

# **Social Support Experiences of Breast Cancer Patients**

## **A Literature Review**

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Abstract  <p>Breast cancer is the most common cancer in women worldwide. After receiving diagnosis and during treatments breast cancer patients often find themselves vulnerable and in need of social support. Receiving social support may relieve patients' stress, help them cope with the situation and improve their general well-being.</p> <p>The aim of the study was to describe breast cancer patients' experiences of social support during their illness. The purpose was to present most recent information for nurses that can help them to acknowledge patients' individual support needs in order to better meet them. Furthermore, this could improve the outcomes of social support provided by nurses.</p> <p>The study was implemented as a literature review. The data were collected using two databases: CINAHL and MEDLINE, resulting in the selection of seven articles that were analyzed using inductive content analysis. The following four main categories of social support experiences emerged from the analysis: emotional support experiences, informational support experiences, instrumental support experiences and spiritual support experiences.</p> <p>As a conclusion, it was found that breast cancer patients' experiences of social support are highly personal and reflect their individual needs. Women's experiences may further be affected by their native or adapted cultures and also by their religions. Therefore, nurses should provide breast cancer patients with more personalized care that would pay attention to their personality, age, religion and cultural background. Nurses could also routinely contact women who are waiting for surgery and make a follow-up call after treatments, which would improve both emotional and informational support for breast cancer patients.</p>		
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# 1 Introduction

Breast cancer is the most common cancer in women worldwide. Its prevalence is globally highest in Finland and other Nordic countries. (Joensuu 2015, 6.) In the year 2014, there were 5008 Finnish women diagnosed with breast cancer. The disease is more common in women going into menopause and the average age of a patient receiving breast cancer diagnosis is 60. (Vehmanen, 2017.)

In the last decades the number of breast cancer patients has increased, but at the same time the prognosis of the disease has significantly improved because of the early detection of the cancer. Nowadays women know how to self-examine their breasts and they participate in mammography screenings. The treatments have also improved especially with the development of medication combined to surgery and radiation therapy at the early stages of breast cancer. (Joensuu & Rosenberg-Ryhänen 2014, 6).

Breast cancer patients may experience fatigue after the cancer treatments. They often suffer from depression as they are faced with a serious illness and other problems concerning their femininity after surgery or problems due to the treatments. (Joensuu & Rosenberg-Ryhänen 2014, 27.) During their stay in the hospital for surgery and treatments and during recuperation they may receive support from the staff, friends, families, peer support persons or groups. It is vitally important for patients to receive support during hospitalization, since it relieves their stress, helps them cope with the situation and improves their general well-being. However, several studies show that the patients feel that they do not receive adequate support in the hospital. (Mattila, Kaunonen, Aalto, Ollikainen & Åstedt-Kurki 2010, 734.)

The aim of the thesis is to describe breast cancer patients' experiences of social support during their illness. The purpose of the thesis is to present most recent

information for nurses that can help them to acknowledge patients' individual support needs in order to better meet them.

## 2 Breast Cancer

### 2.1 Definition, Prevalence and Types

Cancer occurs when the normal functioning of body cells is disrupted as one or more cells begin to divide and grow uncontrollably. Cancerous cells take up space from healthy cells and form a tumor. The female hormone estrogen plays a major role in the development of breast cancer since it increases the division of cells and the number of ducts in breast tissue. (Kaarnalehto 2014, 125.)

Each year a million women are diagnosed with breast cancer and the number is predicted to grow with 20 % by 2020. The increase in numbers is mainly due to longer life expectancy, life habits and growth of obesity in general public. Cancer is also diagnosed more often and earlier in mammography screenings. (Kaarnalehto 2014, 125.)

The most common type of breast cancer is ductal carcinoma (80 % of cases) that originates from walls of the milk ducts (Gästrin 2012, 29). Sometimes this form of tumor is situated only inside the breast milk duct and is called ductal carcinoma in situ (DCIS). The latter can be classified as a form of pre-cancer. (Joensuu & Rosenberg-Ryhänen 2014, 15) The second most common type of breast cancer is lobular carcinoma (ibid.) that develops from the lobules of breast tissue (Gästrin 2012, 29). There are also other types of breast cancers that are rarer and have a better prognosis (Joensuu & Rosenberg-Ryhänen 2014, 15).

## 2.2 Risk Factors, Symptoms and Diagnosis

Breast cancer can result from multiple factors (HUS n.d; Vehmanen 2017), but most risk factors are hormone-related such as early start of menarche (menstruation) or late start of menopause (Joensuu & Huovinen 2013, 595). Long lasting hormonal replacement therapy at menopause also increases the risk for breast cancer (ibid; Vehmanen 2017).

Some risk factors are connected to Western reproductive behaviors like giving birth to less children, at a later age and nursing for a shorter period of time. Life-style related risk factors include obesity after menopause and daily or abundant use of alcohol. Hereditary factors account for 5-10 % of breast cancer cases. (HUS n.d.)

The most common symptom of breast cancer is a lump in breast tissue. The lump is often painless, but can also cause stinging or pain, changes in the skin or nipple discharge. Sometimes, more rarely, the first sign is presented by a lump in the armpit or other symptoms caused by the spreading (metastasis) of the cancer. (Vehmanen 2017.)

Diagnosis for breast cancer is reached by three diagnostic approaches that include inspection and palpation, imaging tests and pathological tests from biopsies (Sudah 2015, 10). Symptom(s) of breast cancer like a lump can often be detected by a woman herself during self-examination. Clinical breast examination by doctor can also reveal symptoms (Joensuu & Rosenberg-Ryhänen 2014, 8.)

In further examination of findings, the primary imaging test is mammography. In order to complete the latter, an ultrasound test is performed (Sudah 2015, 10.) During the ultrasound it is possible to take core needle biopsy (ibid). Tissue samples from the biopsy are examined microscopically, which usually confirms the diagnosis

(Joensuu & Rosenberg-Ryhänen 2014, 9). Despite the outcome of the biopsy, any suspicious finding from inspections or imaging tests is confirmed with surgery (ibid).

Breast cancer surgery and treatments will be discussed in the following section in connection with the effect of breast cancer on women's life.

### 2.3 Effect of Diagnosis and Surgery on Women

According to research, receiving the breast cancer diagnosis is a highly stressful experience for women (Drageset, Lindstrøm & Underlid 2009, 149-150; Stanton & Bower 2015, 232). Initially, the diagnosis seems life-threatening and causes powerful feelings of anxiety and depression. At first, women are shocked and find themselves in disbelief or denial, psychological distress also causes them to have problems with sleeping, eating, and concentrating. (Stanton & Bower 2015, 232.)

Adjusting to the diagnosis relieves the problems with psychological and physical dysfunctions (Stanton & Bower 2015, 232), especially if women actively accept the diagnosis (Drageset & al. 2009, 150). However, due to individual variation, significant number of women face a risk for persistent distress that may linger on even for years, disrupting their lives (Stanton & Bower 2015, 234).

Waiting for surgery can be equally stressful as receiving the diagnosis (Drageset & al. 2009, 149-150). However, surgical procedures have developed over decades, causing less damage to women's bodies (Ganz 2008, 642). Nowadays, breast cancer surgery can include either removal of a part of the breast (breast-conserving surgery) or removal of the whole breast (mastectomy). Surgeries are designed to remove the tumor and to locally minimize the risk of cancer's recurrence. (Leino 2011, 26.)

During surgery a sentinel lymph node biopsy is performed in order to find out whether the cancer has spread to the axillary (underarm) lymph nodes and also to



discover the cancer's stage; i.e., the size and spreading. This includes the removal of one or more lymph nodes. (American Cancer Society 2017a.) In most cases, surgery is executed removing a small portion of breast tissue and sampling only few axillary nodes (Ganz 2008, 642). However, in some cases, a more extensive number of lymph nodes (10-40) is removed by axillary lymph node dissection. (American Cancer Society a 2017.)

After surgery women often experience various symptoms that also have an effect on their quality-of-life. Usually they feel tired and have difficulties sleeping. (Maukonen, Salonen, Rantanen, Suominen & Kaunonen 2011, 276.) Both sleeping and movements are limited due to the pain in the wound areas. The arm on the side of the surgery may have poor range of motion or lymphedema; i.e., swelling caused by build-up of lymph fluid. These symptoms complicate daily activities like showering or driving. (Leino 2011, 28.)

Limited physical functioning affects women's self-esteem, alters their sexual functioning and may induce sexual inhibitions. Changes that surgery has inflicted on their bodies may lead them to feel less "normal", less perfect, and make them question their womanhood and the image they had of themselves. (Berterö & Wilmoth 2007, 200.)

## 2.4 Effect of Treatments on Women

Over time, breast cancer treatments have become less damaging and at the same time more complicated and time consuming. Long lasting treatments interrupt social life, daily activities and complicate planning ahead. (Ganz 2008, 642, 644.)

Depending on the stage of cancer and the type of surgery, radiation therapy is given to breast cancer patients (American Cancer Society 2017a). Practically all women who have had breast-conserving surgery are additionally treated with radiation

(Joensuu & Rosenberg-Ryhänen 2014, 17) in order to lower the risk of cancer's recurrence (American Cancer Society 2017a). The treatment may cause several side-effects varying from tiredness to lymphedema and skin reactions in the treated area (American Cancer Society 2017a).

Radiation therapy usually lasts for several weeks and is given five days a week (Syöpäjärjestöt n.d.-a). It is a daily commitment that requires traveling, which in part increases fatigue caused by the treatment. Skin reactions vary from redness to blisters and burns and appear at their worst near the end of the treatment. Even badly burned skin starts to heal rapidly after the treatments have finished and the overall side-effects seem minor. (Joensuu & Rosenberg-Ryhänen 2014, 18-19.) However, women may display strong fears of possible side-effects. Nurses can relieve these fears by being supportive and providing necessary information on the treatment and its adverse effects. (Leino 2011, 34.)

Both surgery and radiation therapy are local treatments of breast cancer. Chemotherapy is a systematic treatment for cancer that has spread (metastasized) to other parts of the body. (American Cancer Society 2017b.) Chemotherapy is also implemented after surgery in order to destroy any remaining cancer cells or before surgery with a goal to diminish the tumor in size (American Cancer Society 2017a.). It is implemented by intravenous or oral administration of drugs for one or several days at 1-4 week intervals (Joensuu & Rosenberg-Ryhänen 2014, 22).

Chemotherapy is a toxic treatment that is not likely to be applied in cancer cases with marginal risk of recurrence (Hersman & Ganz 2015, 256). Since chemotherapy affects all cells of the body, it may destroy even healthy cells and has numerous side-effects (Syöpäjärjestöt. n.d.-b). Typical ones include hair loss, nausea and vomiting, sores in mouth or throat, diarrhea or constipation, muscle pains and peripheral neuropathy; i.e., pains and numbness in hands and feet (American Cancer Society 2017a).

Browall, Gaston-Johansson and Danielson (2006) studied postmenopausal women's experiences of chemotherapy. The women in the study perceived the treatment as an attack on their bodies. Loss of hair felt worse to them than the loss of a breast. They experienced constant fatigue that affected their bodies and minds. It was also difficult for them to concentrate and some experienced memory impairment. (Browall et al. 2006, 34-41.)

For younger, premenopausal women, chemotherapy induces slightly different side-effects. They may experience changes in menstruation and are at risk for infertility. (American Cancer Society 2017a.) Moreover, it is likely that women will be faced with an earlier onset of menopause, especially, if they are over 40 (Hersman & Ganz 2015, 257-258). Younger women are not prepared for premature menopause and suffer notably from the symptoms. One woman relates "feeling old. I have constant hot flashes, headaches, and can't sleep. No one explained that I would go through with this. I'm pretty upset." (Boehmke & Dickerson 2006, 1123.)

Another treatment that may induce menopause symptoms is hormonal therapy (Boehmke & Dickerson 2006, 1125) that is given for hormone-receptor positive breast cancers. Most breast cancers' growth is dependent on hormones like estrogen and/or progesterone. Hormonal therapy attacks these hormones chemically in order to prevent cancer's growth. (Cancer. Net 2016.) Drugs are taken in the form of tablets for 5 to 10 years (Leino 2011, 27). The therapy plays a significant role in the treatment of breast cancer. However, some women do not commit to medication, possibly due to the uncomfortable side effects. (Hersman & Ganz 2015, 258.)

After the breast cancer treatments, some women experience feelings of loneliness and uncertainty as they face the future (Boehmke & Dickerson 2006, 1124, 1126). They may still suffer from treatment-related symptoms that affect quality of life (Janz et al. 2007, 1349.) Furthermore, some women exhibit fear of cancer recurrence

(Boehmke & Dickerson 2006, 1121; Janz et al. 2007, 1349 Stanton & Bower 2015, 231). The fear is reportedly stronger in younger women (Boehmke & Dickerson 2006, 1126; Stanton & Bower 2015, 235) and in women with limited social support (Stanton & Bower 2015, 235). Lack of social support additionally presents a risk factor for psychosocial distress (Ganz 2008, 645; Hewitt & Holland 2004, 61). The importance of social support during breast cancer will be discussed in more detail in the following section.

### **3 Social Support**

#### **3.1 Definitions of Social Support**

Social support refers to the interactions between an individual and his/her social environment. The concept is also used to describe the resources generated from social interactions. These resources promote health and wellbeing of the individual. Moreover, social support portrays the process in which support is formed and delivered. (Mikkola 2006, 24.)

First definitions of social support emerged in the 1970's. While researchers' concepts varied, they still shared the notion that social relationships could reduce stress and consequently have a positive effect on a person's health. (Vangelisti 2009, 40.) Like his colleagues, Cobb (1976) acknowledged that social support offered protection against negative health consequences of various life crises (Cobb 1976, 310). According to Cobb (1976), the recipient of social support receives information that makes him/her feel cared for and valued, furthermore giving him/her a sense of belonging to a network of communication (ibid., 300-301).

Cobb's (1976) early concept of social support portrays one-way communication, information being received, whereas a later definition by Kahn and Antonucci (1980) emphasizes reciprocity in communication (Mattila 2011, 16-17). Kahn and Antonucci describe support as an interpersonal exchange that highlights expressing positive feelings and offering help. Simultaneously, it stresses recipient's perception of receiving help as a strengthening experience. (ibid., 17.)

Another way of approaching social support is through its objectives. Support is thus perceived as actions or resources whose goal is to support well being and coping of the recipient. (Mattila 2011, 17.) In breast cancer care this kind of social support may be realized by using psychosocial interventions. These interventions have been developed to support the patient and her family during the course of the illness (Idman & Aalberg 2013, 860.) However, access to this type of hospital based support has been reduced since breast cancer patients' stay at the hospital has been shortened and their care shifted to outpatient facilities (Hewitt & Holland 2004, 161).

Social support is also associated with social networks and contacts. Being a member of a social group may create feelings of belonging and sustain perceptions of support. (Mattila 2011,17.) Still, having several personal contacts is no guarantee for receiving adequate support (Leino 2011,43). Sometimes social contacts may even increase feelings of stress (Mattila 2011,17). Furthermore, received support is not always seen as a positive experience (Leino 2011,43). Support might not be wanted nor regarded helpful by the recipient (Vangelisti 2009, 42). He/she may perceive support either as a positive or a negative act depending on the social context and the nature of his/her relationship with the provider of support (ibid., 43, 45).

### 3.2 Types and sources of social support

When defined through its functions, social support is usually divided into three different types: emotional, informational and instrumental (Mattila 2011, 18).

Some studies consider that emotional support is the most important form of support due to its established connection to health. Besides, according to other studies patients have also experienced emotional support to be the most beneficial type of support. (Mattila 2011, 18.) Receiving this type of support may relieve patients' emotional burden, increase their emotional resources and facilitate coping (Mikkola 2006, 44).

Emotional support entails listening, encouraging, showing empathy and acceptance (Mikkola 2006, 44). These interventions are all employed in nursing care, with empathy as a prerequisite (Kuuppelomäki 1999, 143). Other methods include being present, showing respect, acknowledging patient's feelings and discussing them (Mattila 2011, 35). It is also important to pay attention to patients' individuality in order to recognize their specific support needs (Mattila, Kaunonen, Aalto & Åstedt-Kurki 2010, 32).

In general, breast cancer patients turn to their spouses, families and friends for emotional support, whereas their main sources for informational support are healthcare professionals (Salonen, P., Tarkka, M., Kellokumpu-Lehtinen, P., Koivisto, A., Aalto, P., & Kaunonen, M. 2013, 397). In addition, research has shown that it is easier for patients to express their informational needs rather than voice their emotional needs (Mattila 2011, 25).

Patients' informational needs relate to their illness, its treatment and self-care (Mattila 2011, 25). Information should be based on individual needs and delivered both in verbal and written forms (Browall et al. 2006, 40; Mattila 2011, 25). Receiving informational support from nurses reduces insecurity and increases feelings of trust and hope. However, if received information is inadequate, patients may feel highly distressed. (Leino 2011, 56.)

Resulting from the shortened treatment periods, informational sources outside the hospital are becoming more significant for patients. Therefore, women are searching for information from literature and especially from the Internet. From the latter, they expect to find factual information rather than emotional or individual information. They may also obtain informational support from friends and acquaintances with experiences of breast cancer or from support groups. (Leino 2011, 56-57.)

Instrumental support is a concrete form of support that involves offering help and services (Mattila 2011, 19). Practical support may mean assistance with daily activities, such as making meals or driving the patient to the hospital (Hewitt & Holland 2004, 61).

On the whole, different providers of support offer different types of support. Thus, emotional support may be supplied by breast cancer patient's spouse, whereas more practical support may be delivered from other sources. (Lehto-Järnstedt 2000, 19.) According to research, the results of social support depend on the patient's own perception of received support (ibid., 18). The importance of patient's perceptions and experiences in relation to social support guided the selection of present study's topic that is presented in the following chapter.

## **4 Aims and Purpose**

The aim of the thesis is to describe breast cancer patients' experiences of social support during their illness. The purpose of the thesis is to present most recent information for nurses that can help them to acknowledge patients' individual support needs in order to better meet them. Furthermore, this may improve the outcomes of social support provided by nurses.

Research question: What kind of experiences do breast cancer patients have of social support during their illness?

## **5 Methodology**

### **5.1 Literature Review**

A literature review is a selected compilation of documents that are available on a certain topic. It includes evidence-based data and ideas that are presented to reach a certain goal or to express a particular point of view. In addition, it shows skillfulness in searching for relevant materials. However, in the current study, the goal is not to include excessive amount of literature, but to use material that is narrow to describe breast cancer patients' experiences of social support during their illness. (Hart 1998, 13.)

Previous research is analytically assessed in a literature review. The writer makes comparisons, classifies and comments on the previous body of work. (Turun yliopisto n.d.) Analyzing individual research papers in comparison to other papers creates a more complete view of the research area and may even provide new insights into the topic (Aveyard 2014, 6).

A literature review can be used as a part of a study or as a study in its own right. It not only presents themes from previous research but also charts possible problems within the material and gives critique. A researcher finds gaps in research; gives suggestions and validation for further studies. (Turun yliopisto n.d.) As a research method, a stand-alone literature review is well suited for novice researcher since the sources have already been published and are easy to access. Moreover, this type of



research requires no ethics approval (Aveyard 2014, 15-16.) For these reasons the present study was conducted as a literature review.

Conducting a literature review should be systematic in describing its phases in such an explicit manner that the reader can evaluate each phase's execution and reliability. In addition, following five phases should be included in a literature review: 1) Defining the aim and the research question, 2) searching for and selecting literature, 3) appraising literature, 4) analyzing and synthesizing literature and 5) reporting results. (Niela-Vilén & Hamari 2016, 23.) The present literature review systematically followed the aforementioned steps in order to give the research process clarity and transparency.

## 5.2 Literature Search

Preliminary literature searches were conducted by one researcher in June 2017. After making readjustments, such as limiting the scope of search more suitable for a single researcher, the final literature search was conducted on 14 September 2017 using two databases: CINAHL (Ebsco) and MEDLINE (Ovid). CINAHL (Cumulative Index to Nursing and Allied Health Literature) was used since it contains journals related to nursing and MEDLINE (Medical Literature Online) was chosen as it was recommended by a information specialist at Jyväskylä University Library. Besides, they are both recognized as highly valuable databases for nursing research (Moule, Aveyard & Goodman 2017, 46).

In CINAHL first search term was a MeSH (Medical Subject Heading) term *breast neoplasms*. The second one (connected with the boolean operator AND) was a free search term *social support* that was searched for in the abstract (AB) of the article. The search in MEDLINE database used the same two search terms. Some limiters were applied already at the beginning of both searches: full text available, published between 2008 and 2017, English language, gender: female and peer-reviewed (this

limiter available only in CINAHL, but MEDLINE’s articles were all peer-reviewed). The subsequent search in CINAHL yielded 87 results and in MEDLINE 33 results. The full inclusion and exclusion criteria are summarized in Table 1.

TABLE 1. Inclusion and exclusion criteria.

<b>Inclusion criteria:</b>	<b>Exclusion criteria:</b>
<ul style="list-style-type: none"> <li>• Full text available for students</li> </ul>	<ul style="list-style-type: none"> <li>• Quantitative study</li> </ul>
<ul style="list-style-type: none"> <li>• Peer-reviewed</li> </ul>	<ul style="list-style-type: none"> <li>• Not primary research</li> </ul>
<ul style="list-style-type: none"> <li>• Published between 2008-2017</li> </ul>	<ul style="list-style-type: none"> <li>• Not relevant to the research topic</li> </ul>
<ul style="list-style-type: none"> <li>• Study in English</li> </ul>	<ul style="list-style-type: none"> <li>• Not answering the research question</li> </ul>
<ul style="list-style-type: none"> <li>• Gender: female</li> </ul>	<ul style="list-style-type: none"> <li>• Not the point of view of the patient</li> </ul>
<ul style="list-style-type: none"> <li>• A qualitative study</li> </ul>	
<ul style="list-style-type: none"> <li>• Primary research</li> </ul>	
<ul style="list-style-type: none"> <li>• Answers the research question</li> </ul>	

An additional inclusion criterion evolved from the use of “hierarchy of evidence”. It was implemented by searching for a particular type of research that would offer the strongest evidence for the literature review question. (Aveyard 2014, 65.) The question was: What kind of experiences do breast cancer patients have of social support during their illness? As the question aimed at exploring data (experiences) instead of measuring them, qualitative research design was the preferred choice (ibid., 62-63) in selecting the articles for the review. Literature from primary sources was also preferred since it originated straight from the researchers’ work and was thus less vulnerable to possible bias or distortion (Moule et al. 2017, 42). Finally, the most important criterion for including the articles was whether they answered the research question.

A total of 120 studies were yielded from the database searches. The studies were then screened by the reviewer to see whether their titles and/or abstracts appeared

to meet the inclusion criteria. Full texts of the 9 remaining studies were then assessed resulting in the final selection of 7 studies. At this stage, as there were no duplicates to be removed so the number of included studies remained at 7. The screening process is described in Table 2.

TABLE 2. The screening process.

Database	Search terms	Results	Chosen based on the title and/or abstract	Chosen based on the full text
CINAHL (Ebsco)	MH breast neoplasms AND AB social support	87	6	4
MEDLINE (Ovid)	MH breast neoplasms AND AB social support	33	3	3

### 5.3 Description and Appraisal of Data

The seven included research articles were conducted in the USA (n=3), Norway (n=2), Jordan (n=1), and Israel (n=1). The articles were published between 2008 and 2017. All studies were original research, peer-reviewed and qualitative in nature. One American study focused on young (between 20-40 years old) African American women with breast cancer (Jones 2015). Another American article studied older (between 65-83 years old) African American, Asian American, Caucasian and Latina women (Yoo, Levine, Aviv, Ewing & Au 2010). Age was not a determining factor in rest of the articles that came from various locations and represented women with diverse cultural backgrounds. Two articles studied social support experiences of

Norwegian women and were written in 2012 and 2016 by the same four authors: Drageset, Lindstrøm, Giske & Underlid. Two studies came from the Middle East. The first originated from Israel and explored Palestinian women's experiences of breast cancer in the occupied Palestinian territory (Hammoudeh, Hogan & Giacaman 2017). The second came from Jordan and studied Jordanian women's experiences of social support (Alqaissi & Dickerson 2010). The last study came from the USA and examined the experiences of Latina breast cancer survivors (Buki, Garcés, Kogan, Hiestrosa, Carrilo & French 2008). A more comprehensive overview of the studies is shown in the Appendices (see Appendix 1).

The 7 included studies were appraised by the reviewer using the Critical Appraisal Skills Program (CASP) for qualitative research. The CASP tool helps in systematic evaluation of qualitative research and consists of 10 questions. The first two questions are screening questions appraising the aims and the methodology of the research. The rest of the questions assess following aspects: research design, recruitment strategy, data collection, relationship between researcher and participants, ethical issues, data analysis, findings and research value. The questions are answered with yes, no or unclear. (CASP 2017, 1-5.)

All 7 analyzed articles addressed the two screening questions on the aims and the methodology of the research. Out of 7 studies, 5 addressed 5 of the remaining questions concerning recruitment strategy, data collection, data analysis, findings and research value. One article stated the research design but failed to discuss whether it was appropriate to address the aims of the study (Jones 2015). None of the 7 studies examined the relationship between researcher and participants. Researchers from one of study asked informed consent from the participants through a nonprofit cancer support organization and did not contact the participants themselves for confidentiality reasons (Buki et al.2008). However, compensation was given to the informants, which seems to violate ethics of research (ibid. 2008). Also concerning ethics, another study failed to mention getting informed consent from the informants. The recruitment was executed by local cancer organizations

and by a local Cancer Registry, so presumably permission was asked from the participants. (Yoo et al.2010.) As the overall quality of the studies was good, all were included in the present review.

#### 5.4 Data Analysis

In the present literature review the data from research articles were organized and processed by qualitative content analysis in order to retrieve the essential information and meaning embedded in the data (Moule et al. 2017, 370-371). In addition, this method was chosen since it can be used to examine various kinds of communication like in this case the interviews from the selected studies.

Furthermore, content analysis process gives access to extensive comprehension of communications of interest and assists in interpreting findings. (Jackson 2009, 79,82.)

The content analysis was conducted in an inductive way by extracting specific, smaller units from the data and combining them into larger entities (Elo & Kyngäs 2008, 109). The data from the interviews were read several times by the researcher, who tried to find the information relevant to the research question. The process of 'coding' was used to reduce the quantity of data (Moule et al. 2017, 371). Open coding proceeded from the specific to general as words or sentences with similar meanings were combined into fewer categories (Elo & Kyngäs 2008, 108-109). Data for the analysis were extracted from the findings of the selected articles. Coding was executed by highlighting words or sentences and making notes. The expressions were then combined into categories, first into many sub-categories that were further grouped into fewer main categories. Formulation of the categories created an overall description of the research topic through a process called abstraction (Elo & Kyngäs 2008, 111). Finally, as the data in the formulated categories addressed the research question (Aveyard 2014, 153), the question was placed on top of the main

categories. The figure 1 shows an example of the progress of inductive content analysis.

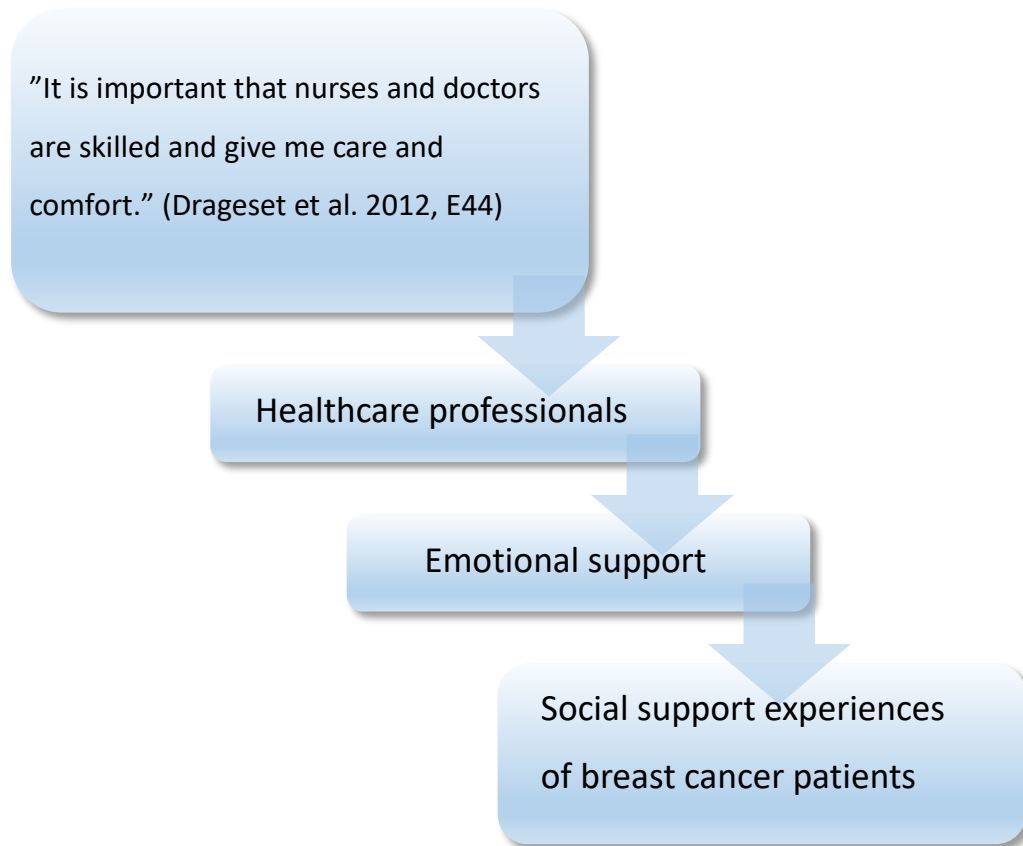


FIGURE 1. An example of the progress of inductive content analysis.

## 6 Research results

Findings from the 7 studies revealed 4 main categories of social support derived from the experiences of breast cancer patients: emotional support experiences, informational support experiences, instrumental support experiences and spiritual support experiences. The main categories and their subcategories are illustrated in the Figure 2. The 4 main categories are discussed in detail in the following sections.

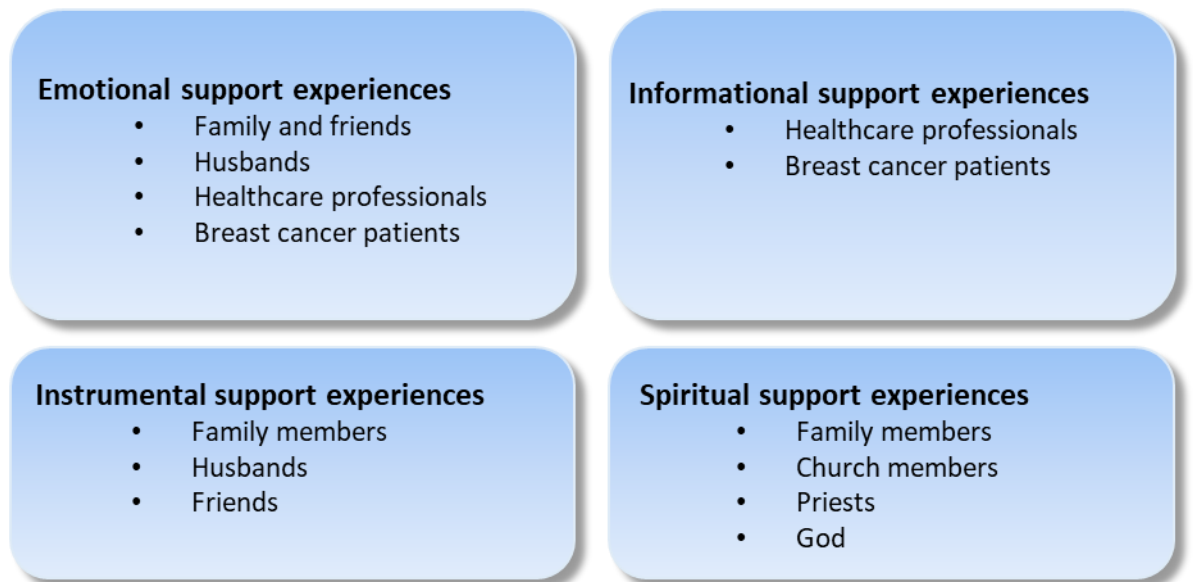


FIGURE 2. Four main categories of social support experiences

## 6.1 Emotional support experiences

Emotional support was highly valued by the women in the studies, as one of them expressed: “I need care above all; the fact that somebody loves me and says something nice to me.” (Drageset et al. 2012, E43). It was demonstrated by empathy, understanding, appreciation, respect and love (Drageset et al. 2012, E43) and usually provided by closest **family and friends** (Buki et al. 2008, 165; Drageset et al. 2012, E43; Drageset et al. 2016, 342; Jones 2015, 8; Yoo et al. 2010, 1526). Sometimes the mere knowledge of available support made women feel strong and secure. Neither were face-to-face contacts necessary as support often came in the form of telephone calls or text messages. (Drageset et al. 2012, E43.) In Palestinian society, emotional support was also shown by friends and female family members in the form of physical presence, by “just being there” (Alqaissi & Dickerson 2010, 356).

Informants felt that receiving emotional support from the family was positively related to their psychological well being, meaning “feeling good, feeling self assured, and not feeling depressed” (Buki et al. 2008, 165). On the other hand, they experienced rarer, unsupportive acts within families as emotionally devastating

(Hammoudeh et al. 2017, 492). Sometimes, showing sympathy was construed as pity or could make women feel scared and vulnerable. Paradoxically, women wanted company, but also needed some time alone. (Drageset et al. 2012, E43.)

It was important for Norwegian women to share their breast cancer experiences with their families. However, some of them felt that their families worried too much over them and chose to talk to their friends instead. (Drageset et al. 2016, 342.)

Contrastingly, Jordanian women preferred not to talk about breast cancer and expected their friends to do the same. Avoiding the subject was considered as an act of support. (Alqaissi & Dickerson 2010, 356.) Some informants reported that receiving support and care from the family instead of providing it was a welcomed experience: "It is good to lean on a shoulder without having to ask for it. I'm used to being strong and a comfort to others." (Participant quote Drageset et al. 2012, E43). For others, it was not easy to accept support from the family (Drageset et al. 2012, E44; Yoo et al. 2010, 1525). A study into older women with breast cancer showed that women over the age of 70 were reluctant to ask for help from their younger family members. They would rather appear self-sufficient than emotionally needy. Nevertheless, some, especially ones who were treated with chemotherapy, learned to ask for support and were pleased with the outcome. (Yoo et al. 2010, 1525-1526.)

**Husbands** were recognized as main sources for support during diagnosis, treatments (Alqaissi & Dickerson 2010, 356; Hammoudeh et al. 2017, 492) and in long-term survivorship (Buki et al. 2008, 166). Palestinian men provided emotional support by reassuring their wives and by accepting the physical changes caused by cancer (Hammoudeh et al. 2017, 492). Jordanian husbands, by contrast, showed emotional support mainly by being physically present at the time of surgery and chemotherapy (Alqaissi & Dickerson 2010, 356, 359). Still, many Jordanian women experienced that their husbands were unsupportive and did not accept breast cancer or resorted to emotional and physical abuse (ibid., 356). In the Norwegian study, husbands were sometimes perceived overprotective or the amount of support seemed excessive:



“My husband is so caring I think it is simply too much of a good thing.” (Participant quote Drageset et al. 2012, E44).

Although emotional support was mainly received from husbands/partners, family and friends, **healthcare professionals** were also recognized as important sources of emotional support: “It is important that nurses and doctors are skilled and give me care and comfort.” (Participant quote Drageset et al. 2012, E44). Particularly patients who waited for surgery craved for contact from the hospital as a sign of caring (Drageset et al. 2012, E44). Similarly, older women needed emotional support from nurses during chemotherapy and other treatments. After learning to receive support, they were satisfied with the emotional care from the staff. (Yoo et al. 2010, 1526, 1528.) Some women wanted to talk to professionals since they were perceived as more neutral parties than families or friends. However, reaching for emotional support by calling to the hospital was difficult for these women, especially, if they were not familiar with the nurses. Some contacted their family doctors for more personalized support and were pleased with the outcome. (Drageset et al. 2012, E44.) On the whole, being treated as an individual by professionals was important. In some cases, women felt that doctors had treated them more as an object or a diagnosis than a person. (Drageset et al. 2016, 343.)

Alongside individual support, women also needed continuity of support. Patients who were treated by same nurses or doctors as before were feeling comforted and satisfied with the hospital care, as one woman stated: “The doctor asked what had happened since last time. It gave me confidence”. Some patients met new doctors who communicated poorly with them. These experiences made them uncertain and doubtful of professional care. Continuity of support also meant that nurses were available by phone to patients after treatments, which was realized for most women and welcomed as a positive experience. (Drageset et al. 2016, 343.)

Women often recognized professionals as a possible source of emotional support, but preferred emotional support to be sourced from their social network (Drageset 2012, E41). The form of support they mainly sought from professionals was informational support (discussed further in the following chapter). Information from nurses could also be perceived as emotional support since knowledge brought consolation to women. (ibid., E43.) The Palestinian study showed that lack of emotional support from family and friends could not be replaced by professionals due to the deficiencies in the local health care system. For example, psychosocial care could only be provided by one hospital. (Hammoudeh et al. 2017, 494.) Availability of hospital based emotional care was also a dilemma in the Jordanian study. Women were treated in two hospitals, those who were in the cancer center hospital experienced positive supportive care, whereas women from the public hospital did not report similar experiences (Alqaissi & Dickerson 2010, 359).

In Norway, emotional support from the hospital included a possibility to attend a nurse-led peer support group. Most women reported that attending this group helped them because they could share experiences by talking with other **breast cancer patients** and gain perspective by listening to their stories. (Drageset et al. 2016, 342.) Some informants found talking in a group therapeutic (ibid.) and others felt empowered by the experience (Buki et al. 2008, 166). However, some participants felt that the members of the support group were too different (Drageset et al. 2016, 342) or only complained about their negative experiences (Alqaissi & Dickerson 2010, 357). In addition to group support, women accessed individual support from breast cancer survivors among family or friends (ibid.) or from the peers in the internet chat rooms (Drageset et al. 2016, 342).

## 6.2 Informational support experiences

Breast cancer patients received informational support mainly from **healthcare professionals** (Drageset et al. 2012, E41). Women who received professional support were mainly satisfied with the amount of gained knowledge (Alqaissi & Dickerson 2010, 357; Drageset et al. 2016, 345) and trusted it more than information from nonprofessionals (Drageset et al. 2012, E45). Patients appreciated information on their diagnosis, the care plan and possible treatment options (Alqaissi & Dickerson 2010, 357). They also valued repetition of forgotten information with a nurse (Drageset et al. 2012, E43), hospital leaflets (Drageset et al. 2016, 345) and gaining information from a nurse-led support group (ibid.). Overall, women reported that receiving informational support during diagnosis and treatments had positive effect on their mental health (Buki et al.2008, 166).

However, some participants found deficiencies in informational support. They felt that the support could have been more personalized. One realization of individual care could have been a phone call from the nurse after the diagnosis. Patients had been advised to contact nurses when necessary but they were hesitant about calling themselves as one explained: "I don't want to disturb. Physicians and nurses are busy; they don't attend only to me. I don't know what is expected of me in a situation like this." Consequently, patients preferred that the nurses would take the initiative. (Drageset et al. 2012, E45.) Women also felt that they needed more information especially on issues that stressed them like pain and treatment side-effects (Drageset et al. 2016, 343-344).

In some Jordanian health care settings patients reported that their doctors gave inadequate, false or no information regarding diagnosis and treatment options. Here, due to cultural influences, information was controlled by physicians by for example not disclosing the diagnosis. In the Jordanian culture, doctors are perceived as professionals, whose decisions are not to be questioned and who are only protecting

the patients by their non-disclosure. For these reasons, patients accepted any information given without questioning it, though several stated that they needed full disclosure of their illness. However, within the same study, patients of the cancer center hospital received full informational support, probably due to the hospitals funding being tied to the requirement of full disclosure. These women felt they were given adequate information and a chance to make their own decisions concerning treatments. (Alqaissi & Dickerson 2010, 357-359.)

In several studies, informants automatically associated breast cancer with death (Alqaissi & Dickerson 2010, 355; Buki et al. 2008, 165; Hammoudeh et al. 2017, 491; Jones 2015, 7), avoided talking about it (Alqaissi & Dickerson 2010, 356) and refrained from using the word “cancer” (Hammoudeh et al. 2017, 491). This could be caused by poor local prognosis for breast cancer (Alqaissi & Dickerson 2010, 358), cultural beliefs or lack of knowledge (Alqaissi & Dickerson 2010, 360; Buki et al. 2008, 167; Jones 2015, 7). Some African American respondents had no knowledge of, for example, breast self-examinations and additionally their culture discouraged them from touching their bodies. These women learned about breast cancer mainly through their experiences and also from the experiences of other **breast cancer patients**. (Jones 2015, 7.) Many informants appreciated informational support from their peers (Drageset et al. 2012, E44; Drageset et al. 2016, 342) and one suggested that breast cancer survivors could best deliver information on the illness to the general public (Jones 2015, 9).

### 6.3 Instrumental support experiences

**Family members** provided instrumental support by helping breast cancer patients in daily chores. This practical help came from immediate or extended family and most often from female family members (Alqaissi & Dickerson 2010, 356; Hammoudeh et al. 2017, 492.), as one woman stated: “At time of chemotherapy, my sister and my sister-in-law used to do everything for me. They cooked for me, they gave me bath,

and they took care of my daughter.” (Alqaissi & Dickerson 2010, 356). Many informants appreciated tangible help as it alleviated their emotional strain (Jones 2015, 8) and assisted them in providing for their families’ everyday needs (Hammoudeh et al. 2017, 492). However, some women felt guilty for not being able to manage their families by themselves (Hammoudeh et al. 2017, 492). Older women found it also difficult to ask for practical help, like rides to the hospital during chemotherapy. Still, most accepted their immediate families’ assistance since it was vitally important for them. (Yoo et al. 2010, 1527.)

For Jordanian women, the most essential form of instrumental support was financial aid that came from their families and **husbands**. For example, according to their cultural roles, Jordanian husbands were expected to financially support their wives. Some respondents also received money from **friends**, which they interpreted as an act of caring, especially, if they came from less wealthy families. Moreover, poor women found out that they were in desperate need of monetary assistance, as one explained: “I cannot afford the transportation. It costs me 7 dinars to reach the cancer center.” (Alqaissi & Dickerson 2010, 357.)

#### 6.4 Spiritual support experiences

Participants from most studies regarded spirituality as an important source of support during their illness (Alqaissi & Dickerson 2010, 359; Buki et al. 2008, 166; Hammoudeh et al. 2017, 493; Jones 2015, 9; Yoo et al. 2010, 1527). Women received prayers from, for example, their **family members** (Alqaissi & Dickerson 2010, 358; Drageset et al. 2012, E43) or other **church members** (Yoo et al. 2010, 1527). In one study, prayers were used by **priests** as a part of spiritual healing, an African American ceremony. Most informants trusted the priests and would have chosen spiritual healing over medical treatment. (Jones 2015, 9.) An opposite view was presented by Palestinian women, as both Christian and Muslim participants regarded treatment as part of **God’s** will. As one patient expressed: “I came here to the hospital knowing

that God is the one that cures, God created the treatment and God created the medicine (cure).” (Hammoudeh et al. 2017, 493.)

For Jordanian women, spiritual support from God was realized as they talked and prayed to Him. Religion gave meaning to their experiences: breast cancer was seen as a token of God’s love, a gift and a test of faith. In order to pass the test of faith women thankfully accepted their condition (Alqaissi & Dickerson 2010, 358-359.) Similarly, Palestinian women perceived cancer as test of faith and as God’s will. They, too, accepted their illness, though some experienced weaker moments that led them to question their fate. Overall, women were being active by using spiritual support as a coping tool instead of being passive and blindly submitting to destiny.

(Hammoudeh et al. 2017, 493-494.) Spiritual support was also employed successfully by Latina women. As a result they developed a closer relationship to God and religion and started to see God’s love manifested in their experiences of social support. (Buki et al.2008, 166.)

## **7 Discussion**

### **7.1 Discussion of key results**

The aim of this literature review was to describe breast cancer patients’ experiences of social support during their illness. Qualitative data from 7 studies were organized and processed by inductive content analysis. Results revealed experiences from 4 categories: emotional support, informational support, instrumental support and spiritual support. A previous study by Mattila (2011, 18) also employed same categories, except for the category of spiritual support that could also have been placed here under the emotional support category. However, the present study’s findings showed the importance of spiritual support to the informants and thus it was presented separately.

According to some studies, breast cancer patients experienced emotional support as the most helpful type of support (Mattila 2011, 18). Similarly, the present study showed that emotional support was greatly valued by the women. This type of support relieved their stress, empowered them and enhanced their coping, as verified by Mikkola (2006, 44). However, correspondent with previous research by Leino (2011, 43) and Vangelisti (2009, 43, 45) the current study's findings suggested that emotional support could also be perceived as a negative experience. Findings further indicated, in agreement with Lehto-Järnstedt (2000, 18), that the quality of perceptions was dependent on the personalities of the patients.

Consistent with previous research (Salonen et al. 2013, 397), patients' main sources for emotional support were their spouses, families and friends. The present study further showed that most women readily accepted help from their families, with the exception of older women, who were hesitant to ask for either emotional or instrumental support. For some women it was also difficult to ask for emotional support from the hospital. Accordingly, Mattila (2011, 25) stated that it was more difficult for patients to voice their emotional needs than it was to express their informational needs. The present study's findings indicated that women turned to health care professionals mainly for informational support, as confirmed by Salonen et al (2013, 397).

According to a previous study, patients felt that the support they received from the hospital was insufficient (Mattila et al. 2010, 734). Correspondingly, the current review revealed inadequacies in hospital based support. Results showed that patients desired more personalized care that would, for example, include a call from a nurse prior to surgery and also a check-up call after the treatments. Furthermore, a previous study suggested that paying attention to patients' individuality would help in recognizing their specific support needs (Mattila et al. 2010, 32). Possible shortcomings in professional support were probably partly caused by developments in local health care systems leading to shorter hospitalizations (Hewitt & Holland 2004, 161). They could have also resulted from underdevelopment of local health

care systems leading to inadequate support resources as presented by the two Middle Eastern studies of this review. Lack of informational support could also be due to cultural influences like in the case of the Jordanian doctors' non-disclosure.

The present study indicated that availability to professional, both emotional and informational support was vitally important to breast cancer patients. Mattila and others (2010, 734) reported that receiving support from professionals relieved patients' stress, helped them cope with the situation and improved their general well-being. The current study's findings coincided with this and further concluded that informational support could also provide patients with emotional support. In effect, receiving information gave patients comfort and had a positive effect on their mental health. Correspondingly, Leino (2011, 56) found that informational support reduced patients' insecurity and increased their feelings of trust and hope. However, present study revealed that women needed more information on stressful issues like pain and treatment side-effects. Receiving adequate information could relieve patients' fears of, for example, side-effects as pointed out by Leino (2011, 34).

According to the present study, patients could experience fear not only caused by inadequate information but also caused by cultural beliefs. Findings from four studies showed that breast cancer was culturally associated with death, which could make women avoid talking about the illness or even mentioning the word "cancer". It seems that women from cultures with adequate public education and information on breast cancer were more open and less fearful than their less educated peers. Interestingly, findings from the same four studies, revealed that spiritual support was regularly employed and highly valued by informants in these studies.

Compared to other types of support, instrumental support was in a minor role in the findings of the current study. However, practical help was essential for women in cooking, housekeeping and getting transportation to the hospital. It also served as emotional support as it relieved patients' emotional burden. Another form of tangible support was financial support from families, husbands and friends. For



example, Jordanian women's experiences of care and support were dependent on the wealth of their husbands and families.

As mentioned earlier, the importance of spiritual support emerged strongly from the findings of this study. For many women, religion provided meaning to the breast cancer experience and made them accept and embrace the illness. Interestingly, spiritual support could function in collaboration with health care or against it. For Palestinian informants, breast cancer treatment embodied God's will, whereas their African American peers would choose traditional spiritual healing over medical treatment.

## 7.2 Ethical considerations and reliability

As this literature review collected secondary data and had no contact with the participants from the published studies, no ethics approval was needed (Aveyard 2014, 16). The reviewer trusted that the researchers had acquired the necessary permits and conducted their research in an ethical manner. The original articles were deemed reliable, since they were accessed using trustworthy databases and had been peer-reviewed.

The present study followed the instructions of the Finnish Advisory Board on Research Integrity and strived to conduct research in an ethically responsible manner. The researcher tried to avoid falsification by presenting results without changing or omitting any information relevant to the conclusions. All accessed data were also referenced to in order to avoid plagiarism. (TENK 2012, 33). Furthermore, the review was checked for plagiarism by using the Urkund system.

Reliability of a literature review is dependent on precisely described and documented protocols and processes. The protocol of the present study was

carefully planned in advance. Furthermore, it presented the research methods employed in the review and aimed to minimize errors at every stage of the process. (Valkeapää 2016, 64.) As the research methods, the inclusion and the exclusion criteria were set beforehand, the risk of introducing bias was reduced (CRD 2009, 6). The research process was also documented with care, which ensured repeatability that is essential to the reliability of the review. (Valkeapää 2016, 64.)

### 7.3 Limitations and strengths

Present study would have benefited from the involvement of another researcher in order to reduce bias and error (CRD 2008, 4). Having another researcher involved in the research process would have provided more reliability to the literature review (Pudas-Tähkä & Axelin. 2007, 46), although it was not required in a bachelor's thesis (Niela-Vilén & Hamari 2016, 27). Further limitations included using only published data, which could produce publication bias. Possibility of language bias also existed, since the review included only articles published in English. (Pudas-Tähkä & Axelin. 2007, 53.)

The strength of the present study was the richness of data in the included studies. Informants came from diverse cultural and religious backgrounds, which provided more variation to the results.

### 7.4 Conclusions and recommendations for further studies

The present study showed that breast cancer patients' experiences of social support were highly personal and reflected their individual needs. Furthermore, women's experiences seemed largely bound to their native or adapted cultures. Surprisingly, religion also played a major role in their experiences.

Consequently, breast cancer patients could benefit from a more personalized support that would pay attention to their personality, age, religion and cultural

background. As Finland is becoming more multicultural, there is a growing need for culturally sensitive care. Further research could be conducted to study breast cancer patients from different nationalities to find out their individual support needs in order to provide culturally competent care.

Emerging from this study, were further recommendations for practice: nurses could routinely contact women who are waiting for surgery and also make a follow-up call after treatments. These relatively small interventions would provide major effect by improving both emotional and informational support for breast cancer patients.

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## Appendices

### Appendix 1. Methodological details of the included studies.

References, country	Research objective	Participants	Design/Methods	Findings
Alqaisi et al. (2010), Jordan	To explore the common meanings of social support by Jordanian women after diagnosis and throughout the treatment	A purposive sample of 20 Jordanian women diagnosed with stage I, II, or III breast cancer; between 24-72 years old	Qualitative research Interpretive phenomenological research design Individual semi-structured interviews Heideggerian hermeneutical analysis	Instrumental support was provided by female family members in the form of practical help and from husbands in the form of financial assistance. Availability of informational support from professionals depended on hospital resources. For Muslim women, spiritual support assisted coping with breast cancer and they accepted the disease as a test of their faith.
Buki et al. (2008), USA	To examine the experiences of Latina breast cancer survivors from diagnosis to long-term survivorship in order to develop psychosocial interventions	18 breast cancer survivors; between 35-67 years old Latina women, ancestries were Central American (n=8), South American (n=5), Mexican (n=3), Dominican (n=1), unknown (n=1)	Qualitative research Grounded theory In-depth, semi-structured focus groups Grounded theory coding, categorization	Social support from the family, professionals and peers was critical at all stages of the breast cancer experience. During diagnosis and treatment women's psychological well-being was also related to receiving informational support from the professionals. After treatments women valued peer support and spiritual support. During long-term survivorship women appreciated support from the family, especially coming from the husband.



References, country	Research objective	Participants	Design/Methods	Findings
Drageset et al. (2012), Norway	To describe women's individual experiences of social support during the time between diagnosis and surgery	21 newly diagnosed breast cancer patients; between 41-73 years old women	Qualitative, descriptive design Individual semi-structured interviews Qualitative meaning condensation analysis	It was important to have support available, if needed. Some also required emotional support by physical presence. Sometimes emotional support was perceived intrusive or "overprotective". After surgery, some needed continued support from health care professionals. For many, the amount of individualized information from the professionals felt inadequate.
Drageset et al. (2016), Norway	To describe women's individual experiences of social support during their first year after primary breast cancer surgery	10 women who had undergone breast cancer surgery 1 year before; between 48-68 years old	Qualitative descriptive design Semi-structured interviews Qualitative meaning condensation analysis	Women valued peer support from breast cancer survivors. All appreciated emotional support from family and friends. Most accepted the "normalization" of support from social network one year after surgery, others still felt in need for support. Informational support from professionals was considered adequate, but could have been more personalized. Informational support also functioned as emotional support.

References, country	Research objective	Participants	Design/Methods	Findings
Hammoudeh et al. (2017), USA/ Israel	To explore women's experiences of breast cancer in the occupied Palestinian territory	35 women at various stages of breast cancer, coming from areas in the West Bank, a few from Gaza Strip; between 25-71 years old	Inductive qualitative design Semi-structured interviews Thematic analysis	Husbands were vitally important in providing women with emotional support, whereas instrumental support was mainly provided by female relatives. Both Christian and Muslim women relied on their faith and God for spiritual support.
Jones (2015), USA	To develop an understanding of the knowledge, beliefs and attitudes of breast and breast cancer from the perspective of young women of African descent and their biological mothers	Young (between 20-40 years old) African American women with breast cancer (n=8) and their mothers (n=6)	Naturalistic qualitative research Semi-structured interviews Qualitative content analysis	Emotional support from the immediate and extended family was crucial for survival. Young women also received support from partners, friends, classmates and friends. Spiritual support in the form of spiritual healing was regarded more important than medical treatment, women also prayed and received prayers.

References, country	Research objective	Participants	Design/Methods	Findings
Yoo et al. (2010), USA	To describe the impact of breast cancer diagnosis on older, racially/ethnically diverse women and their subsequent need for social support	47 older African American, Asian American, Caucasian and Latina women; between 65-83 years old	Qualitative research Grounded theory approach In-depth interviews Grounded theory analysis with both inductive and deductive methods	Women were reluctant to accept or ask for emotional or instrumental support, but learned to receive and seek support during chemotherapy. They needed mostly tangible support and received it from their immediate family. Many women sought out spiritual support from church leaders and members. Some also obtained peer support from church members who were cancer survivors.