

The Experience of Diagnosis and Time of Chemotherapy of Women With Breast Cancer – A Meta-Aggregative Review

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ABSTRACT

Breast cancer is one of the most prevalent malignancies in women worldwide and affects all dimensions of health. The aim of this meta-aggregative review is to describe the experience of diagnosis and the subsequent period of therapy of women with breast cancer. Following a systematic literature research, ten publications were included in the meta-aggregative review and the study results were synthesized by categorization. Emotional burden, challenges, psychosocial support, and individual coping strategies were described by affected women, and disease-related information sharing and fulfilment of expectations in health professionals were experienced as unsatisfactory. There is a need for improvement in the context of information and counseling measures by health professionals.

Keywords: Breast cancer; Experience; Diagnosis; Chemotherapy; Meta-aggregative review.

BACKGROUND

The incidence of breast cancer, the most common cancer in women and the second leading cause of cancer death in women worldwide [1, 2], currently continues to increase [3, 4]. In Germany, more than 17,800 women die of cancer every year, whereby breast cancer is the most common cause of death among women [5]. In 2017, 5,417 women were diagnosed with breast cancer in Austria. This type of cancer thus represents the most common tumour disease, accounting for around 30 per cent of all carcinomas [6, 7]. In addition, about 6,500 precancerous breast lesions are diagnosed every year in Germany [8].

Breast cancer (mammary carcinoma) is a malignant originating from the glandular tissue and localised in the breast tissue [9]. Almost every tenth woman will develop breast cancer in her

lifetime [10]. The average age of women affected is between 45 and 70 years [9]. For this reason, breast cancer screening programmes with regular screening mammography have been offered with the aim of detecting changes in breast tissue as early as possible [11].

Once the diagnosis has been confirmed, it is essential to start therapy to eliminate the tumour. In addition to the surgical removal of the tumour or the complete resection of the breast, treatment with chemotherapeutic agents usually follows [12]. Chemotherapeutic agents or cytostatics are substances to which cancer cells react very sensitively because they stop normal cell division. A negative effect of the therapy measure is that even healthy cells are affected and prevented from their regular function [13]. Cytostatic drugs are mostly used for hormone receptor negative tumours [10]. These cytostatic drugs are not only known for their use in cancer treatment, but also for their numerous undesirable side effects. Common side effects are nausea, vomiting and hair loss (alopecia). In addition, chronic fatigue, chemotherapy-induced pain, loss of appetite, immune deficiency with resulting susceptibility to infections, and blood count disorders with anaemia can complicate the daily lives of those affected [14].

The diagnosis of breast cancer is a dramatic experience for those affected and often leads to depression and other mental illnesses [15]. A stable family network, friends and caregivers as well as health professionals can play a supportive role [5]. In a holistic approach to caring for those concerned, there needs to be an adequate relationship of closeness and distance between the carer and the person affected. Once a relationship of trust has been established, health professionals can learn what is helpful in coping with stressful situations from the perspective of the person affected. In addition, health professionals can expand their own knowledge and understanding of how best to provide holistic care to those affected. If they do not have essential information regarding the diversity of the experience of the diagnosis of breast cancer, nurses in particular cannot meet the holistic care and support requirements [16].

The aim of this meta-aggregative review is to summarise the described experience of diagnosis and the time of chemotherapy of women with breast cancer based on the results of qualitative individual studies.

METHODS

The meta-aggregative review was conducted according to the guidelines of the Joanna Briggs Institute [17]. Starting with a sensitive, systematic literature search, the results (findings) of qualitative primary studies were extracted, the extracted data structured by content analysis (categorising) and then subsequently aggregated in a comprehensive synthesis structure (aggregation). The aim of this process was to develop generalisable, topic-specific statements on the current object of knowledge and to subsequently provide implications for healthcare practice.

LITERATURE RESEARCH

The methodological procedure for the literature research was based on the six process steps defined by Paré and Kitsiou [18]. Figure 1 illustrates the process of the systematic literature search.

The research question (*"How do women experience the diagnosis of breast cancer and the subsequent period of chemotherapy?"*) was formulated using the PICO-Mnemonics [19]. The

literature research was conducted from May to August 2020 in the databases MEDLINE (via PubMed), CINAHL (via EBSCO host), Academic Search Elite (via EBSCO host) and The Cochrane Library. Using Boolean operators and truncation, the search terms derived from the PICO components and their synonyms including MeSH terms were logically linked in the databases. A total of 88 publications were identified after a title screening.

After removing the duplicates, in a first selection step the abstracts of the identified publications were independently assessed for eligibility by two researchers using defined inclusion and exclusion criteria. Any qualitative primary studies in German or English with a publication date between the years 2000 and 2020 were included. The study population was restricted to adult women who had been newly diagnosed with breast carcinoma and/or had undergone chemotherapy according to the defined context. After completion of the abstract screening, a total of 13 studies remained for full text analysis; a further three studies were excluded after this analysis step.

The remaining ten studies were independently assessed for quality by two people using a standardised assessment tool [20]. No further studies were excluded following this step of the process.

A predetermined extraction protocol was used to extract relevant study data. The criteria of publication year, country, study design, setting, sample, data collection and data analysis as well as the results (examples, sub- and main categories) were transferred into a matrix. Study results were analysed using MaxQDA20 analysis software [21] for inductive categorisation and aggregation of syntheses.

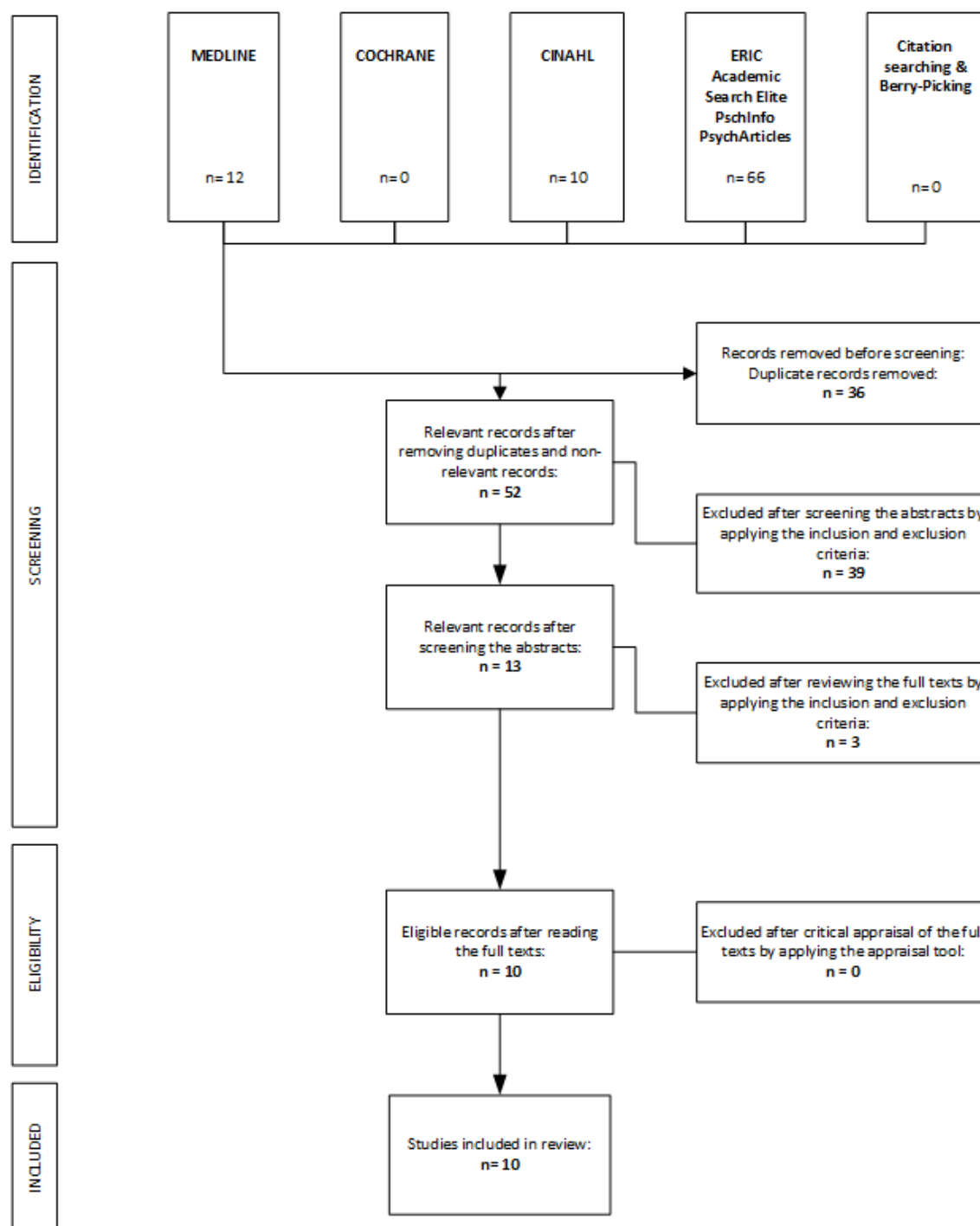


Figure 1: Presentation of the literature research (adapted from Moher, Liberati, Tetzlaff, & Altman, 2009)

RESULTS

Characteristics of the included studies

Seven studies examined populations from the European region [22–27], another study was conducted in Australia [28] and two studies in Asia [29, 30]. A total of 213 patients were interviewed about their experience of diagnosis and/or time on chemotherapy, with sample sizes ranging from seven [24] to 42 [31] study participants. A total of 222 findings (range 18;

36) were extracted from the primary studies and aggregated after inductive categorisation into the six syntheses described below. Table 1 gives an overview of the objectives, the methodological procedure and the respective main results. Figure 2 provides a graphical overview of the number of included findings in the aggregated syntheses with relation to their occurrence in the individual studies.

Emotional burden

Levesque et al [28], Nies et al [29], Lai et al [30], Hellerstedt-Börjesson et al [25], Drageset et al [26], Remmers et al [31] and Landmark et al [24] described in their studies that the women found fear and uncertainty most stressful. The first administration of cytostatic drugs as well as possible side effects caused them immense anxiety [28–30]. Most women in the study by Lai et al [30] described chemotherapy basically as "*[...] a suffering [...]*" (LAI/MC3/SC1), and they also described severe fear of a recurrence of the tumour. Fear of the future and death were among the burdens that automatically arose after diagnosis. Fear of the consequences of treatment or the loss of independence influenced the daily lives of breast cancer patients. Emotional reactions to the diagnosis were "*[...] shock, despair [...]*" (BAK/MC1/SC1, [27]), "*[...] overwhelm [...]*" (DRA/MC1, [26]) or "*[...] exhaustion [...]*" (LAW/MC3, [22]). It was striking that those patients who had not yet received chemotherapy did not want to or could not talk about their emotional situation. One study participant wanted to "*[...] fight everything alone [...]*" (LEV/MC3, [28]). Other emotional burdens included physical side effects of chemotherapy, which the women found difficult to come to terms with [24, 28–30]. For the women concerned, a world collapsed: "*[...] I felt completely alone in my own world*" (LAN/MC/SC2, [24]).

Challenges

Patients receiving cytostatic therapy found the side effects of chemotherapy to be the most challenging [22, 24, 25, 27, 28, 30]. Chemotherapy-induced pain, which fluctuated and continued for several days after chemotherapy, was "*[...] sharp as a knife cutting you [...]*" (LEV/MC1, [28]). The physical changes made this situation much more difficult, challenging them not to stop chemotherapy and not to lose faith in the cure [22, 24, 27, 29, 30]. In addition to the physical challenges, women noticed different personal character and nature changes [24, 28–30]. In some cases, they were no longer able to cope with stress and isolated themselves from society in order "*[...] not to hurt anyone [...]*" (NIE/MC2, [29]). The studies by Drageset et al [26], Remmers et al [31] and Landmark et al [24] also revealed that the women with the disease experienced social withdrawal from friends, family or neighbours, "*[...] they changed sides of the street, [...] it made me feel alone [...]*" (DRA/MC3, [26]). Another challenge was exhausting waiting times that the women experienced throughout the illness phase. From the first examination to the time of diagnosis, the discussion of the histological findings, the start of treatment to the next therapy appointment, the waiting times were almost unbearable [22, 23, 31]. The waiting times were often accompanied by a lack of continuity in treatment, which is why the women were unable to build up a stable relationship of trust with the treating team [22, 23]. Remmers et al [31] emphasised that continuous treatment by the same doctor and already known nursing staff had a positive effect on the therapy as well as on the patient.

Psychosocial support

The most important psychosocial resources for patients were family and friends, who provided them with strength, security and understanding [22–24, 26–28]. Drageset et al [26] described that breast cancer patients received comfort, respect and a sense of well-being from family,

friends, or hospital staff. At the same time, the women needed a balance between closeness and distance to their confidants to be able to deal with their new life situation in detail. If they subjectively received too much support, they felt frightened and feared that their disease prognosis would worsen. Support from professionals was essential for many women [23, 24, 26, 27, 31]. Humour and cheerfulness helped the women to feel more hopeful and affirmed them in their fight for survival. Conversations and regular doctor's appointments helped them cope better with their stresses. One participant in the study by Remmers et al [31] *"[...] felt taken seriously here at the doctor's, [...] with my questions and everything"* (REM/MC2). While many women responded positively to this kind of support, patients who had not started therapy often rejected any support [27, 28, 30].

Coping strategies

After some time, the women developed coping strategies that made it easier for them to overcome the shock and face the recovery process. They mainly strived for an active way of life to maintain their health. Housework, sports, walking the dog or other social activities contributed to physical and mental strength [22, 23, 25, 28–30]. Nies et al [29], Lai et al [30], Baker et al [27] and Remmers et al [31] showed that the women tried to cope with their situation by thinking positive thoughts. Especially towards the end of their treatment, they began to develop more plans for their own future. This strengthened their will to live and encouraged them to persevere. Additional conversations with people who were also ill were extremely helpful [23, 26, 28, 30].

Unmet professional information needs

Results of seven studies indicated that all women wanted more professional information to be able to deal with the disease and treatment in an informed way [23–27, 29]. Nies et al [29] and Lai et al [30] highlighted that women felt inadequately informed in relation to chemotherapy. Hellerstedt-Börjesson et al [25] pointed out that they had not been informed about the severity and duration of the side effects of chemotherapy, which consequently increased uncertainty: *"The uncertainty was stressful, I tensed up, which probably made it worse"* (HEL/MC2). Although the women in the study by Drageset et al [26] were informed and educated about their disease, they could hardly remember any information due to the shock in the situation of diagnosis and therefore felt inadequately informed about the impact of chemotherapy, surgery and other changes due to the disease. Patients *"[...] did not get the information they needed [...]"* (DRA/MC/SC1). Landmark et al [24] added that after the end of treatment, the patients would have liked to have more frequent discussions with health professionals in order to be able to deal with depressive moods, among other things and emphasised that the women needed not only care and compassion, but much more professional information and unvarnished information about their illness [23].

Expectations towards health professionals

Most women welcomed the provision of disease- and therapy-specific information by health professionals in oral and written form (e.g. information leaflets), as it made them feel taken seriously and cared for [23, 26, 29]. *"I want good information [...] when I need it [...]"* (DRA/MC2) emphasised one patient in Drageset et al's [26] study. Nies et al [29] and Drageset et al [26] both described the presence of oncology professionals during chemotherapy, especially during outpatient chemotherapy, as desirable in order to have health- and disease-related information directly communicated. Patients in the studies by Levesque et al [28], Hellerstedt-Börjesson et

al [25] and Drageset et al [26] particularly emphasised the importance of nurses playing an essential communication and counselling role. Furthermore, the positive influence of the implementation of individual care and prevention measures in the context of therapy is pointed out. As a prerequisite for coping with the disease, patients described good interdisciplinary communication and the provision of everyday tips for dealing with the disease [30, 31]. Many women considered discussions with a doctor and a nurse even after the end of treatment to be essential in order not to feel alone with the burden of the disease [24, 26]. Landmark et al. [24] also described the frequently expressed wish for professional support for family members in order to be able to involve them even more in coping with the disease.

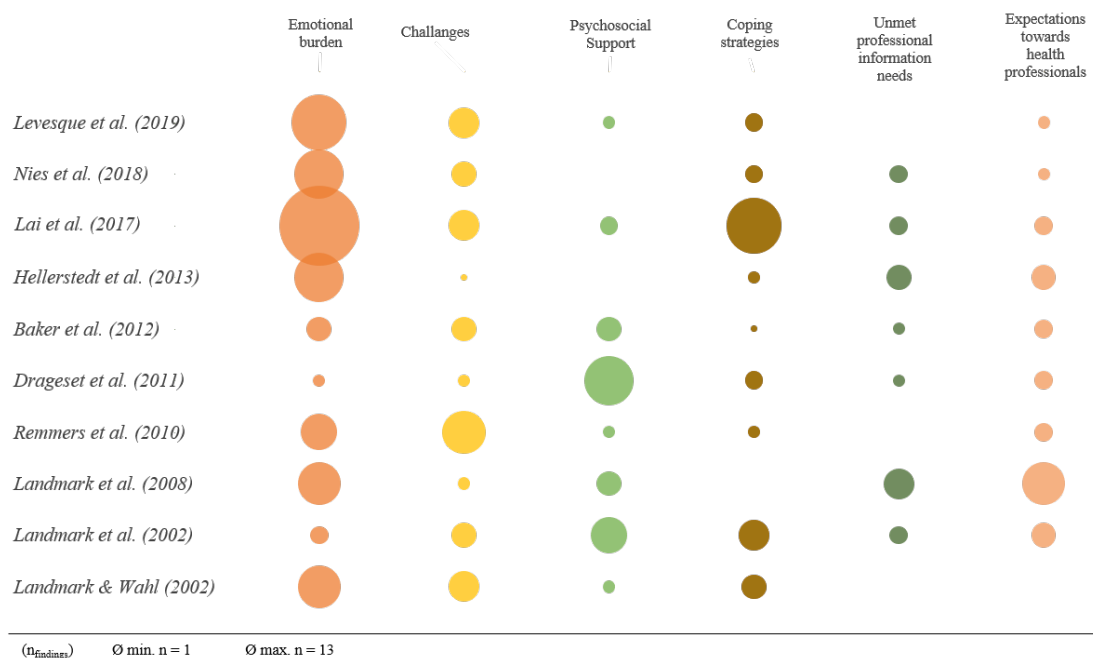


Figure 2: Number of included findings in the aggregated syntheses

Table 1: Description of the included studies

Author, Year	Aim(s)	Design, Sample	Data collection and analysis	Main results
<i>Levesque et al., 2019</i>	Experiencing Diagnosis and Coping Strategies	Qualitative- descriptive design <i>n</i> =24	Semi- structured focus group interviews Data analysis according to Braun & Clarke	LEV/MC 1: Psychological effects of the diagnosis <i>Uncertainty, fear, change of character</i> LEV/MC 2: Challenges <i>Dealing with side-effects</i> LEV/MC 3: Support and coping strategies <i>Disease management; psychosocial support; inability to talk about the disease; family as support; activities; interaction with other affected people</i> NIE/MC1: Lack of knowledge about chemotherapy <i>Lack of expertise; lack of information</i> NIE/MC 2: Symptom management <i>Emotional impairment; self-quarantine; quality of life after chemotherapy; measures to reduce suffering</i> NIE/MC 3: Health promotion after chemotherapy <i>Avoiding the risk of infection, dealing with immunodeficiency</i>
<i>Nies et al., 2018</i>	Experiencing illness and chemotherapy	Qualitative- descriptive design <i>n</i> =35	Semi- structured individual interviews Data analysis by coding and categorisation (4-phase)	LAI/MC 1: Pre-chemotherapy <i>Psychological strain; uncertainty; information seeking; information delivery;</i> LAI/MC 2: While receiving chemotherapy <i>restrictions; Impairments; Pain; Sleep problems; Fatigue; Loss of appetite; Stress; Low mood; Negative thoughts</i> LAI/MC 3: Post-chemotherapy <i>Concern; side effects; doubts about the future; plans for the future</i>
<i>Lai et al., 2017</i>	Experiencing outpatient chemotherapy	Qualitative- descriptive design <i>n</i> =10	Semi- structured individual interviews Data analysis according to Graneheim and Lundman	HEL/MC 1: Tolerable pain <i>Contrast between personal perception and expression about pain intensity</i> HEL/MC 2: Pain beyond imagination <i>Social isolation; contrast between personal perception and expression about pain intensity</i> HEL/MC 3: Paralyzing pain <i>Pain of death; fear of the future</i>
<i>Hellerstedt- Börjesson et al., 2013</i>	Experiencing chemotherapy and pain	Qualitative- descriptive design <i>n</i> =16	Semi- structured individual interviews Data analysis by coding and categorisation	BAK/MC 1: Patients undergoing chemotherapy <i>Emotional distress; emotional support; information provision</i>
<i>Baker et al., 2012</i>	Describing emotional needs after diagnosis	Qualitative- descriptive design	Semi- structured individual interviews	

Author, Year	Aim(s)	Design, Sample	Data collection and analysis	Main results
Drageset et al., 2011	Experience of social support between diagnosis and therapy	<i>n</i> =42	Data analysis by coding and categorisation	BAK/MC 2: Patients without therapy onset <i>Dealing with emotional distress; refusal to communicate; refusal to provide information</i>
				DRA/MC 1: Disposable support <i>Availability of caregivers physically and digitally; shock, overwhelm, numbness; family; support from health professionals</i>
				DRA/MC 2: Information and advice <i>Diagnosis by telephone; presence of trusted persons; lack of information; conversation possibilities with nursing staff; information from affected persons</i>
Remmers et al., 2010	Describe specific burdens and expectations on health professionals	Qualitative-descriptive design	Semi-structured individual interviews	DRA/MC 3: Trusted persons <i>Aversion; outsiders as a resource; communication with health professionals</i>
		<i>n</i> =21	Data analysis by coding and categorisation	DRA/MC 4: Balance between closeness and distance <i>Balance between support and personal space; fear enhancement due to support</i>
				REM/MC 1: Burdens <i>Anxiety due to insecurity; shock, despair; withdrawal of social caregivers</i>
Landmark et al., 2008	Describing health system-related needs after diagnosis	Qualitative-descriptive design	Semi-structured focus group interviews	REM/MC 2: Staff needs <i>Appreciation; Respect; Listening; Maintaining continuity of treatment; Interdisciplinary communication; Prompt realisation of measures</i>
		<i>n</i> =42	Data analysis by coding and categorisation	LAN/MC: Awareness of psychosocial support in terms of physical, emotional and social perspectives <i>Desire for information from professionals; chemotherapy-related physical changes; self-image, sexuality, activity and rest; emotional perspectives; emotional support; social perspectives regarding relatives and health professionals</i>
		<i>n</i> =7		
Landmark et al., 2002	Experiencing social support with newly diagnosed breast cancer	Qualitative-descriptive design	Semi-structured focus group interviews	
		Grounded Theory	Narrative individual interviews	LAB/MC: Social support <i>Interactions with loved ones; support; closeness; understanding; withdrawal, ignorance from/by friends and neighbours; interactions with organisations and health professionals;</i>
		<i>n</i> =10	Data analysis by coding, categorisation	

Author, Year	Aim(s)	Design, Sample	Data collection and analysis	Main results
Landmark & Wahl, 2002	Experiencing the immediate period after being diagnosed with breast cancer	Grounded Theory <i>n=10</i>	and contrasting	<i>conversations; information provision and gaps; treatment continuity</i> LAW/MC1: Will to live <i>Strength; Death throes</i>
			Narrative individual interviews Data analysis by coding, categorisation and contrasting	LAW/MC 2: Emotional reactions <i>Trauma; crisis; emotional imbalance; shock</i> LAW/MC 3: Physical alterations <i>Total exhaustion; misery, depression; tenseness; intensification of suffering</i> LAW/MC 4: Experiences with social support <i>Family members; talking about illness difficult; lack of professional support; lack of continuity of treatment; waiting times</i>

Abbreviations
MC_x = Main Category

DISCUSSION

The aim of this review was to describe the experience of diagnosis and the period of chemotherapy of women with breast cancer. Emotional distress with feelings of fear, uncertainty, shock and subsequent fears of the future, loss and death can be identified as a central theme in all studies [22–31]. For those with the disease, psychosocial support is important throughout the diagnosis and treatment process, with family members or friends taking a high priority. Women find just knowing that support is available helpful [22, 23, 26–28, 30, 31]. During their illness, those affected develop extensive strategies to cope appropriately with the new situation [22, 23, 25–31]. Lack of treatment continuity is described as a major challenge [22–31]. Generally, women experience a lack of information from health professionals and formulate wishes for improvement in this regard [23–27, 29]. The desire for ongoing communication opportunities with health professionals persists after treatment ends [23–26, 28, 31].

Anxiety, uncertainty and shock were experienced by the affected women in all studies. The experience of emotional distress in the context of a diagnosis of life-threatening malignant disease and subsequent therapies is consistently and largely independent of the type of malignant tumour associated with anxiety, especially in relation to loss and death [32, 33]. These feelings were perceived as particularly challenging when the start of therapy was delayed, and the associated waiting times further reduced quality of life. These challenges are in line with the study results of Neal et al [34], who also describe a reduced quality of life due to a delayed start of therapy. The worries and fears expressed by the study participants associated with the long waiting times until the start of chemotherapy are also highly relevant in that the delay in therapy is associated with increased tumour-related mortality [35].

Psychosocial support played an important role in the women's experience of the disease. Family and friends, as well as medical professionals, were essential social resources for those affected. While Yoo, Sudhakar, Nhung Le and Levine [36] showed that women with early breast cancer can better accept the disease through the support of family and friends, Leng et al [37] also describe family, friends and health professionals as the most important supportive resources. Patients who were able to rely on these people as social stabilisers considered themselves to be stronger and happier as a result [37]. However, women reported that from the time of diagnosis, some people from their family and friends significantly reduced or discontinued their social contacts with the affected person. In this context, Moore, Leung, Bates and Ho [38] show a positive correlation between the presence of a functioning social network and the probability of survival. Conversely, the mortality of those affected increases with increasing isolation. In addition to social activities, physical activity, music and conversations with other affected persons were described as strategies for coping with the disease. These activities are also identified as beneficial coping strategies in other studies [36, 37].

In general, there was a lack of information for the majority of women regarding the disease and therapy. Above all, the women demanded a comprehensive and realistic presentation of their disease situation regarding its severity and consequences. The frequently disregarded wish for the truth about the disease situation was expressed by the affected women to the health professionals. The demand for clear communication of potentially lethal diagnoses and their consequences is supported by several studies worldwide [39–41]. The experiences of those affected in the included studies make it clear that the dilemma in which health professionals find themselves regarding the avoidance of possibly unrealisable hope on the one hand and the removal of any hope of a cure on the other [42] seems to persist.

The way in which information is provided and the possibility of resorting to counselling were described as inadequate overall - both in the context of acute disease treatment and after the end of therapy. These unmet needs concern on the one hand the dialogue between affected persons and health professionals, and on the other hand the perceived insufficient inclusion of relatives in the communicative-informative process in the context of disease management and aftercare. Even if the provision of assessments for the multidimensional recording of unmet needs is considered state-of-the-art in the holistic care of cancer patients in the context of therapy [43] and follow-up care [44, 45], essential needs of those affected still remain partially unmet.

From the point of view of methodological anchoring in the qualitative paradigm, the included studies are suitable for providing a profound insight into the illness experience of women diagnosed with breast cancer, as the subjective views of those affected are at the centre of the "[...] analysis [...] of complex interpretive systems [...] [in a defined] context of action [...]"[46]. A common weakness in the studies [24–31], however, refers to the lack of specification of the chosen study design; only two studies [22, 23] explicitly disclose grounded theory as the methodological procedure and describe the study plan accordingly. Seven studies collected data using individual interviews [22, 23, 25–27, 29, 30], while three studies [24, 28, 31] collected data by interviewing focus groups. According to Krueger and Casey [47], focus groups should be purposefully sampled in order to be able to collect the occurrence of as many different views and attitudes as possible among the individual focus group members and thus to map contrasting opinions. The sample selection or the targeted, contrasting composition of

the samples in those studies that collected data by means of focus group interviews was not sufficiently described in these studies, which limits their internal validity.

The quality criteria of qualitative social research postulated by Mayring [48] were addressed heterogeneously in all included studies. The *procedure documentation* is characterised by the detailed description of the research process so that it can be verified intersubjectively [49]. These relevant methodological procedures were sufficiently cited in all included studies. With regard to *rule-guidedness*, it should be emphasised that although the applied analytical procedures were presented in a comprehensible manner, in two studies [25, 31] no reference was made to the application of a concrete coding or analysis model, whereby this quality criterion is only partially given and consequently limits the credibility of the results [50]. Strikingly often, more detailed information on the *communicative validation* of the results was omitted. Only in four studies [22–24, 27] the involvement of the participants in the step of testing the validity of the interpretatively analysed data was presented. Although the *proximity to the subject* as a further quality criterion of qualitative social research is basically given in the individual studies, since the studies take into account the interests and relevance systems of those affected [49], only the participants in the study by Baker et al [27] were able to choose for themselves where the corresponding interview should take place. The persons affected were mainly interviewed in hospital, which only corresponds to a limited extent to the everyday world orientation associated with this basic principle and could have a potential influence on the descriptions expressed by the participants.

The procedure for the aggregative review was guided by the process steps of the systematic literature review by Paré and Kitsiou [18] and the methodological guidelines of the Joanna Briggs Institute [17]. The literature research was conducted independently by two people as an iterative process, comparing the records generated at each step of the process and discussing divergent judgements regarding the eligibility of individual publications to ultimately reach a consensus decision. By taking these measures, a potential interpretation bias was reduced. As all included publications were in English and there was a risk of semantic misinterpretation during data extraction, unclear findings were submitted to an independent professional translator to avoid interpretation errors. After the literature search had been completed, the study quality was also assessed in an independent procedure carried out by two people. The general assessment tool used was basically suitable for assessing the study quality in terms of comprehensibility, credibility and applicability [20]. Nevertheless, the use of a quality assessment form specifically designed for qualitative studies might have led to a more restrictive assessment of study quality, and thus possibly lower rated studies would not have been included in this review. To avoid interpretative bias, the coding of the findings was carried out by two researchers independently of each other and the allocation to the consensually created category system was checked in terms of intercoder reliability [51].

The strength of the review is the methodical procedure for the content-analytical extraction of the findings as well as the inductive categorisation and aggregation of the data. In addition to the descriptive-narrative synthesis of the results, the added value lies in the quantified presentation of the synthesised findings. This graphical representation provides an overview of the thematic weightings within the individual studies as well as across all included studies. Thus, specific underrepresented aspects of the experience of being diagnosed with breast cancer and the time of chemotherapy can be identified and research gaps highlighted.

CONCLUSION

The results of this work underline that the diagnosis and the period of chemotherapy in women with breast cancer must be understood as a multidimensional experience of illness. In addition to the described emotional stresses and challenges and the resulting coping strategies with the need for social support, it is particularly evident that the demand for holistic care by health professionals is demanded but perceived as insufficient. Above all, the structured and comprehensive transfer of information as well as the counselling and educational tasks in the multiprofessional team are experienced as highly relevant, but at the same time as frequently inadequate. These aspects continue to offer health care research a variety of questions and research fields to contribute to high-quality care for this target group and to ensure and optimise the further development of care strategies.

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