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Evaluation of families with two or more mastectomized women: a case study

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ABSTRACT

Aim: to evaluate the structure, development and functionality of families with more than one woman with breast malignancy and mastectomies. **Method:** this is a qualitative study involving the theoretical basis of structural, developmental and functional categories, as proposed by the Calgary model, and using case study as a methodological strategy. Data was collected through home visits with 10 families with mastectomized women, between August 2014 and February 2015.**Results:** conflicting subsystems were present in only two families and all presented with support network elements from systems other than family, including neighbors and health institutions. In the care process, the link established that support and frequent monitoring helped to ease some of the difficulties experienced. **Conclusion:** it is believed that the Calgary model enables a broader view of the family to be taken, better understanding in terms of internal and external relations, and enabled weaknesses and strengths to be balanced.

Descriptors: Family; Neoplasms; Nursing; Women's Health.

INTRODUCTION

Family structure is founded on emotional and social relationships and is where those belonging to it turn in times of need and, above all, share happy times rather than kinship. Ultimately, what unites a group of individuals as a family is the relationship of emotional, financial, educational, or social support among its members. Family is the mainstay of people nowadays, and when some of its members present themselves at risk by any imbalance, it needs to be strengthened in its integrity[1-2].

Generally, families are not organized to face illness or to deal with the suffering of some of its members[2]. In the case of a diagnosis of malignant neoplasm of the breast, the effect is even more devastating: either by fear of the mutilations and possible side effects derived from the treatments, or by the emotional and psychosocial impact[3], especially when more than one woman falls ill due to this disease in the same family unit.

A population-based study found that family history is a risk factor for breast cancer and that it is approximately double for first--degree relatives compared to the general population[4].

Family plays a key role in the lives of women with breast cancer, providing strength, helping them through the diagnosis of the disease and overcoming the subsequent side effects (such as treatment), ensuring a better and less stressful life, and with prospects of cure[5].

Since this is a chronic disease, treatment will be carried out throughout life. For this to be successful, family members need to have knowledge of the possible changes resulting from the treatment, including signs of complications, and act positively in respect of them from the time of discovery[4-5]. As a result of this, the upheaval caused by oncological disease in the family, and the ways of coping with it, are individual to each family unit due to their values, beliefs, routines and different histories[5-6].

Based on the investigations carried out, professionals need to use their knowledge of each family to ensure holistic care and in order to link biological, social and spiritual factors, preparing the best care from it[1,3].

Given this context, the Calgary Family Assessment Model (CFAM), was used. This allows an expanded spectrum, covering internal and external relationships and weaknesses and strengths. The CFAM consists of a multidimensional structure that assesses the family and acquires knowledge and skills necessary for possible interventions. Its use gives understanding of functioning and family dynamics in an interactional way, allowing an evaluation of its elements and the observation of changes in its dynamics[2,7].

In Brazil, the CFAM has been rarely used in addressing adult families with oncological diseases; it has been more commonly used in research with children, adolescents, the elderly, and in the area of mental health. The use of this model allows nurses to meet the family in their own environment and identify their needs, as well as consider private support options for their condition.

This research is relevant because it deals with an important topic and explores the gap in the evaluation of families with more than one woman suffering with malignant neoplasm of the breast (evidenced when performing a search in the nursing literature). In addition it is a fact that malignant neoplasm of the breast is the most frequently occurring cancer among women, both in Brazil and in the world[4].

Given the above, the following questions arose: What is the structure and functioning of

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families with more than one woman suffering with breast cancer submitted to mastectomy? What is the emotional bond between its members?

To answer these questions, the objective of this study was established to evaluate the structure, development and functionality of families with two or more women with breast malignancy who had undergone mastectomy.

METHOD

This is an exploratory-descriptive and qualitative study, in which reference of the case study and the assumptions of the Calgary Family Assessment Model respectively, were used both methodologically and theoretically.

The CFAM is a multi-structural model composed of three main categories: structural, developmental, functional and its multiple subcategories[7] which allow the gathering of elements to grant and direct care to families[1-2], as shown in **Figure 1**.

It is imperative to explain that it is a function of each nurse to select the subcategories of this model to be explored. To that end, not all subcategories are assessed on a first meeting, and some will never be explored[1.7].

The structural category comprises the family structure, i.e. individuals who are part of it, the emotional bond between its elements compared to outsiders, and its context[2.7]. Three aspects of family structure can be checked: internal structure, external structure and context, with their subcategories[6], as described in Figure 1.

Two instruments are used to lay out the internal and external structures of the family: the genogram and eco-map[1-2,7]. The genogram is a graphical representation of the family internal structure[7]. The eco-map is a diagram of the existing relationships, or otherwise, between the community and the family, which enables an estimation to be made of social benefits and available networks[1.7].

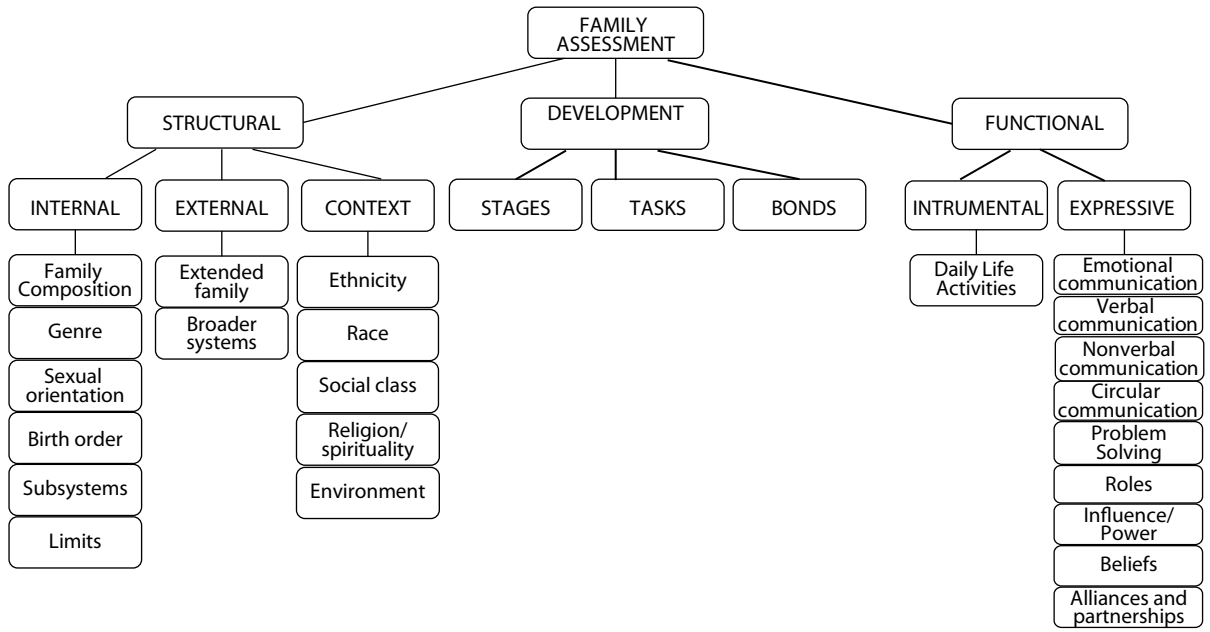
The category of development refers to the progressive change of family history during the stages of the life cycle: its history, the flow of life, growth, birth and death[2].

The functional category refers to the way in which family members interact. The aspect of the instrumental functioning, which is related to activities of daily living, and the aspect of the expressive functioning, referring to the modes of communication, problem solving, beliefs, roles, rules, and alliances can be explored.

The case study is a comprehensive method that can be applied to a range of problems. It can be used in several areas of research to provide greater understanding and involvement of the researcher in a real observed situation[8].

The families were initially selected with the help of key informants, namely health professionals who know the study participants[9]. In this case, they are nurses from a philanthropic association located in Minas Gerais, whose goal is to assist people with cancer (AVACCI-Volunteer Association in Support Against Cancer in Itaúna and Surroundings). The continuity of the selection of families was ensured by means of the snowballing technique[9], that is, from the identification and location of a family with certain characteristics that were adopted as inclusion criteria. Interviewed families also acted as informants, identifying other participants with the same characteristics who could be included in the investigation. This process was repeated in order to identify the greatest number of families that could contribute to the study[8].

Figure 1 - Schematic representation of the Calgary Family Evaluation Model[7]. Divinópolis, 2015.



Fonte: Modelo Calgary de Avaliação de Famílias [7] .

Initially, an informal contact was made to check whether family members were available to be part of the research; subsequently, each interview was scheduled at the home of each family, with the date and time chosen by the participants. The first two families lived in the same municipality; the other eight lived in different cities in Minas Gerais. There was no degree of kinship established between them.

Selection criteria were adopted based on convenience sampling: families with at least two women, first-degree relatives (mother and daughter(s) or sister(s)), but who did not necessarily live in the same household; who had undergone treatment for breast cancer, including mastectomy; one of the women still in adjuvant treatment at the time of the survey; and at least one of those women alive. Families of women who had undergone mastectomies and were not willing to participate in the meetings were excluded as were those who were unable to understand and/or answer the questions posed due to intellectual disability.

The study took place between August 2014 and February 2015 and was carried out by means of four meetings with each family studied. The first meeting presented the ethical and legal aspects and invited participants to join the research. On the second visit interviews were conducted with semi-structured questions, guided by CFAM. These were recorded with permission of the participants and lasted an average duration of 60 minutes. Following this, to enable analysis and meet the objectives of the study,thegenogram and eco--map were prepared with family participation. During the third and fourth visits discussions and considerations regarding the genogram and eco-map and specific guidance took place, as necessary, in relation to each situation experienced by the family.

Following the collection of information and the full transcript of the interviews, we used a strategy of thematic analysis for the

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elements, seeking patterns within the data; the themes that emerged were placedinto categories[10-11]. This review used different approaches, including: deductive, based on models of predetermined codes (template); and inductive, driven by data. In this study, the method chosen is a hybrid model, which comprises both deductive and inductive[10]. Initially the data was inductively analyzed, resulting in codes and initial themes, and then the template was applied. This research used the Calgary Model, with the goal of identifying both meaningful and deductive text units[10]. At the end, data was obtained within the structural, developmental or functional assessment categories proposed by CFAM.

Anonymity of participants was ensured by adopting the letter E, followed by the sequential number of the interviews held, and the letter F, accompanied by family number. There were 31 participants who were members of 10 families: five husbands, 14 children and 12 women who underwent mastectomy (a family member with breast cancer from families 1, 3, 4, 6, 7, 8, 9 and 10 and two members with malignant neoplasm of the breast from families 2 and 5).

Whilst not all members of the families participated in the research, it is of note that the focus was on the family unit. All participants were asked to observe their families, as recommended by the CFAM reference[7].

The development of the study was in compliance with ethical principles. The project was approved by the Committee of Ethics and Research of the Federal University of São João del Rei, in accordance with CAAE 28929914.5.0000.5545, and protocol number 620,273. To preserve their individual identity, all subjects were identified with fictitious names and their families were anonymized by the use of letters and numbers i.e. F1, F2, F3.

RESULTS

Data analysis will be presented in accordance with the Calgary model categories.

Structural assessment

In relation to the **internal structure**, five were of the nuclear type (F1, F3, F6, F8, and F9), composed of a couple and their children. Of these, two were individuals in a second marriage. (F3 and F9). Two families were of the extended type (F2 and F5), and the remaining three were single parents (F4, F7, and F10), as shown in Table 1.

The age of the participants of the 10 families in the four meetings ranged from 18 to 59 years (average of 35.1 years). In relation to the study, it was noted that families consisted mostly of five subjects and no elderly. In those cases where members had first degree breast cancer, it identified three families that had mastectomized sisters (F2, F6 and F10), four families that had daughter and mother with the disease (F1, F5, F7 and F8) and three other participants with a sister and mother with the disease (F3, F4 and F9); of these 23 women, five mastectomized women, from different families, died as a result of their malignant neoplasm (F1, F3, F4, F8 and F9).

The impact of death on families was great at the time of the death of their mothers. In Family 1, this was due to the time of life when it occurred: two months after diagnosis, Rosa had a mastectomy and adjuvant chemotherapy and Radiotherapy; her eldest daughter reported regularly being afraid that a recurrence might cause her mother to die, as had been the case with her grandmother. In Family 4, the youngest member reported the same fear because her grandmother had died of breast cancer when she was the same age as her mother.

Table 1 - General characteristics of households and data on the treatment of women who underwent mastectomy. Divinópolis, 2015.

FAMILY DATA	FAMILY 1	FAMILY2	FAMILY 3	FAMILY 4	FAMILY 5	FAMILY 6	FAMILY 7	FAMILY 8	FAMILY 9	FAMILY 10
Members and age (in parentheses)	Rosa(44) married with Cauã(44) and with three daughters: Lia, Orquídia and Violeta (18, 14, and 8)	Sisters Dália(50), widow and Acácia, divorced(48) and their only children: Lírio and Jasmin(28 and 17)	Vera (46) married to Peter (50) years in the 2nd marriage and children João (19) and Lucas (18)	Lúcia (55) divorced and children Liu (23) and Vivian (19).	Marcia (41) widow, her mother Sônia (59) and her daughters Mira (21) and Julia (18)	Lelia (47) married to Rubens (55) and children Otávio and Rúbia (19 and 18)	Rita (43) widow and her daughter Roberta (25)	Léia (56) married to Renan (58) and children Carla and Paulo (25 and 20)	Lígia (49) married to Ruan (45) and Ruan (26) Lílian's son from the 1st marriage and Livia (9) the couple's daughter	Violante (51) and her daughter Flávia (28)
Profession	Rosa-manicure	Dália-pensioner	Vera and Pedro-traders.	Lúcia-public servant	Márcia-teacher Sônia-retired Mira and Júlia--studants	Lélia-secretary Rubens-electrician Otávio--father's assistant	Rita-pensioner	Lélia-administrative assistant	Lígia-shopkeeper	Violante--autonomous saleswoman
	Cauã-security agent	Acácia- retired	João and Lucas-studants	Liu-waiter		Rúbia-studant	Roberta--lawyer	Renan-broker	Ruan--Commercial Manager	Flávia-teacher
	Lia-studant/ salewoman.	Dália's son, Lírio-Physical educator		Vivian-studant				Carla-cashier in a supermarket	Ruan-psycologist	
	Orquídia and Violeta-studants	Jasmim--studant and messenger						Paulo-clerk in a Pharmacy	Lívia-studant	
Family members with malignant neoplasm of the breast	Rosa	Sisters Dália and Acácia.	Vera.	Lúcia, her sister Cely(58) and her mother Cíntia deceased (1994)	Márcia	Lélia	Rita	Léia	Lígia, her sister Sílvia and her mother Sofia deceased (2010)	Violante
	Rosa's mother Maria-deceased (2012)		her sister Elza(43) and her mother Iara deceased (1999)		Sônia	and sister Raquel (43)	Mother Julieta (60)	Mother Serena deceased (1993)		Sister Bianca
Year of diagnosis	Rosa-2012.	Dália-2009	Vera-2010	Lúcia-2011	Márcia-2014	Lélia-2013	Rita-2014	Léia-2012	Lígia-2014	Violante-2010
	Maria-2010.	Acácia-2010	Elza-2011	Cely-2009	Sônia-2005	Raquel-2011	Julieta-2008	Serena-1989	Sílvia-2013	Bianca-2013
			Iara-1990	Cíntia-1992					Sofia-2002	
Treatment current	Tamoxifen	Both	Adjuvant chemotherapy and radiotherapy.	Both	Adjuvant chemotherapy and radiotherapy.	Tamoxifen	Adjuvant chemotherapy and radiotherapy.	Tamoxifen	Adjuvant chemotherapy and radiotherapy.	Both
		Tamoxifen		Tamoxifen					Sílvia-Tamoxifen	Tamoxifen

Source: Data from interviews, genograms and ecomaps. Developed by the authors, 2015.

The subsystems identified in the internal structural assessment refer to, amongst others, the relationships between husband and wife, parents and children, grandmother and grandchild, mother and daughter; and to these primarily maintaining the family unit and the development of care and support to the mastectomized woman. Family ties were strengthened in all families after the advent of cancer. Conflictive subsystems were present in Families 2 and 3. In Family 2, there were a number of conflicting relationships between the sisters due to differences in personality and way of life during adjuvant treatment with tamoxifen. In moments of stress they sought out the younger sister (Paula), with whom they have a strong relationship and who is a reference for the whole family since the death of their parents.

In Family 3, the relationship between the father and the youngest son showed little affectionate interaction. It involved aggressive talk and a lack of control over the teenager's behavior, who spent more than a day away from home using psychoactive substances. By contrast, the subsystem of the couple (father and mother), showed affection and complicity during the four home visits.

Among the limits observed in the internal structural assessment, the impact of cancer diagnosis was felt both by women and by their families, not only due to the severity of the disease, but for all that they experienced. All participants revealed that they hid their feelings, crying, fears and uncertainties. In order to demonstrate strength, they did not talk about the disease, especially with the sick woman, and avoided showing discouragement or externalization of their emotions.

As regards the **external structure**, it was found that all families had multiple members of the family supra-system, such as friends, neighbors, relatives, church, workplace, and primary, secondary and tertiary health care services, all providing a social and support network. It is noteworthy that when family members need care at the tertiary level, they are sent to the state capital where they reside. They stated that they follow all the guidelines of the health professionals correctly and that, despite it being time consuming, the care provided is good quality, as shown in Table 2.

Regarding the structural **context** of evaluation, it was observed that social class and financial position did not affect the quality of care provided to the mastectomized women. Two families (F3 and F9) received more than 10 minimum wages, one family earned a salary of five minimum wages (F1), and the other seven families earned between six and ten times the minimum wage. In relation to housing, eight families lived in their own home; Family 2 lived in a house provided by one of his brothers and Family 4 paid rent.

With regard to the subcategory religion and spirituality, the search for spiritual support was reported by both sick women and several family members. Spiritual support and faith gave strength to them to overcome the obstacles, provided comfort by maintaining hope and helped promote well-being in families. In the subcategory environment, it was found that all families lived in neighborhoods with satisfactory social and health conditions.

Development assessment

Regarding the **stages** of family life: two families were at the stage of "families with teenage children" (F3 and F6); one family lived with adolescents and children (F1); in another family there was a young single adult and a child (F9); three families included unmarried young adults (F7, F8 and F10); a further two in-

Table 2

SOCIAL INTERACTIONS	FAMILY 1	FAMILY 2	FAMILY 3	FAMILY 4	FAMILY 5	FAMILY 6	FAMILY 7	FAMILY 8	FAMILY 9	FAMILY 10
Subsystems	Cauã's Parents	Seven brothers	Sisters	Lúcia's friend	Aunts	Parents	Mother	Renan's Parents	Brothers	"Brothers Sisters in law"
	Eight brothers and father of Rosa.	Nephews	Pedro's Mother	Father	Sister		Friend			
			Lucas's friend	Brothers	Márcia's friend		Sister			
Broader systems	Friends	AVACCI	Friends	Church	Hospital in BH	Friends	Friends	Friends	Friends	Friends
	AVACCI	Friends	Hospital in BH	Friends	Friends	Church	Comadre	Hospital in BH	Neighbors	Club
	Neighbors	Neighbors	Club	Comadre	Church	UBS	Hospital in BH	Church	Church	Work
	Church	Church	School	Neighbors		School	Work	School	UBS	Church
	UBS	UBS		School		Work	Church		School	
	School			Work					Work	
	Work									
significant/ supporters contacts	Sister (Vilma)	Younger sister (Paula)	Sister (Elza)	Lúcia's friend	Sônia's Sister	Mother	Mãe Julieta(60)	Husband	Sister Sílvia	Sister Bianca
					Márcia's friend		Friend			
Most frequented environments	Church	Dália--trip with friends	Clube	Church	Church	Church	House of neighbors	House of friends	House of friends	House of friends
	Parties	House of friends	Parties	House of friends	House of friends	House of friends		Church	Church	Trip
	Ranch of Cauã's parents		Trips							

Source: Data from interviews, genograms and ecomaps. Developed by the authors, 2015.

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cluded a young single adult and an adolescent (F2 and F4); and in one family a grandmother, a young adult unmarried daughter and a teenager lived together (F5).

In this study, two to four generations live together in the households; therefore, these generations interact and families often perform development **tasks** simultaneously, offering support to promote this new internal organization for the performance of the roles that correspond to the various stages of treatment. With regard to **bonds**, the families said they felt strong ties except in Family 3, where the teenage son presented weakened links with the other family members. Although he sought psychological independence, he needed to keep living with his parents and brother due to financial dependence and irrespective of the conflicts with them.

Functional assessment

Within the functional assessment process, the **instrumental** evaluation found that families had support from other family members, facilitating coping, family reorganization and the distribution of daily tasks, from the outset of the discovery of the disease.

Regarding the **expressive** function, religious and spiritual beliefs specifically assisted in the process of accepting and coping with the disease.

In the significant evaluation, it was observed that families developed effective **communication** between its elements; each one understood and considered the other. However, in Family 3, communication with the son who used psychoactive substances was difficult.

On the issue of **problem solving**, the families evaluated showed empowerment in the face of the disease/treatment due to their previous experiences, showing a dynamic and effective ability to solve problems, using the resources available in each family and within the social context.

DISCUSSION

The structures of the families studied were as follows: two were comprised of people in a second marriage; a further two were of the extended type; and three were families with one parent, i.e. new family configurations. The literature indicates that changes in the socio-economic and cultural contexts have been altering the family structure and dynamics, allowing variations in its traditional pattern and organization. There is an emergence of new family configurations resulting from the increasing number of divorces, remarriages and the growing number of extended and single parent families[12].

In this regard, with the reduction of the traditional nuclear family, it is essential that nurses expand the concept of family in order to encompass new family configurations and larger systems with a view to expanding the family group support network for effective and comprehensive care[2,13]. People who are not part of the family may nevertheless represent a legitimate support for treatment decisions, clinical procedures and patient-family behavior, as shown in this study.

In this study, it was observed that half of the families faced the death of one of its members as a result of breast cancer, which at the time of death, caused great suffering. The strengthening of family ties was a very important factor to assuage feelings such as fear, loss, grief, anguish and helplessness.

Family relationships became more solidified, forming a source of support, security and

emotional stability. The ability to adapt to the demands of the different levels of subsystems is being developed by each family member. Corroborating these results, a survey conducted in the context of the families of women diagnosed with malignant neoplasm said that all members are mobilized to welcome, comfort, care and follow the woman as she dealt with the oncological disease, strengthening family ties[14].

In this regard, another study conducted with families that had one member suffering from malignant neoplasm, pointed out that confronting the disease was possible in families that were able to harness positive feelings and organize the family routine. Although the disease shows the weaknesses of the patient and the family group, the joint force overcame the difficulties and led to the growth of greater love, respect and gratitude among its members[15]. The ability of the family to adapt to the illness of one of its members is directly linked to its composition, its communication patterns, and he family dynamics[15-16].

However, it was identified that occasionally family members projected their thoughts beyond the present and into the future as in the case of the two families regarding the fear of the death of their mothers. In these cases, there was a recognition that their plans for the future may not happen.

Both the meaning that family members give cancer (as a disease that brings them closer to finitude) and the fear of recurrence can be terrifying. The word cancer becomes synonymous with death and is firmly established in their feelings and interpretations[16] after experiencing it in their family.

The impact of the diagnosis of another family member with cancer was highlighted in the internal structural evaluation. It was voiced by women with the oncological disease and their families, not only due to the severity of the disease but, more importantly, due to what they have already experienced. All participants revealed that they often hid their fears, weeping, uncertainties and avoided talking about the disease so that they could pretend to be fearless, especially with the mastectomized woman.

To tackle the disease, the family needs support. They seek help in the community, the church and in the other institutions involved. Clearly, nurses have a key role to play. In order to provide support, they need to understand how the oncological disease mobilizes the entire family dynamics and once that has been established, to plan and direct comprehensive, bespoke and quality assistance in order to contribute to the effective tackling of the disease for each element of the nuclear family.

It is of note that all families had multiple support elements arising from family supra-system, including friends, neighbors, relatives, health services, and the church. In the structural context of evaluation, it was observed that the social class/financial position did not influence the quality of care provided to women who had mastectomies, all of whom lived in neighborhoods with satisfactory health and social conditions.

According to scientific literature, the fundamental source of help and support of people with cancer are their families. However the social network, consisting of other individuals who can support the person such as friends and neighbors, is also seen as fundamental and indispensable to overcome difficulties[14-15].

The search for spiritual support narrated by women who underwent mastectomy and most of their family is worthy of comment. As well as being a support tool, faith/spirituality

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was important in determining why the disease had occurred as part of a greater understanding and gave strength to overcome obstacles in terms of comfort and maintenance of hope. Confirming these data, a study found that faith helped the people to trust a higher power and maintained hope[16]. Spirituality and faith contribute to a constructive way of thinking and for the development of a sense of confidence in which the best will always happen[1,16].

Faith is a feeling rooted in culture and is as indispensable as other forms of coping with a chronic condition[15-16], such as the malignant neoplasm of the breast. Spirituality is a subject that has attracted the attention of health professionals regarding comprehensive care. Recent research advocates that this may be an alternative to improve the quality of life and accelerate the healing process and/or coping with diseases[15-16].

For most of the time during the meetings with the studied families there was a link between emotional connections and demonstrations of affection and closeness; harmony was present and evident in the actions and words of everyone who was interviewed.

There is an assumption that beliefs, values, behaviors resulting from bonds, social life and life experiences have been built up by individuals and family during the health/disease process and in self-care[1]. From this assumption, nurses must understand the family, accepting and recognizing their experiences in order to mobilize the research of new knowledge and ways of learning and in order to exercise appropriate caution with the sick family members. They need to highlight that the priority are the people and their families, not the nurses. For this, professionals need to continuously study and improve themselves, in addition to providing more humanized care[1,3,14].

Families reported having effective communication amongst their members, i.e., each understood and respected the message of the other. However, in one of the families, communication was complicated due to the child using psychoactive substances. The scientific literature shows that, when the psychoactive substances are used compulsively, they impact not only on the person who uses them, but also on the life cycle of the family, and they can even lead to the interruption of the passage of an evolutionary phase to another.

The family with the child who is a drug user was referred to a support group whose purpose is to create a family-oriented environment for reflection and questioning, not only for issues specifically related to drug use but also for the effect of the behavior on the family and the personal life of each member. This referral was based on the belief that sessions with guidance and counseling groups have obtained good results, family members do not feel lonely and are able to share experiences with people who are going through the same problems in an understanding and support environment[17].

It was remarkable to realize that the processes involving cancer lead to several changes, both in the lives of mastectomized women and in their families. The understanding of this experience is important when planning appropriate nursing interventions for each family member.

The unpredictability of the course of malignant neoplasm can bring new responsibilities and conflicts; therefore, the nurses' role is to assess the changes over the course of malignant neoplasm that may interfere in the family context, in order to assist women with breast cancer and their families with actions that can be implemented in support of overcoming those responsibilities and conflicts.

CONCLUSION

The family assessment based in the Calgary model makes it possible to understand a family and raises the fundamental aspects of its structure, development and operation. It is a fact that one of the great potentials of home care is the ability to provide support and strengthen families within their specific environment, in order that they can handle critical situations such as breast cancer and so that suffering and overload are minimized.

It is believed that the results of this study can be used by nurses to support the work of planning the care of mastectomized women and their families.

A limitation of this study was due to the qualitative method used which does not allow for generalization of the results or the establishing of cause and effect relationships. Further, it was impossible to interview all surviving women with breast cancer in the families due to the fact that they either live in remote states of the country or abroad.

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