangeness and mutilation

when faced with the consequences of treatment. These results bear similarity to the present study.

Environments and Relationships Category: In the 'environments and relationships' category, the way in which the participants dealt with and perceived their family, social and work environment were explored, as well as the relationships they established upon the moment of identifying a symptom and received diagnosis. When subjects were questioned regarding who they turn to or count on in times of difficulty, all subjects stated counting on family members, who as informed by 23 participants, they maintain close proximity to; three reinforce that they equally count on God; In addition, subjects characterized their relationship with close people as "wonderful," "excellent," "very good," and "good," as well as defining their family relationships as "great," "very good," "happy", "calm", "good even though there are disagreements". One participant describes this relation through negative adjectives: "terrible", "threatening", "it sucks". Within the 34 interviewees, 32 live with relatives, either a spouse/husband/wife/partner, children, parents or siblings. Subjects stated they have as a network of support their family and friends and maintain with them some proximity, in spite of the disease and its implications. Two reported counting on, in difficult times, especially with their family, and even with relatives residing in other cities. There are also those who report that family members who have greater contact and closeness (in the sense of affection) include, besides a spouse, children, parents and in-laws.

In accordance with this thought, Monteiro and Lang (2017) assert that the family member with greater proximity will often also be the caregiver of the oncological patient precisely because it is someone influential regarding the patient. In the moments that identify some need or apprehension it is to these people (family and friends) that the participants seem to turn to for help. In a general way, all participants reported that the people with whom they have most contact and affective closeness were those with whom they shared the news about the disease. It is observed that there are in some reports, for example, contents that translate into positive emotions due to the attention and affection given by the participants' friends and family. It is inferred that this fact has positive connotations and brings subjects some comfort in the face of their diagnosis and illness. From this perspective, Silva (2001) emphasizes the patient's need to receive attention and care and how these can be challenging to the family system in a long term. Regarding her work activities, one interviewee reported that her workplace relationships passed away due to illness; six report that, in spite of the illness, they have contact with co-workers, and 21 consider that they do not have contact because they are away from work or retired. There are reports that owing to the disease the participants felt obliged to leave, which certainly implies on abrupt changes within their routines. The interruption of the employment relationship due to illness is evaluated as a loss. There were still those who retired due to disability as a result of the illness, which indicates that returning to work activities will no longer be possible. It is inferred that this condition of departure from work and compulsory retirement can help rising more feelings of disruption, in addition to those that already accompany the illness. Besides the natural losses owing to the disease, others are also experienced. The felt absence from work or from working and missing co-workers are examples drawn from the responses of some participants.

There were also those who in their relation with the disease emphasize that the manifestations of the initial symptoms were felt during the work. There were also those who being freelancers chose to keep on working for as long as possible. This fact represented a significant contribution to treatment. The importance given to the work observed in the manifestations of grief over the interruption of this important aspect of the course of their lives is, according to what Zanelli and Kanan (2018) point out: work gives purpose and meaning to people's lives; it is through it that the identity of each subject is consolidated, and also built through work are many of the social relations that people embrace in their environment. Therefore, it remains evident the grief for the loss of work (part of their identity?) present in some speeches. In a general way, analysis undertaken within this category makes it possible to perceive that in establishing a relationship between cancer and the family, social and work environments, the participants carry within them intense feelings of both farewells and approximations in and within these environments. The participants made an important reference to their relatives and friends and showed the contribution that they provide or provided upon the time of diagnosis. However, there were also reports of subjects who got into conflicts and distancing from family and friends, precisely in what may be one of the most difficult periods they have ever experienced: coping with the disease and the treatment that comes from diagnosis. Such issues tend to be mobilizing of feelings and energy, and therefore are either contributive or disruptive, depending on the resilient capacity of each individual.

No less important is the labor issue. It is observed that given the course of the disease, some impositions are felt as losses experienced, as for an example, the obligation to step away from work to dedicate themselves exclusively to treatment (often imposed by family members or a doctor or by the fragility caused by disease). Opposed to that, the need to stay at work even when facing treatment is also present in the manifestations of some participants. Although the knowledge of changes in the social and psychological context are naturally expected, this does not mean that such transformations do not cause angst or distress; or, otherwise, will not allow for the opportunity to devote themselves exclusively to their own health. It should be considered, with aid from Monteiro and Lang (2017)'s understanding, that the aspects raised here do not rule, determine or define the lives of patients and their families. How the situation will be faced will depend on how it was perceived and the behavior assumed facing this perception; this behavior will be modeled based on the experiences of each subject/interviewee. Thus, in a unique way, each one faces reality in a reasonable/bearable way.

Coping Strategies Category: Within the Coping Strategies category, statements have emerged remarking that faith seems to provide support and to contribute to the experience of this stage of subject's lives. Thus, one can say that the most evidenced themes discussed by the participants were support and religion. In addition to these, strategies of both internal (emotional) and external changes due to the diagnosis of the disease were observed. When questioned as to which strategies they used to confront or to move on with life since diagnosis, participants demonstrated faith and self-care - in order to feed themselves well and faithfully follow medical guidelines. In addition, they reported taking care of their thoughts so that they would remain positive and would retain joy in spite of the disease, as if these strategies were for them something

favorable to the cure. Participants also characterized the support they received as something important that helped them facing their fears and insecurities, an aspect that is more closely explored within the Environment and Relationships category. This fact is in accordance with what Peçanha (2008) affirms, since for the author, an individual with cancer needs to mobilize psychosocial resources in an attempt to adapt to stress in consonance with this disease. This process of emotional, behavioral, and cognitive mobilization that aims to an adaptation, related to each stage of the disease, is called *confronting*, or *coping*, in the English language. This seems to indicate that subjects feel and identify as a strategy being emotionally well and staying well. Reports that highlight the strategies used against the disease, such as positive thoughts, joy, faith and the possibility of reversing a bad situation into something better, as well as not letting oneself be beaten down by disease, are common.

Other participants have also enlisted as a strategy their care towards food nourishment. Both physical and mental health care seem to be at the same level as strategies aimed at coping with the disease and the sequence of life within the parameters of a possible normality. Thus, Silva *et al.* (2017), in their article concerning a multidisciplinary perspective for cancer, explain that along with all individuals who are experiencing health related afflictions - as is the case of patients suffering from cancer - it is necessary to adopt a complete approach of this being (patient). This is because it is necessary to recognize them as subjects with their own needs, not only organic (food), but also social (relationships) and emotional (support). There are also subjects who report that their strategy for coping with illness is seeking and accepting support from friends and family, the attention they are given, as well as their faith. These factors seem to be related to something that enables and maintains the emotional balance of respondents despite the disease. Another aspect to be considered is the association between their condition and mourning related aspects, given the threat to life that cancer represents. It remains clear, therefore, the appropriateness of Arrieira *et al.* (2017, p. 05) affirming: "It is common that along with the proximity of death comes the valorization of life". From this understanding evidences have been observed among some participants regarding their will to live as something essential to the period they face.

Concerning religion, participants reported being Catholic, some practitioners and others not. There are also among the attendants Evangelicals, Protestants. In addition to those, there were subjects who defined themselves as someone without a particular religion, but rather as sympathizers of several religions, as someone gifted with faith and with the possibility that it might be rewarding. A connection with something superior, not visible, but declared by them as understood; as if there had been some correspondence between creator and creature. Some have said that they have already known and have transited through several religions and beliefs and that they do not currently use them as a strategy to move on with life. Some subjects are devout, some are not. There are those maintaining faith and spirituality - most of them, although it is common upon getting sick to raise questions and doubts about transcendence or the finitude of being. However, in general, it is observed that believing, keeping the faith, praying, beseeching, trusting, seems to bring comfort, cherishing and hope to the participants. Thusly, this represents an important strategy for quality of life and a certain guarantee of

maintaining emotional balance while facing disease, treatment and its deleterious effects. A similar understanding is found in Mesquita *et al.* (2013), who assert in their study that faith and belief are important ways to confront disease. Through the reports of the subjects, it is observed that faith plays a significant role in the period of coping with cancer; it is through faith they find the strength to keep on fighting the disease. Thus, it was possible to evaluate that the participants seem to evidence the strength of faith as something of almighty potency, more powerful, as strong as or even stronger than the treatment or the disease itself. Therefore, the interviewees delineate in faith a powerful strategy for coping with the disease and still as something that comforts them if they do not happen to find a cure. Consistent with this finding, the article by Delgado-Guay *et al.* (2012) mentions that most of the patients they interviewed have raised spirituality and religiosity as an auxiliary motor source against cancer. They also point out that religiosity served as a source of strength and comfort, which eventually suggested that the religious confrontation was mainly seen by them in a positive way. Participants refer as important aspects in this period between symptom, diagnosis and treatment, the fact that they remain emotionally well, the support they receive from family, friends and that which they encounter in faith, religiosity, belief. It is understood that these - friends, family and faith - are aspects conducive to their well-being, since they say bolstered, conformed, enthusiastic, cheerful and helped, which concurs for them to experience some comfort in the broad sense of the term. It is worth reflecting that such meanings referred to by them can be embraced both by the faith dimension as well as by the social and family relations dimension.

Final Considerations: In the face of the findings that justify the importance of knowledge production, the present study had as its goal the evaluation of cancer patients' perception regarding their health and their extensive environment in the period between symptom, diagnosis and treatment. Thus, it was possible to conclude in an important way that in relation to their health, the participants initially demonstrated to associate the pain symptom as a "warning sign" regarding their health. This happening is not always efficient as a single form of attention, since the sensations such as "dizziness, nausea and diarrhea" mentioned by the participants were also important changes in the functioning of the organism, which already signaled the need for zeal. It was also possible to verify in some cases that the patient had a "certainty" that the symptom was a serious illness, although medical appointments and examinations did not predict this possibility. Faced with this, it can be defined then that both situations describing the patient's perception about its health were presented in a polarized way in this study, that is, the perception of "relativizing" the symptom, as well as "overestimating it". It was also possible to conclude that facing the identification of the symptom, confirmation of the diagnosis of cancer and the beginning of treatment, transformations in the general aspects of a patient's life are inevitable, which include significant and often abrupt changes in the social, work and family environments, since from these moments, the modifications in their routines, their behaviors and destinies, as well as in their ways of thinking, acting and believing become inevitable. Such remodeling is generally associated with the fact that the disease is accompanied by a death stigma, which coerces the patient to "recalculate its course", as well as arouse feelings and sensations such as insecurity, anguish and fear. Regarding namely the social environment, is the fact that patients have to

change their habits by virtue of treatment, causing them to lose the interest they used to had in leisure moments; in spite of that, they report as fundamental the permanence and understanding of friends in this process of facing the disease.

In the family environment, it became evident how much the relationships are amplified from the diagnosis on. Also noteworthy is the fact that in spite of a good family relationship (more broadly), patients elect someone with whom they can count on more closely; however, this closeness was not necessarily physical, but emotional, in the sense of confidence and comfort. Regarding the work environment aspect, it was evidenced that patients perceive the rupture/withdrawal, either temporary or permanent, as a loss, and perhaps the intensity of this feeling is due to the fact that the disease often does not present the patient with a choice, only the need for more specific tending. As a coping mechanism, it can be concluded that subjects resort to faith, denial and pursuit (search for alternatives) in a more expressive way. The evaluation of the results makes it possible to observe that this study's goals were achieved and, in addition, they may significantly contribute to those who have some relation to cancer, whether they are patients, family members or mainly health professionals, considering the brevity of the history of psycho-oncology and how distant the access to it still is in practice; parallel to that, the scarce but growing number of studies carried out in the area. The number of people afflicted by cancer also justifies further studies within the area, since it is already manifested through the knowledge produced in psychosomatics and psychoneuroimmunology that not only does the biological reflect in the emotional, but also how much the emotional demonstrates its influence in the biological aspects. Psycho-oncology therefore arises as a possibility to the emergency need to respond to the emotional aspects of cancer, either during the time of the discovery of the symptom, of diagnosis confirmation, during treatment, or even when the possibility of cure is no longer possible.

Evidence highlights that the union of psychology and oncology has been evaluated as something favorable, increasing survival, the possibility of real choices, life quality and emotional strengthening even in cases of terminality. In this sense, the increase of research is suggested, on the search for data on the relationship of psychological support for cancer patients. Finally, in this study, the diagnosis was described by patients as the most difficult period to face (in comparison to the symptom and the treatment), however, given human subjectivity, this is not a protocol, which demonstrates how alert the health professional should be. Anxiety, fear, insecurity, uncertainty, strangeness, fear of mutilation, bitterness, rancor, stress, anguish, apprehension, resentment, everyday aspects to cancer patients, come to affirm the importance of being accompanied by a professional who disposes of time (which very often those professionals who maintain closer contact to the oncological patient, such as doctors and nurses, do not have) and specialized knowledge. In this case, the oncologist psychologist is the qualified professional in order to assist and contribute to the occurrence of well-being, because as this study has shown, the emotional issues presented were not of lesser value even when compared, for an example, to something that participants deem significant, like physical pain. The production of knowledge proposed in this study requires an interdisciplinary perspective. On this possibility it is observed that interdisciplinarity is not

something fully defined or finished, it is necessary to "construct" it. In the context of oncological patients' health, this construction is the role of the team that shares their different knowledge in a condition of reformulation of knowledge, which tends to result in a reorganization of the health team (Castro and Barreto, 2015). Some teams are called multidisciplinary, however, for some reason, do not count with the professional support of a psychologist. In this study, the interdisciplinary perspective was the order of the investigation, since in its essence the subject covers many dimensions that are not restricted to only one area of knowledge, and the oncologist psychologist must be prepared (in terms of theoretical and practical knowledge) to act. And, in order to finish this study - though it does not terminates here - the words of Ana Claudia Quintana Arantes, in the book "Death is a day worth living" (2016) are borrowed: "Desire to see life in another way, to follow another path... for life is brief and needs value, sense and meaning. And death is an excellent reason to seek a new look at life. "

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