

Review Article

Oncological Disease in Metastatic Breast Neoplasia and Palliative Care: A Review

Luísa Soares ^{1,*}, Raquel Vasconcelos ¹, Ana Lúcia Faria ²

¹ Universidade da Madeira, Departamento de Psicologia, FAH, Funchal, Portugal

² Universidade da Madeira, Departamento de Psicologia, FAH, Funchal, e NOVA Laboratory for Computer Science and Informatics, 2829-516 Lisboa, Portugal

*Correspondence: Luísa Soares (Isoares@staff.uma.pt)

Abstract: Cancer is the second cause of death worldwide, affecting one in six people, with breast cancer being the most prevalent in females. Adapting to an oncological disease entails many physical and psychological changes that affect the patient and their families. This work aims to present existing scientific research on adaptation to oncological disease and the end of life of women with metastatic cancer aged between 45 and 65, framing with Acceptance and Commitment Therapy. (TAC). Fifty documents with publication dates between 2002 and 2022 were included in this study. It was found that there is much information on the topic in question, as it is a problem that affects not only women but also all the systems they are in. When faced with a terminal diagnosis, a woman faces many doubts and uncertainties, in addition to all the physical effects of the disease. Therefore, she should be accompanied by a team specialized in Palliative Care, which can provide her and her family with all the support needed in this challenging phase.

Keywords: Metastatic Cancer; Acceptance and Commitment Therapy; Palliative Care; Adaptation to oncological disease

How to cite this paper:

Soare, L., Vasconcelos, R., & Faria, A. L. (2023). Oncological Disease in Metastatic Breast Neoplasia and Palliative Care: A Review. *World Journal of Cancer and Oncology Research*, 2(2), 122–132. Retrieved from <https://www.scipublications.com/journal/index.php/wjcor/article/view/802>

Academic Editor:

Mohamed Kotb El-Sayed

Received: October 1, 2023

Revised: October 29, 2023

Accepted: November 1, 2023

Published: November 3, 2023



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1. The Cancer

Cancer is a disease that affects how cells work, especially how they form and divide. The usual procedure in our body is to form new cells and, when necessary, eliminate old cells, but sometimes, this procedure does not work as expected. There is the formation of new cells without need and the non-elimination of old cells, which gives rise to a tumor. This tumor can be benign or malignant, and it is this that gives rise to cancer and may or may not metastasize, which is when cells like those of origin migrate and begin to grow in other organs and these are the most significant cause of death from cancer [1, 2]. Cancer affects any individual regardless of age, gender or social status and is currently the second cause of death worldwide, affecting one in every six people, equivalent to 9.6 million deaths annually [2]. In Portugal, it is also the second cause of death, corresponding to 25% of deaths that occur, with prevalence rates by gender similar to those worldwide [2, 3]. In the Autonomous Region of Madeira (RAM), Portugal, out of every 1,200 tumors diagnosed, 203 are related to breast cancer, and 26% are in stages II and IV [4]. In this region in Portugal, the prevalence for males reveals that the highest number of cases are prostate cancer, followed by lung, colon, rectal, and bladder cancer. In women, the highest incidence is in cases of breast cancer, colon, body of the uterus, rectum and Non-Hodgins Lymphoma. Based on these data, it became pertinent to address oncological adaptation in cancer with the highest incidence worldwide, breast cancer in women.

According to the [5] one-third of cancer deaths come mainly from environmental causes, namely (a) tobacco use, (b) high body mass index, (c) alcohol consumption, (d) low consumption of fruits and vegetables and (e) lack of regular physical activity.

In 2020, 2.3 million women were diagnosed with breast cancer, which corresponds to 685,000 deaths worldwide and is the type of neoplasm with the most disability-adjusted life years, mainly due to treatment sequelae, such as radiotherapy and chemotherapy, but also due to the secondary consequences of surgeries, such as (a) axillary dissection, (b) mastectomy and (c) breast reconstruction. They are also limiting and lead to patients having a higher rate of absenteeism from work and psychological sequelae, such as the feeling of loss of femininity and side effects of chemotherapy cycles, such as (a) changes in sexuality, (b) early menopause, and with it (d) infertility, (e) or reproductive problems. This type of pathology, if diagnosed early, allows 98% of cases to survive. Diagnostic or screening exams are recommended between 40 and 74 years of age through mammography (with or without tomosynthesis) and ultrasound [1, 2]. In this way, by extending the national coverage of oncological screenings for breast cancer to 77.8%, even though there is disparate coverage, for example, 100% coverage (which exceeds the recommended 90%) for RAM and 20% for the capital city in greater Lisbon, it promotes equal access to cancer treatment and allows women, regardless of where they live, to have free screening exams.

The importance of taking screening exams on time to achieve one of the goals of the national program for oncological diseases in 2020, which is to promote citizenship about cancer disease, as well as promote quality and equity of access to cancer treatment and ultimately increase the cancer survival rate [6].

Although a single cause for the emergence of breast cancer is unknown, and it is known that there is a genetic predisposition in some women, its main etiological and predisposing factors are, for the most part, environmental factors, but they can also be risk factors. , (a) the woman's age, as the older she is, the more likely she is to develop cancer; (b) genetic factors, as around 10% of cancers have a genetic origin; (c) obesity, (d) excessive consumption of alcoholic beverages, (e) very early menarche and late menopause, (f) previous medical history, if, for example, you have had cancer before, the greater the likelihood of developing new cancer, (g) the patient's family history, (h) women who did not breastfeed, and (i) nulliparity or late motherhood [2]. Cancer can be defined according to its severity in Stages, ranging from stage 0 to stage IV. It is the stage at which cancers are metastatic and may require palliative or end-of-life care [2]. Treatments carried out at this stage are not to treat the disease but to reduce cancer symptoms, improve quality of life and increase the lifespan of the individual with breast cancer. [2].

About a third of women diagnosed with cancer will develop comorbid psychopathology such as (a) generalized anxiety, (b) depression or (c) adjustment disorders [7]. With the side effects of treatments can result in physical and psychological changes that can also contribute to (a) anxiety, (b) vasomotor symptoms, (c) fatigue, (d) depression, (e) sleep disturbances and (f) general decrease in perceived quality of life [8]. Women's sexuality is also compromised during and after cancer treatments due to associated symptoms and the abovementioned issues of body dissatisfaction and self-image disturbances [9].

Patients with metastatic cancer may face, because of the disease, a progressive functional decline and diverse symptoms, which cause suffering, as well as some disability. Symptoms that may be experienced may progress over time.

The disease affects patients' quality of life and may include (a) sleep disturbances, (b) pain, (c) anxiety, (d) depressive symptoms and (e) fatigue [10, 41].

The present state of the art aims to reveal scientific research on the topic of adaptation to oncological diseases and end of life, more specifically in women with breast cancer between 45 and 65 years old. According to the [5] breast cancer is the most significant cause of death from cancer in women and the one that allocates the most resources. Also, according to Portuguese regional, national, and international data, the age group from 45 to 65 years old is in a higher risk zone for developing a disease—breast neoplasia [3, 4, 11].

According to [12], these women then belong to the so-called generation X, who (a) can be individualistic, ambitious and dependent on work, (b) value personal satisfaction, freedom and privacy, (c) appreciate the notion of hierarchy and are creative and entrepreneurial, (d) aim for a balance between personal and professional life, (e) are realistic, conservative, attached to their family and overprotective and (f) are also very active physically and psychologically. According to [13] in this late middle age phase, (a) they are more likely to develop chronic diseases such as cardiovascular diseases, strokes, depression and cancer, (b) they have control over their lives and assume multiple roles and heavy responsibilities, (c) most people are in good physical, cognitive and emotional condition and feel good about their quality of life (d) those at the end of the stage have already raised their children and therefore have a greater sense of freedom and independence. Therefore, it is a step to reevaluate objectives, desires, and time to take stock and decide what they want the rest of their lives to be. Therefore, based on these statistical data and scientific literature, this work focuses on women aged between 45 and 65.

2. Methodology

To carry out this work, we reviewed existing literature at national and international levels to search for scientific articles, theses, or other scientific material to present state-of-the-art on adaptation to oncological disease and to the end of life in women with metastatic breast cancer. In this sense, a search was carried out between the dates of 27/09/2022 and 29/11/2022 in the databases B-On, Rcamp, PubMed, Google Scholar, Semantic Scholar and Scielo, using combinations of keywords in the different languages researched, "Psycho-oncology," "Breast Cancer," "Acceptance and Commitment Therapy," "Advanced Cancer," "Palliative Care," "Spirituality," "Intervention," "End of Life," "Cancer breast disease," "sustainability," "COVID," "humor" and "oncology patient."

The research sought to focus on articles that addressed adaptation to oncological disease, risk factors and preventive measures for psychological problems arising from the disease, end-of-life care and approaches and intervention plans that may exist provided to oncological patients according to the Acceptance and Commitment Therapy.

This search was carried out with the help of the Boolean operators "AND" and "OR" and with the truncators "*" and "", obtaining 150 articles initially. Scientific articles dated less than 2002 that did not meet the topic sought after reading the abstract were considered exclusion factors. The research covered scientific articles in English, Portuguese, French, and Spanish, published since 2002, with free access and information collected from a lecture about the theme, resulting in 50 documents.

3. Theoretical framework

When a patient receives a cancer diagnosis, they initially react with shock and disbelief and then go through different coping phases such as (a) denial, (b) acceptance of reality, (c) struggle in the face of the challenge, (d) hopelessness, (e) hope and (f) depression, which some authors define as almost a mourning for a healthy body [14, 15].

Patients may experience some feelings and thoughts, such as (a) fear of death, (b) fear of the pain they may experience and (c) loss of control and fear of stigmatization [14, 15].

Any cancer brings (a) feelings of impotence and uncertainty, (b) changes in the perception of a healthy body, (c) disturbances in the usual routine (due to treatments and their side effects), (d) confrontation with the possibility of death and (e) fear of recurrence of the disease, but breast cancer also brings with it changes in the perception of body image, especially if subject to mastectomy (partial or total) and rejection of the body [14].

Women who undergo cycles of chemotherapy report having a lower perceived quality of life, especially when compared to those who undergo hormonal treatments or radiotherapy, as they may present symptoms such as (a) vaginal dryness, (b) tiredness, (c)

vomiting, (d) muscle weakness, (e) anemia, (f) transient amenorrhea, (g) intestinal changes, (h) alopecia and (i) weight fluctuations [16].

Some treatments and surgeries can also affect women in terms of (a) their body satisfaction, (b) their sexuality, (c) perceptions of self-image, (d) feelings of inferiority and repulsion towards the mutilation they experience after surgery and increased levels of anxiety and depression, especially in those who did not undergo breast reconstruction after mastectomy, which leads to concerns about their appearance and resistance to looking at their naked body, which affects their psychosocial functioning and more intimate relationships [14].

Despite all the setbacks and more negative impacts that accompany cancer, some people present what is called Post-Traumatic Growth, which is the subject's notion of the advantages that may have come with cancer as a traumatic event, such as (a) a greater appreciation for life in general, (b) better relationships with others, (c) focus on the meaning of life, (d) greater Spirituality, and (e) Spirituality with internal strength [14].

When people think about cancer and its associated treatments, they feel (a) fear (b) anxiety and (c) anguish, and this affects their life and perception of quality at an (a) physical, (b) psychological level, (c) sexual, (d) social, (e) spiritual and (f) perception of health. All this decrease in perceived quality of life affects not only the patient but also their family members [14]. Women facing metastatic breast neoplasia face challenges such as arduous treatments, side effects, a panoply of symptoms, and emotional distress [17].

Medical Care for metastatic cancer has evolved to extend patients' years of life and improve palliative Care. Despite these improvements, women facing terminal invasive breast cancer face several challenges, such as (a) dealing with uncertainty, both about their remaining life span and what they can expect from the disease over time, (b) changes in social roles (family and work), (c) loss of previous functionality, concerns about those closest to you, (d) communication difficulties with medical care providers and (e) above all fear of death and suffering [17]. It is also essential for those facing metastatic cancer to find meaning in their lives and their experiences as cancer patients. Satisfaction with life, optimizing quality of life, positive mood, and sense of purpose act as protective factors. In a shift of exclusive focus on reducing anguish and dealing with the challenging and stressful experiences of living with cancer [18, 19].

In women affected by cancer, the anguish is very high. It justifies that around 30% of patients suffer from some psychopathology, hence the need to identify possible disturbances in this area early. Factors such as (a) high pain, (b) severe fatigue, (c) high symptom load, (d) physical disability and (e) previous mental health problems may contribute to these disorders [14].

In addition to all the physical parts that are affected, the woman's psychological part is compromised, as the area affected by cancer is associated with sensuality, motherhood, and femininity. The woman has to mourn her previously healthy body and her usual reality that no longer exists in the way it existed before receiving the diagnosis, which implies a readjustment of plans and projects for the future. As protective agents, the literature considers (a) satisfaction with life, (b) making money and improving quality of life, (c) a positive mood and (d) having a sense of purpose in life [14].

[20] states that the initial emotional state of a woman when diagnosed with cancer can also influence the effect of the treatments adopted, harming or stimulating them.

When a woman adapts to chronic and terminal oncological disease, she reacts through her reorganization, reintegration or reorientation, which involves several elements, such as (a) essential cognitive reconciliation with her health and the impact of the nature of the disease and its chronicity, (b) the emotional Acceptance or internalization of being a chronic cancer patient and (c) the search for personal, interpersonal and work goals [9, 21].

A woman's psychological adaptation to cancer can happen through 3 main items: (a) the disease itself, where it is located, its stage, the inherent treatments and the trust you

have in your medical team that assists you; (b) how the person is, their personality traits, their coping strategies, their emotional state and their social support, such as family and friends and (c) the culture and society in which the woman lives [9].

There are individual differences when adapting to cancer, and this depends on factors (a) social, which refers to the social support network that the patient may have and which contributes positively to the adaptation to the disease; (b) cognitive, which influences the way with how they perceive and experience the oncological disease and which encourage the perception of a better quality of life after diagnosis and when carrying out the necessary and (c) behavioral treatments, such as frequent relaxation techniques, as well as a regulated diet and regular physical activity, which can help reduce suffering and lead to a better adaptation of the person to cancer [15].

When a person is diagnosed with cancer, they build in their mind what "having cancer" means to them, and it is this immediate meaning that influences the way they adapt to the disease [9]. Also, factors such as establishing goals and objectives for the future, the coping strategies used to reduce emotional discomfort, and their suffering help to deal with the oncological disease [9]. These strategies can be passive coping when it takes the form of anxiety, discouragement or hopelessness, or active when the patient feels motivated to fight as well as assuming cognitive avoidance postures [22]. According to [23] an essential aspect of reducing the anguish and distress of these patients and a more effective adaptation to cancer is the support they receive from their partners and extended family.

[24] state that there is a difference in how men and women adapt to cancer, with women showing less psychological adaptation to cancer and greater somatization when they start treatments.

When couples adopt escape or avoidance strategies, they adapt less to the oncological disease, resulting in anguish and suffering [15]. Taking this into account, the fact that the partner is more attentive and collaborative and allows the woman to express her feelings and fears during all stages of the disease and helps her to view her situation more optimistically and positively encourages more excellent adaptation to the disease [15].

Social and family relationships can be a source of support and well-being during the adaptation phase to cancer, but they can also be a source of conflict and tension. Patients receive much support and solidarity at the beginning of the disease. However, as the disease progresses, this support can decline, which makes the patient's perception of the disease more difficult [14].

When patients receive a terminal cancer diagnosis, they can access specialized support through palliative Care (PC). These interventions allow those suffering from a chronic or terminal illness to alleviate their suffering, alleviate the pain felt, and take Care of and Care for other physical, psychological, social, and spiritual problems without neglecting support for their families and caregivers [2].

Oncological diseases and degenerative diseases are the pathologies most supported by palliative Care in Portugal and bring with them the concept of global pain inherent to the disease. However, they also bring to light psychological elements that can amplify pain, such as fear, anxiety, cognitive deficits, or psychosocial stress [25]. Palliative Care is provided by multidisciplinary teams of Doctors, Nurses, Psychologists, and Social Workers and may include Physiotherapists, Speech Therapists, Occupational Therapists, and Spiritual and Religious counselors [25].

Palliative Care can be implemented anywhere, and there is no need for separate palliative care units for this purpose [26]. Around 100,000 people require continued palliative support, including children, young people, adults and the elderly. However, only 30% can access this type of Care [27]. Palliative Care is also called supportive Care, comfort care or symptom control and can be provided together with oncological Care. They are activated when medical treatments are no longer carried out to treat the disease. This type of Care does not treat the disease but prevents or controls the symptoms or secondary adverse effects that arise as quickly as possible [26, 27].

Palliative Care makes a difference in the patient's life (maintaining their dignity and quality of life and reducing their suffering), their families (providing medical, social, and psychological support), and also health entities (because in this way, they use emergency care fewer times). Their main objective is not to reduce the person's illness but to allow them to reduce their suffering and maintain the most significant possible dignity in the time they have left [26, 27].

[26] states that for every moment of pain and suffering demonstrated and verbalized by the patient, an infinitely more significant amount of it is invisible and unexpressed. For [27], the disease is a destabilizing element, which causes the patient to lose some of their meaning in life, leading to multidimensional suffering. The palliative care team does not intend to do charity with the patient but rather to provide them with a humanizing intervention based on technical and scientific facts to provide a new meaning to life and relief from suffering [26]. For those who work in palliative Care, it does not matter what the diagnosis or disease is; the main thing is that the patient does not feel abandoned and feels valued as a Human Being in all their dignity [27].

When a family deals with their family member's oncological disease, they become so absorbed with the treatments and all the demands inherent to the disease that they become, in a certain way, "pregnant" with the patient from the time of diagnosis they focus all their focus on resolving that situation, so that when the patient suffers, the family tends to feel lost, without objectives and given over to their pain, because people are not prepared for the negative even though they know it is inevitable [26, 27].

One of the crucial components in Palliative Care is the dimension of Spirituality. Spirituality is defined as "the set of all emotions and convictions of a non-material nature, with the assumption that there is more to living than can be fully understood, referring to issues such as the meaning and meaning of life, not limited to any specific type of religious belief or practice" [25]. It is, as defined by [26], what makes the individual feel part of the World in which they live and connected with themselves.

4. The Role of the Psychologist in Palliative Care

The role of a psychologist in palliative Care essentially focuses on three axes: (a) intervention and support of the patient and their family, (b) intervention and monitoring of the families' grieving process after the patient's death, and (c) support for health professionals who make up palliative care teams [25]. It also acts as a mediator between professionals, the patient and the patient's family. It operates in the so-called "Conspiracy of Silence," which is when families avoid talking about the disease, diagnoses or predictions about it in front of the patient, which leads to suffering in the family and creates changes in habitual dynamics, in addition to creating in the patient, a feeling of suspicion and isolation concerning their loved ones [25].

When there are young children, it can help in the way the diagnosis is communicated to them, considering their developmental and cognitive level and helping family members to deal with both anticipatory grief (which begins from the moment of terminal diagnosis and encompasses all the losses that characterize each stage of the disease), as with genuine mourning after the patient's death [25].

5. COVID-19 and palliative Care

Taking into account the pandemic situation generated due to the COVID-19 virus, many health services that provided palliative Care faced severe difficulties in being able to meet all the needs of their patients, especially those in-home Care and immunocompromised, which was a source of anguish and suffering both on the part of family members and the patients themselves as both perceived time as something limited [28]. Alternatives to in-person Care were then created using telephone means and alternatives given the impossibility of receiving visits via video calls or online platforms (e.g., Zoom) [28].

6. Sustainability point of view

The global costs of cancer place tremendous physical, emotional, and financial pressure on individuals, families, communities, and health systems, with the economic impact in the European Union alone exceeding 100 billion Euros annually [1, 5].

According to [26], investing in preventive methods saves financial resources and reduces the carbon footprint. The most significant expenditures worldwide are on oncological treatments, anxiolytics and antidepressants, so it will be more advantageous in terms of costs and ecological sustainability to invest in prevention [2].

Furthermore, many chemical compounds resulting from the sometimes-abusive prescription of remedial methods, as well as products resulting from chemotherapy and the excessive use of benzodiazepines, can be found in the waters of treatment plants and some tributary soils of these same plants, affecting the entire surrounding environment [29, 30]. [26] states that certain medical circles insist on subjecting the patient to various cycles of chemotherapy in search of a cure that does not exist; in addition to weakening the patient physically and psychologically, they contribute to the pollution of the entire surrounding ecosystem.

As mentioned by [30], preventive methods in mental health are the most advantageous approach to saving financial resources in the long term and reducing the carbon footprint in general and have shown to be quite effective in various disorders such as depression, anxiety, and first psychotic episodes. According to the Declaration on Sustainability in Mental Health [30], four principles were defined for sustainable healthcare: (1) preventing mental illnesses through the construction of social capital, promoting the well-being of the individual and the community, (2) empowering patients, medical personnel and caregivers to take Care of their mental health, (3) reducing activities that cause unnecessary waste and (4) favoring the use of alternatives low carbon consumption.

Taking into account what was mentioned in the third point, we can point out that many chemical compounds resulting from the sometimes-abusive prescription of remedial and treatment methods, such as products resulting from chemotherapy and the excessive use of benzodiazepines, can be found in the water of treatment centers and some tributary soils from these same plants affecting the entire surrounding environment [26].

7. The perspective of using Humor in cancer

End-of-life care often neglects mood, but it has been proven that it can promote the general health of patients, benefiting them on a (a) physiological, (b) psychological, (c) communicational, (d) level. Social and (e) spiritual [31, 32]. Creating moments of Humor with patients and their families can improve the perception of their quality of life and influence it on four levels: (a) fostering relationships, (b) helping to manage different circumstances, (c) favoring the expression of sensitivity and (d) promoting physiological benefits. It can also improve the relationship between patients, family members, health professionals, and the team of health technicians [32]. The fact that stressful women laugh more than men and use Humor to deal with more sensitive health situations [32] makes it something relevant to take into account when dealing with women with metastatic breast cancer.

8. Palliative Care in the Autonomous Region of Madeira, Portugal, South Europe

The Palliative Care Unit (UCP) has existed since October 1, 2012, is located at Hospital Dr. João de Almada in the capital city of Funchal and has 11 beds. It also provides home support to patients who do not have a place in these facilities or prefer to be assisted in their homes [33]. Initially, it supported 32 patients, but it currently supports 526 patients and their families, going from an initial response rate of 23% to 71% [33]. Their motto is "Caring when treating is no longer possible" and "Giving value to life and not to support life." They aim to empower the patient and their families, establishing plans for their lives

and preparing for death (one of the stages of life) naturally as if it were the closing of a stage [33].

The European Palliative Care and Hospice units follow the British model. In Japan, despite structurally following the same model, it presents some differences: (a) it allows the application of alternative therapies, (b) it favors contact with nature, and (c) it privileges the patient's decision above the medical decision [34, 35, 36].

9. Acceptance and Commitment Therapy intervention model

The Theory of Acceptance and Commitment (ACT) is a transdiagnostic therapy focusing more on the general psychological mechanisms that generate the disorder rather than the specific sets of each psychopathology [37, 38]. This therapy focuses on the function and context of psychological events rather than how they occur [37, 38]. In order to obtain Flexibility, the TAC makes use of six concepts that are interrelated and can be overlapped: (a) Acceptance, which concerns experiencing life events, their thoughts, feelings or emotions as they are without trying to control them (b) Cognitive Defusion, which refers to not identifying with negative thoughts or experiences (c) the Self as context, insofar as we perceive ourselves as being within the experience and not like the experience; (d) Being in the present moment, which refers to being aware of the experiences that life brings you today; (e) Personally significant Values, which relate to essential areas in the life of the person and (f) the Actions committed to these personal values [37, 38].

Acceptance and Commitment Therapy (ACT)'s main objective is to increase psychological Flexibility so that less positive experiences regarding thoughts, feelings and even the disease symptoms interfere less and less with valued activities. [10, 37]. This therapy guides the individual to change their expectations of eliminating pain to live as best as possible with pain [37]. The ultimate goal of TAC is not to restore full function but rather to learn to live with dysfunctionality [39]. This type of therapy aims to reduce the interference of the symptom with the individual's ideal functioning. At the same time, Cognitive-Behavioral Therapy (CBT) focuses on changing complex thoughts to reduce suffering; TAC perceives suffering and anguish as being normative and focuses on the behavioral impact of challenging thoughts [10]. It is achieved through consciously accepting the subject's internal experiences while taking actions committed to their Values. It is, therefore, suitable for cancer patients who often struggle with distress and psychological and physical barriers to valued actions. On the other hand, focusing on meaningful actions may be considered of particular importance when life span is perceived as limited [10].

Psychological Flexibility is the experience of the present moment while aligned with actions committed to significant Values [10, 37]. Through metaphors and experiential exercises, the subject learns to be oriented toward control strategies and the advantages of acceptance-oriented strategies in response to internal negative experiences such as pain and discomfort [37].

Individuals are encouraged to explore their Values and set goals consistent with those Values to improve their overall quality of life and functioning [37].

Recent research indicates that patients with metastatic breast cancer may present a more significant number of physical and psychological symptoms and that this would be associated with greater inflexibility, or the avoidance of internal experiences considered difficult [10]. One of the reasons that may justify these conclusions is related to the fact that the avoidance of thoughts and emotions of unwanted symptoms can be used as a coping mechanism to deal with symptoms associated with cancer. Likewise, attempts to avoid symptoms can have the opposite effect and exacerbate them, as patients may use inappropriate symptom control strategies, such as not seeking adequate medical Care, as well as avoiding being with their loved ones to preserve themselves, despite this being out of tune with their values [10, 40, 41].

TAC reduces the intensity and frequency of more negative thoughts and emotions and improves the behavioral attitude towards these same thoughts and emotions. It helps

the patient focus on the present, what is happening in the present moment and on the path that leads to Acceptance and personal growth even in the most disturbing and crisis moments [40]. Acceptance of reality leads to achieving a notion of herself as a sexually and functionally adequate person [40].

Psychological interventions using CAT have thus demonstrated reductions in (a) sleep disturbances, (b) depression, (c) worries, (d) general mood and (e) suffering in situations of advanced cancer [39]. Its effectiveness has also been verified in reducing (a) anxiety and dysfunctional attitudes, (b) depressive symptoms, (c) pain intensity, (d) spontaneous thoughts and (e) cognitive conflicts, and acts positively (a) on problem-solving skills, (b) logical memory and (c) resilience [40].

TAC allows the patient to focus on promoting behaviors (committed actions) congruent with their values. It allows the person to act more effectively and purposefully, even when facing more challenging situations, using mindfulness, Acceptance, and different behavioral approaches [8].

It was found that women with breast cancer have high rates of avoidance to forget the reality of having cancer, such as suppressing any aversive content related to the disease, which reduces their well-being. -being in action or behaviors not aligned with their values. The lack of actions committed to their life values and experiential avoidance are also associated with depressive symptoms [8].

Interventions using CAT and more meditative exercises are well accepted even by people with strong religious convictions in Catholicism who understand that Mindfulness practices are not associated with any ritual practiced by other religions [8].

10. Final reflection

Although much has already been done regarding screening and preventive Care, there is still a lot to be done immediately after the diagnosis is communicated to the woman, as sometimes patients do not have the necessary support from healthcare entities. It would be necessary to intervene more in monitoring this phase of personal and family crises before the patient's cancer affects the whole family.

It is essential to create more active specialized programs or interventions for patients with cancer and promote the benefits of prevention in reducing medication costs and treatments for symptoms associated with cancer. The literature also shows it is necessary to train more palliative doctors and specialized personnel to increase the reach of this Care to those who need it, as well as promote literacy about palliative Care among the general population and medical professionals.

Finally, providing the UCP with greater capacity and increasing its range of action and coverage will be essential. Palliative Care should be humanized spaces where dignity is promoted, trust is established, relationships with others are prioritized, and compassion is promoted. May they be places where human warmth is increasingly felt so that those who leave do so in the most peaceful way possible and those who stay remember them humanely.

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