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Anxiety, depression, and health-related quality of life: perspectives of cancer survivors

Ansiedade, depressão e qualidade de vida relacionada à saúde: perspectivas dos sobreviventes de câncer

Ansiedad, depresión y calidad de vida relacionada con la salud: perspectivas de sobrevivientes de cáncer

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ABSTRACT

Objective: To analyze the perception of cancer survivors about anxiety, depression and health-related quality of life. **Method:** Qualitative study, using the concept of culture as a reference. Data collection was carried out through a semi-structured interview script containing sociodemographic and clinical variables, followed by questions about quality of life, anxiety and depression. Content analysis was performed for data analysis. **Results:** Conducted with 13 cancer survivors. The categories that emerged were: Life affected by cancer and its health-related quality of life; Psychological aspects of cancer survivors: fear, anxiety and depression; and Support network in coping with diagnosis and treatment. **Final remarks:** Survivors reported not being satisfied with their health-related quality of life, since the adverse effects resulting from treatment still persist even after the end of treatment.

Descriptors: Depression; Quality of life; Neoplasms; Cancer survivors; Anxiety disorders.

RESUMO

Objetivo: Analisar a percepção dos sobreviventes de câncer acerca da ansiedade, depressão e qualidade de vida relacionada à saúde. **Método:** Estudo de abordagem qualitativa que tem como referencial o conceito de cultura. A coleta dos dados se deu por meio de roteiro de entrevista semiestruturada contendo variáveis sociodemográficas e clínicas, seguidas de perguntas sobre qualidade de vida, ansiedade e depressão; para análise dos dados, realizou-se a análise de conteúdo. **Resultados:** Realizado com 13 participantes sobreviventes de câncer. As categorias que emergiram foram: A vida afetada pelo câncer e sua qualidade de vida relacionada à saúde; Aspectos psicológicos dos sobreviventes de câncer: o medo a ansiedade e a depressão; e a Rede de apoio no enfrentamento do diagnóstico e tratamento. **Considerações finais:** Os sobreviventes relataram não estar satisfeitos com a qualidade de vida relacionada à saúde, visto que os efeitos adversos resultantes do tratamento ainda persistem, mesmo após o fim do tratamento.

Descritores: Depressão; Qualidade de vida; Neoplasias; Sobreviventes de câncer; Transtornos de ansiedade.

RESUMEN

Objetivo: Analizar la percepción de los sobrevivientes de cáncer sobre la ansiedad, la depresión y la calidad de vida relacionada con la salud. **Método:** Estudio con enfoque cualitativo, tomando como referencia el concepto de cultura. La recolección de datos se realizó a través de un guion de entrevista semiestructurada que contenía variables sociodemográficas y clínicas, seguidas de preguntas sobre calidad de vida, ansiedad y depresión. Se realizó un análisis de contenido para analizar los datos. **Resultados:** Realizado con 13 participantes sobrevivientes de cáncer. Las categorías que surgieron fueron: Vida afectada por el cáncer y calidad de vida relacionada con la salud; Aspectos psicológicos de los sobrevivientes de cáncer: miedo, ansiedad y depresión; y la Red de Apoyo en el afrontamiento del diagnóstico y tratamiento. **Consideraciones finales:** Los sobrevivientes informaron que no estaban satisfechos con su calidad de vida relacionada con la salud, ya que los efectos adversos resultantes del tratamiento aún persisten incluso después de finalizar el tratamiento.

Descriptores: Depresión; Calidad de vida; Neoplasias; Sobrevivientes del cáncer; Desórdenes de ansiedad.

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INTRODUCTION

Cancer survival has become increasingly frequent worldwide. There are an estimated 18.1 million cancer survivors in the U.S. as of January 2022, representing 5.4% of the American population, with 26 million expected by 2040. According to American statistics, 70% of cancer survivors have lived five years or more after diagnosis, and 11% have lived 25% or more after diagnosis; the rest live between 5% and 25%(1). Thus, it is noted that the population of cancer patients who had cancer and survived it has been growing exponentially, which draws attention to identifying the needs of this group. Brazil has no statistical data on how many survive the disease.

The conceptual question of being a survivor, and in the cancer survival phase, encompasses many definitions and, often, confusion, although the concepts are intertwined. In this study, the conceptual framework adopted for survival to cancer concerns how to live after receiving a cancer diagnosis and completing treatment, extending throughout life. It covers all process phases, from initial diagnosis to ongoing care and monitoring after the end of active treatment(2). This framework is dynamic and nonlinear. It allows us to understand the health needs of those who complete treatment and return to their family and social context. It improves the quality of life and ensures longevity so that the patient can live beyond cancer.

It should be noted that many cancer survivors also present other health problems, whether acute or chronic, often because of the side effects of treatments. Thus, these people are at greater risk of developing new cancers, osteoporosis, or organic dysfunctions, which require continuous and extensive monitoring to promote better quality of life (QOL) by seeking to reduce disabilities and complications and assist in restoring physical, mental, emotional, and social functions(3).

A more specific concept is highlighted in the Health Sciences: the Health-Related Quality of Life (HRQOL), also called perceived health. It represents the person's perception of their health status, considering their expectations and external influences, such as the intensity and duration of the disease, as well as the level of social and family support the patient receives (4). This concept can be translated into the understanding of health in its subjective aspect, encompassing psychological, social, and functional aspects of the well-being of individuals in the face of a disease, in addition to physical aspects(5).

It is known that receiving a cancer diagnosis implies the emergence of a series of emotional discomforts that have led survivors to present, among others, higher incidences of anxiety and depression, when compared to the general population. Tension, excessive thoughts, and worries are characteristic of the psychological state resulting from anxiety and are often associated with physical changes. Additionally, depression involves a complex interaction between physiological, emotional, and environmental factors. It can present as an affective state of anguish, decreased mood, sadness, loss of interest, persistent crying, loss of energy and pleasure, and feelings of impotence(6).

In this sense, it is common to observe remoteness in participation in social activities and difficulty in decision-making. The fear of death, the feeling of destroyed life plans, financial problems, changes in physical appearance, and anxiety contribute to a significant decline in the quality of life of these people(6). Thus, being a cancer survivor involves issues that permeate the subjectivity of the human being and include everything from elementary changes in daily life to the need to live with complications arising from both treatment, often aggressive, and the evolution of the disease. This requires these survivors to position themselves before the adversities imposed(7).

It is important to point out that the health team, especially the primary care team, is fundamental for the continuity of care for cancer survivors. This team requires little from the routine actions of the tertiary level; therefore, the person feels detached from the assistance of the specialized staff of the tertiary level. Thus, primary care must be active in receiving and implementing a therapeutic plan based mainly on listening and meeting the needs of these survivors(8).

This study aims to understand better the universe of those who survive and how they survive a serious illness that can also affect those around them. Therefore, understanding how cancer survivors live, their health needs, and associated comorbidities can improve health care and the oncology care network. Thus, it is necessary to understand the HRQOL and issues regarding the mental health of survivors to establish a situational diagnosis to elaborate follow-up strategies based on specific, individualized actions that contemplate all the nuances the survivor needs for effective coping.

Although some quantitative studies point to important data on HRQOL, this study delves into the subjectivity of this survival context. It brings elements that make up the social imaginary of this group and how it behaves in the face of cancer. We believe this study can support the implementation of a health care network that values the guiding principle of the Unified Health System of care continuity and results in effective actions to promote better QOL and the reduction of anxiety and depression in the public. Therefore, the objective was to analyze the perception of cancer survivors concerning anxiety, depression, and health-related quality of life.

METHODS

This is a qualitative exploratory-descriptive study since it allows the exploration of a set of social representations as the object of study(9). Based on the assumption that the discourses of cancer survivors are loaded with symbols, beliefs, and cultural values, we adopted the concept of culture of medical anthropology as a theoretical framework to guide the analysis of perceptions from the reports of cancer survivors(10). This framework addresses aspects of quality of life and mental health in the subjects' language, either in their intentions, explanations, or in their historicities, from their own life experiences and the diagnosis of the oncological disease, passing through the culture and disease experienced in their daily lives(10).

This study followed the precepts of the Consolidated Criteria for Reporting Qualitative Research (COREQ)(11), a tool that helps to ensure quality, accuracy, and transparency when reporting qualitative studies(11). The data was collected in January 2023 from cancer survivors living in a municipality in the Pernambuco countryside. Initially, a survey on existing cancer patients was conducted at the municipal health department.

The first contact with the patients was by telephone, to understand their clinical situation and verify if they fit the proposed inclusion criteria. Then, some eligible participants were selected and invited to participate in the research. The objectives and stages of the study were clarified. After signing the Informed Consent Form (ICF), those who agreed to participate were scheduled to conduct semi-structured interviews, audiotaped using a digital recorder to ensure data reliability. The interviews were conducted in person in a reserved place at the participants' homes to promote privacy and confidentiality of information, respecting the participants' preferences. The interviews had an average duration of 60 minutes. The answers were transcribed as soon as possible to preserve the impressions from the interview.

The inclusion criteria were patients of both genders, with any type of cancer, aged between 18 and 70 years, who had completed cancer treatments for at least one month, with or without follow-up by the tertiary level of health care. Patients who were undergoing treatment for metastases, had relapses and/or a second cancer, had cancer in childhood, and adult or elderly patients in palliative care were excluded from the study since these patients are likely to have already experienced a decline in HRQOL.

The participants representativeness criterion for closing the data collection was not numerical, but the quality of the answers due to their non-redundancy. This allowed the entire problem to be covered in its multiple dimensions. The data were collected until saturation occurred, that is, the internal logic of the object of study was identified and reflected the various dimensions of the phenomenon under investigation(12). The participants were identified by the letter P, numbered 1 to 13, to ensure their anonymity.

Data was collected in January 2023 using a semi-structured interview script as an instrument with the trigger guiding question: What is the survivors' perception of anxiety, depression, and health-related quality of life? Two instruments were used for data collection: a sociodemographic and clinical questionnaire and a semi-structured interview script. The sociodemographic and clinical questionnaire was divided into two parts: the first investigates information such as gender, age, marital status, education, number of residents in the household, income, municipality of birth, occupation, and religion, allowing an analysis of the socioeconomic context of the participants; the second part addresses clinical variables, including the type of cancer, time of diagnosis, treatments performed (surgery, chemotherapy, and radiotherapy, among others), time since completion of treatment, presence of comorbidities, and psychiatric diagnoses (stress, anxiety, and depression). The use of medication, psychotherapy, and complementary therapies is also investigated.

The semi-structured interview script deepens the patient experience and is divided into two sections. The first investigates the health-related quality of life, addressing (i) the trajectory from diagnosis to post-treatment, including initial signs and symptoms; (ii) physical, emotional, social, and spiritual impacts; (iii) perceived changes in health after the end of treatment; (iv) self-assessment of quality of life; and (v) daily routine and leisure activities after treatment. The second section focuses on evaluating signs and symptoms indicative of anxiety and depression, exploring (i) the feelings and reactions upon receiving the diagnosis; (ii) perception about anxiety; (iii) feelings of failure, discouragement, or hopelessness; (iv) emotional changes after cancer, including physical symptoms; (v) expectations about the future, fears, and concerns; (vi) perception about depression and fear of death; and (vii) support network.

Objective data related to sociodemographic and clinical variables were entered into Microsoft Excel 2013 and submitted to descriptive analysis with numerical and percentage frequencies. The subjective data were fully transcribed and submitted to the content analysis proposed by Bardin(8), broken down into three phases: pre-analysis, material exploration, and result treatment (inference and interpretation). Two researchers were involved in the analysis stage. At the first moment, after the complete transcription, the researchers conducted a first reading, and the first hypotheses were created according to Bardin. The second stage involves coding with clipping of the recording units, as perceived in the previous stage, and that was a consequence of the relevance and exhaustiveness of the process and categorizing these codes; the ideas were manually grouped according to the similarity and semantics displayed in the participant statements. Finally, the treatment stage consists of interpreting and inferring these categories.

The research was approved by the Research Ethics Committee (REC) of the Universidade Federal de Pernambuco, Vitória Academic Center, under the CAAE Opinion No. 5,833,196, and met all ethical assumptions, according to CNS Resolution No. 510/2016.

RESULTS

Thirteen participants were interviewed. Female participants predominated (84.6%) in the evaluation of sociodemographic characteristics. The age ranged from 33 to 62, and 92.3% were married. Regarding the level of education, 46.1% reported having incomplete elementary school 1; regarding income, 46.1% declared receiving up to one minimum wage; regarding occupation, 23.1% declared being retired, and 46.1% were housewives; regarding religion, 53.8% declared being Catholic, and 46.2%, Evangelical.

Chart 1 presents the clinical profile of these participants, providing information regarding the cancer and associated clinical conditions.

Chart 1 – Clinical data of the study participants, Vitória de Santo Antão/PE

Participants	Type of cancer	Treatments performed*	End of the treatments**	Associated pathologies
1	Stomach cancer	Surgery + chemotherapy	3 years	No
2	Breast cancer	Surgery + radiotherapy + medication	2 years and 11 months	Duchenne Muscular Dystrophy
3	Breast cancer	Surgery + chemotherapy + radiotherapy + medication	2 years	SAH***
4	Endometrial cancer	Surgery + chemotherapy + radiotherapy + brachytherapy	3 years	Osteoporosis, arthrosis, and fibromyalgia

Continues

Participants	Type of cancer	Treatments performed*	End of the treatments**	Associated pathologies
5	Non-Hodgkin Lymphoma	Surgery + chemotherapy	1 year	No
6	Oropharyngeal cancer	Radiotherapy	7 months	No
7	Breast cancer	Surgery + chemotherapy + radiotherapy + medication	1 year and 2 months	No
8	Breast cancer	Surgery + radiotherapy + medication	1 year and 9 months	No
9	Endometrial cancer	Surgery + chemotherapy + radiotherapy + brachytherapy	3 years and 3 months	No
10	Breast cancer	Surgery + chemotherapy + radiotherapy + medication	10 months	No
11	Breast cancer	Surgery + chemotherapy + radiotherapy + medication	5 years and 2 months	No
12	Cervical cancer	Chemotherapy + radiotherapy + brachytherapy	3 years and 9 months	SAH, gastritis, thyroid, and rectal disease
13	Breast cancer	Surgery + chemotherapy + medication	2 years and 11 months	SAH and hepatic steatosis

*Oral medication for home use specific to each treatment.
**Time of the end of treatment for January 2023, when the interview was conducted.
***SAH: Systemic Arterial Hypertension

Source: Prepared by the authors.

Chart 2 - Clinical data on the mental health of study participants, Vitória de Santo Antão/PE

Participants*	Medical diagnosis of anxiety	Medical diagnosis of depression	Psychotropic medication	Psychotherapy**
2	No	No	No	Yes
3	Yes	No	Yes	Yes
4	Yes	Yes	No	Yes
5	No	No	No	Yes
6	Yes	No	Yes	Yes
7	No	No	No	Yes
12	Yes	Yes	Yes	Yes
13	Yes	Yes	Yes	Yes

*The other participants, 1,8,9,10, and 11, answered NO for all the variables analyzed.
**Psychotherapy related to follow-up with a professional psychologist during cancer survival.

Source: Prepared by the authors.

Three categories emerged from the subjective analysis, carried out through content analysis: Life affected by cancer and health-related quality of life; psychological aspects of cancer survivors: fear, anxiety, and depression; and the support network in coping with diagnosis and treatment.

In the category "Life affected by cancer and health-related quality of life", the participants perceived that cancer and treatments are directly associated with the decline in HRQOL, evidencing the profound impact of the disease on the lives of these subjects. This impact is not limited to physical health; it also affects fundamental aspects such as identity, independence, and emotional well-being. Cancer causes a series of problems in the interaction within the social environment, manifesting itself in losses in domestic activities, daily routine, leisure time, and work. This can be exemplified by the respective statements of the participants listed below.

"I'm not that person anymore, I can't do things anymore, I can't take it anymore. Everything I do, I get tired, I feel back pain, a lot of pain in the neck area, swelling [...]. What bothers me a lot is that I was a more active person, I worked, I did my things [...] that's what bothers me the most, right? Because I was no longer healthy enough to work" (P6).

"Raising my arm, picking up the things I used to pick up, washing clothes, like that, I don't wash anymore. Lifting weight, picking up a little bucket to wash the terrace. To take a bath, I'm taking it alone. At first my head wouldn't let me, now it is [...]" (P3).

"It hit a lot because I always worked, cleaned, I worked monthly, I did laundry, so I had my money, who bankrolled my house was me, you know? When I got sick, I didn't. My life is very complicated, you understand? I can't go back to work because I feel so much pain [...]" (P4).

"It came to affect my body, today I miss not having my breast, because I sleep with that little pillow on the side to improve the position. But I have to accept myself, that for the rest of my life, I will stay like this. I feel a discomfort, I feel a heaviness, a numbness [...]" (P9).

"Not only the body itself, but the mind. It's not that it shook me to the point that I was ashamed, no, but unconsciously I was embarrassed by the fact that I was mutilated, but, like, in behavior of speaking attitudes, even in the case of my husband, at first it is embarrassing. Okay, I'm dying of shame, but you don't know that I'm ashamed, it's something I can get around, you know? [...]" (P11).

Participant 13 also said, "I was a 100% active person, you know? Everything affected me a lot, just imagining that in the old days I could do things, and now I can't anymore [...]. I can't do a good cleaning today, I can't drag the furniture anymore, when I sweep this house, I go three, four days without sweeping, because I feel a lot of pain in my arm".

The participants' statements portray the difficulties cancer has brought to their lives, with consequences and complications that are often irreversible. The interruption of activities, including household chores and being away from work, gives the survivor a feeling of uselessness, dependence, and failure in the face of the new reality.

"It didn't get better, no, it got worse [...] so I don't want to, but I also have to look from his [spouse's] side. When I have sex one time or another, it's a lot of pain; it's like I have every wound inside, I'm in a lot of pain. It's not normal, no. I have bleeding, I have already had a bowel movement through the vagina. Then, I have a lot of health problems [...]" (P4).

"After the treatment [...] I feel like I'm not the same anymore, right? So, I got a lot of pain in the face [...] I feel a dry mouth, I use artificial saliva, my mouth gets hurt. I eat more liquid, pasty, so when it's a mashed thing, no matter how soft it is, the food hurts, I feel it hurts, I didn't become a normal person as I was [...] more tired. When I walk, I feel like a tired person, a kind of weak person" (P6).

"Dizziness, I had until recently, so much so that when I came back they asked me for some tests, because they thought it was a lack of vitamins, it could be, right, an emotional factor. Numbness in the limbs, some days, I feel in the morning [...]" (P11).

"Dryness in the uterus, weakness, and all because of chemo, I was feeling pain, that's when she [doctor] started giving ointment. I think the rectum is what affected me the most, is that I feel, like, right, those very strong twinges. And there's that pain right here inside the bone, like, dragging down in the legs, leg pain, I think that's what affected me the most [...]" (P12).

"I live more tired today, after this treatment, and I got high cholesterol, I got high triglycerides, then I have to control everything, I got this fat in the liver that I didn't have, I got this low bladder, as I had told you, and I got tired and emotional, if I have a corner and you talk loudly to me I'm already shaking. I was tired, very tired, it's like an allergy, everything I get tired, it also affected my eyes, I have an allergic reaction [...]" (P13).

These statements reflect the participants' current perception of their health status, and the physical consequences reported correspond to the specific type of cancer that affected each participant. Such consequences reflect pain, mental suffering, and the feeling of weakened health, evidenced by the signs present in the body due to aggressive cancer treatments. There is a perception that they are no longer the same after the treatments end.

The statements described below portray the participants' self-perception about their QOL. They show that they are dissatisfied with the complications arising from cancer, which prevent them from living, working, and enjoying leisure time. This decline in QOL has physical, emotional, and social repercussions that directly interfere with the performance of daily activities.

"My life is not good, I would say that it was good and that it would be good if I did not feel so much pains, if the pains were not so much, because it is very uncomfortable, there are times that it is unbearable. You know what my leisure is? My leisure is every evening to spend an hour or two with my daughter-in-law on the phone" (P4).

"Life as I had, no, no more, because in the first place, I lost my health, right? I can no longer work, I no longer walk as I walked, even because of immunity, which I cannot, I feel hoarse, tired, I also do not like exposing myself too much. I can't eat everything, I have difficulty swallowing, I have difficulty chewing, I'm without the prosthesis, it's the life that we are going to lead, because we have to, right?" (P6).

"Quality of life is what I had until two years ago, I could go out, walk without limitation, and today I have to see many things. For me to leave, I have to think three times, so for this difficult period that I am experiencing, this in my physical, in my mental health, then I believe that I will not give 100%" (P7).

"I have no quality of life, because I lost my health, I see my closet with food and I can't eat, to go to the dentist I have to ask for medical permission, do you understand? This is not quality of life, we live, I don't know, by strength of will, but you arrive, you want to eat a loaf and you cannot eat a loaf, it is not quality of life [...]" (P13).

The category "Psychological aspects of cancer survivors: fear, anxiety, and depression" reflects how cancer and treatments interfere with survivors' mental health and reports the exacerbation of post-cancer anxiety. Feelings of fear due to relapses are also frequent in the statements, while the perception of interest in life and depressive symptoms end up appearing from different perspectives.

Anxiety is one of the feelings frequently reported by the participants and is manifested, in this study, through physical and emotional symptoms that did not exist before. The statements show how much anxiety has impacted on the daily lives of these survivors, in terms of the changes in sleep, to the presence of accelerated thoughts and tightness in the chest, which lead to feelings of anguish, fear, and a feeling that things are out of control, maximizing the already existing stress. The statements portray this well:

"Tremors I feel ... like this, not when I'm sitting, sleeping. It has happened... I feel palpitations, I already had, right, now it has increased even more. I feel sadness out of nowhere, agitated, I don't know... it's not normal, there are times I stay, I don't know, there are times I stay, am I going crazy?" (P3).

"I have already in some moments had panic, not strong, but afraid to be sick in traffic, you understand? Very typical of this, but then I already had the knowledge of anxiety, of having arrhythmias sleeping and waking up, I began to find out what it was, a lot accumulates that sometimes emerge, right?" (P5).

"I get shaken by anything, anxious, in that sense, so if I get stressed, if I feel anger, anything, I already feel the difference, tremors in the whole body, as if I had no strength in my arms, in my legs, I think after radiotherapy I was like that. A pain, that tightness in my chest, sometimes I feel my heart racing when something happens, I get nervous" (P6).

"I feel more anxious, and before I wasn't. Constant thinking about something that didn't happen and that you keep thinking it will, the mind doesn't stop, it doesn't stop, and it didn't even happen, and you find it hard to sleep, just imagining. Sleep goes away, the eyes become dry, these days I was even experiencing a certain arrhythmia. I didn't have it, for a few days now I'm feeling like this" (P7).

"The emotional state changes a little, changes, you cry for anything, more sensitive, or you avoid, get a little vulnerable, if I stop and I do not fill my mind, it always comes in the mind" (P8).

"I don't sleep, I get anxious, I have to take medicine to sleep, because I can't sleep, sometimes it's 2:00 in the morning and I'm awake, I was like that after the illness. Sometimes it's a very strong tightness, so, in the heart, as if a fright, a fear of something, I became like that. When I have very strong anxiety, I get that tightness inside me, that terrible fear. You know when that happens to me? When I'm in the hospital and I see those people going through everything that I went through" (P13).

The cancer survivor is surrounded by the fear of the return of the disease and must deal with this uncertainty and the fear of having to experience the treatment again.

"It's because, like, whatever appears in me, I put it in my head that it's already that, you know? A lump appeared here, so, I, my God in heaven, did I get this disease again? I get scared, you know, when any little thing appears, I already think it's cancer, for everything I've been through, I don't want to go through it all again, it's a sadness, very bad. When I do the review, I keep thinking, I only calm down when I see the exam" (P1).

"I feel afraid of everything, of everything, ready, right here on a first floor, my room is there, then I'm lying down, now I still feel, before I felt more. I have the slight impression that her building would fall, if I'm here suddenly it will explode, everything psychological, now I have to go to the market, I haven't been yet, I don't feel safe, I don't know. I feel like that, I don't feel good alone in any corner, I don't feel good" (P3).

"The fear I have of the future today, to be quite honest with you, is for my problem not to come back. I still have this fear, I still have this fear that I want to tear everything from within me, that I have already surrendered to the Lord. Once I stayed, but it's very bad, it's bad you're thinking about it, I avoid it" (P9).

"It affected because it's a kind of thing that we go through, we go through the outbreak of death, you understand? Everything in me that hurts I already think it's back, everything in me that appears I already get scared, if sometimes I have an earache, I already get scared, because it's a very sad thing [...]" (P13).

As described in the statement, any changes that appear in the body act as a trigger for feelings of fear and hopelessness, for a sense that the cancer is still there, that it persists. It is a continuous dilemma between being well and being sick. It is a complex and individual paradox that becomes more evident in routine examinations, a moment permeated by feelings and emotions similar to those experienced during diagnostic investigations and diagnosis. The traumatic event was present in the speech of P3, described by irrational fears resulting from emotional suffering during survival, evidenced by the feeling of dependence and insecurity.

The participants' statements reflect recurrent feelings of sadness and the presence of mental suffering, permeated by discouragement and the lack of strength to move forward.

"There is no interest in life, my desire, my will is to sleep and not wake up, just rest, rest" (P4).

"[...] sadness, I didn't feel like seeing anyone, because depression, the first symptom of depression is you want to isolate yourself. I didn't comb my hair, I didn't straighten myself, my husband came and went and I had hair [...] the clothes I didn't care, I didn't even want to shower, I only showered at night and didn't want to go out, didn't want to see anyone, didn't want to go to church, just wanted to lie down, do the service and lie down [...]" (P12).

"It is a deep sadness, without the will to live, a discouragement, right? [...] When I'm like this, I feel like crying, I want to be alone in the corner. I already try to move myself, you know? To go out, out of thought... what keeps me going is my kids and my husband, you know? I no longer have the strength I had before, my interest in living is small, but it is for the children" (P13).

Such a perception triggers a lack of desire for life and, in some cases, can culminate in suicidal ideation. The result often observed consists of depressive symptoms and social-emotional isolation, with a personal view that death would be the only solution.

In the category "Support network in coping with diagnosis and treatment", the absence of an effective support network is one of the points highlighted by the participants, which can be seen in the following statements:

"I thought the family would stay, but, like, right? To give you an idea, after the news, none came here, didn't come... the strangers came more... I thought I was going to have more hugs, love, kisses, you know? It's... Smooth my bald head" (P3).

"[...] alone, no one... so, what hurt the most was me seeing, me thinking that I had no one. I became disgusted, disgusted of my husband, it was for the way he reacted to everything I was going through, of not having accompanied me, there was no assistance. Nothing, I felt really bad about it because I felt alone, despised, you know?" (P4).

"[...] I felt abandoned even and I cried like a child, I cried a lot, and I thank God to this day that my husband faced it along with me [...]" (P12).

In the three reports, it is possible to perceive a weakened support network, marked by hurts, resentments, and emotional traumas due to the family's abandonment during the challenging periods of treatment. However, some of the interviewees' statements show the presence of a strengthened support network, marked by the monitoring of the entire process from diagnosis to post-treatment. Welcoming and understanding family and friends help the patient better cope with the ups and downs of treatment, providing a sense of belonging and security.

"My support network was total, everyone close, especially the family, my parents, brothers, my mother-in-law. There were many people to stay with me because I had to go, I had to have someone with me, it was always shared, it was no weight for anyone, see? [...]" (P5).

"Everyone supported me, right, so my greatest support, even I felt, like, from my husband, right? Because he lived with my family, everyone has their own homes, right, but, so, to be with myself my husband, right? Although he needed to go out to work, but, like, he was more present at all hours. Accompanying me in the treatments was my sister, my sister-in-law, and my daughter [...]" (P6).

"It was my sister and my niece, it was from her house that support came, she left her house, she came in here. My niece who is, her daughter was the one who took over everything in terms of taking to the hospital, my biggest support was her. My niece was the one who carried everything, and her mother here inside the house, doing a service, mother, granddaughter, everything inside. Because they made themselves available to come here to help me, my biggest support was my sister [...] (P8).

Religion and faith have proven to be a powerful form of support for patients, playing a key role in coping with cancer, providing comfort, hope, and emotional strength during treatment, and helping to cope with the challenges that arise along the journey of fighting the disease.

"About religion, if I was already close, I think now it has increased even more. Every afternoon at 15:00 there is the rosary of mercy, I was very inspired, knelt, took the rosary, everyday [...]" (P3).

"God knows my need and God knows everything I've done in my life, and he won't let me stay that way, I'm sure of that, you understand? So I'm not afraid, a cancer for me, if I see a cancer for me is normal, I will treat it, if I have a chance of treatment, I will treat it. And also if the doctor says that, there is none, go home and wait, I will wait on God [...]" (P4).

"Look, I grasp prayer a lot, we will die one day, but I praise and glorify my God because I will die of something else, I tell people what God has done in my life [...]" (P8).

"The positive side you win. I tell you one thing, I won, I'm winning, I didn't let myself look at the negative things, the negative things I let fall down the drain. I said: Jesus, I know you are with me, because the life of the human being is a passage here on earth, everyone knows that one day they will go, now there are certain things that happen in life that come that we do not expect, right? But I'm here to say that Jesus takes care of us [...]" (P9).

DISCUSSION

Health and disease are intertwined when studying depression, anxiety, and quality of life in the oncological context. Social and cultural aspects and values are very intrinsic to each individual. Therefore, the entire itinerary throughout the survival process is rich in adaptations, beliefs, fears, new beginnings, customs, and challenges to deal with the most diverse experiences. Thus, the results presented in this study show that cancer survival is linked to transformations of various natures, whether physical, such as pain, fatigue, dizziness, which are limiting and can impact the daily routine, or the perception regarding one's own life.

The bodily, socio-emotional, professional, family, and economic changes resulting from surviving cancer can often generate fear, uncertainty, and insecurity, aggravating existing psychological problems or triggering conditions such as anxiety and depression, and reducing QOL(13). In addition, the sociocultural context, lifestyle, and health resources offered to these survivors, as well as the presence or absence of an effective support network and their beliefs and values, will influence how the individual and family members resignify life and react to the changes imposed by the disease, treatments, and complications arising in the short and long term(13,14).

We must respect specificities and individuality, as well as the environment in which each one is inserted, when investigating anxiety, depression, and the QoL of cancer survivors. The subjectivities described by the participants should not be considered in isolation since culture includes values, symbols, standards, and practices. Thus, the meanings attributed to the way of seeing oneself, facing difficulties and fears, and self-reflection regarding the quality of life are personal and have a cultural impact. In this perspective, culture is a socially constructed network of meanings. These meanings are multiple and differ according to the context in which they occur(10).

Given the above and considering the perception and subjectivity of each participant and how they see themselves, we noticed that the cancer survivors participating in this study perceive life with low quality and report that it is difficult and even unbearable to live in this way. In a systematic review and meta-analysis conducted in 2021(15), six studies have shown that women followed for over 1 to 10 years after cancer diagnosis or surgical treatment had, on average, lower performance in the physical, cognitive, social, and emotional domains, as well as a lower sense of well-being. In addition, they reported higher levels of pain compared to the reference groups, evidencing prolonged impacts on the quality of life of these patients(15).

Thus, the survivor must receive care from a multiprofessional team that accompanies the patient fully, considering all the impact the disease triggers in daily life and the repercussions on HRQOL. Additionally, the multidisciplinary team must maintain a link of information and care after the end of treatment, after the return of this patient to the social context, given that this moment is the most neglected by the health care service and network(16).

Therefore, the care of cancer survivors should include a thorough and attentive investigation by health professionals concerning the physical and socio-emotional limitations they may present. Only thus is it possible to implement health actions forcefully and integrally to allow, from physical to psychological and educational interventions, that will allow the self-management of physical and socio-emotional symptoms, reflecting a recovery and a reconstruction/resignification of life(17).

In the second category, fear was evidenced as a very lively feeling among the survivors of the disease. It was possible to apprehend that any bodily alteration, death of treatment partners, or any other situation that made them recall all the suffering experienced, caused the feeling to return(7; 18). Fear is highlighted as subjective, personally and culturally, a social construct of common sense(10). Thus, despite subjectivity, the future is perceived as uncertain, in which plans and dreams are lost. This triggers unpleasant, anxious, and adverse thought processes, which directly interfere with concentration, sleep, social functioning, and decision-making, and can culminate in what they fear most, which is the recurrence of cancer, disability, and death, becoming a vicious cycle(18).

This study showed that anxiety is present in the lives of the survivors, emerging, in their perception, soon after cancer diagnosis, outlining the entire treatment and life with the disease. Survivors reported the most heightened anxiety after the end of oncological treatments. Physical symptoms attributed to anxiety, such as insomnia, tachycardia, fatigue, digestive problems, agitation, sweating, tremors, muscle tensions, change in appetite, loss of energy and weight, excessive worries, reduced immunity, and feelings of pessimism and impotence are also corroborated in another study(19).

It denotes the importance of psychotherapy as professional psychological support to survivors, among other non-pharmacological strategies(13), as well as Acceptance and Commitment Therapy, seen as an important approach that presents integral intervention, allowing the patient to accept their feelings, uncomfortable sensations, and thoughts, and promoting psychological flexibility, allowing the patient to develop adaptive coping strategies, assigning values to existence, and resignifying this phase of their life(20).

Disinterest in life, deep sadness, and loss of the will to live, as well as hopelessness, lack of motivation, sadness, and suicidal behavior, are the primary symptoms of depression. Some participants have reported that these symptoms, besides aggravating their professional activities, family relationships, and social coexistence, are compromised by such symptoms(21). Cancer patients with decreased QOL tend to develop more depressive symptoms, even if they do not appear so (22). The health service must be prepared to recognize these needs and meet the patients' demands. It is reinforced that the multidimensionality of care is not restricted only to physical care, but also to psychological and emotional specificities presented by cancer survivors, which can be ascertained through care guided by sensitivity, empathy, and humanization of a service that recognizes the imminent need for care, even after the end of treatment(23).

Finally, the third category reinforces the fragility of the support network, which seems to contribute significantly to changes in the psychological domain and consequent reduction in perception of HRQOL, since the participants reported feeling alone, abandoned, with limitations and traumas, without the support of those they needed, which is the family. In contrast, the interviewees who had an effective support network throughout coping with cancer report that the strength and desire to live are greater and come from the structured support of the family, which transmits the message that the survivor is a loved person and allows space for attentive listening, reverberating positively in the increase of hope and in how they resignify and face life(24). Thus, the family-centered support network can directly influence the perception regarding the HRQOL of cancer survivors, highlighting that our values and beliefs socially are based on the family construct and that its support and presence are enriching for those who receive it(10).

Social support offered by the family is defined as the emotional, physical, and material support of people who have contact with the patient. This support generates positive effects, as patients feel stronger to face the treatment and the disease without being discouraged, going through the disease and treatments with less trauma(25). Faith and spirituality are crucial elements for hope for healing, and the divine presence, as reported by the interviewed survivors, reinforces the feeling of protection and security. Thus, we note that the disease generates suffering and insecurities about the future, as well as pain for the patients and their families.

The relevance of the present study is to understand, from the survivors' perspectives, the physical and psychological impacts triggered by the disease and how it impacts HRQOL during the continuum of cancer that remains neglected by the health network. In common sense, if the treatment has been completed, everything is fine, and the patient can have a normal life. However, as this study has shown, survivors continue to have unresolved needs and require support from a team prepared to assist them(16).

In this context of a multidisciplinary team, nursing actively acts in the therapeutic path of the cancer patient, experiencing problems with him, from the discovery of cancer to survival or palliative care, building a bond with the patient and his family and being responsible for solving various situations involving care inside and outside the hospital(22).

This study is limited by other factors external to cancer, such as stressful life events, which can strongly interfere with the appearance of depressive and/or anxiety symptoms. Therefore, the findings of this study may be related to factors not investigated here. Thus, we suggest that further studies be directed to the relationship between cancer and mental health so that all related aspects can be wholly ascertained.

FINAL REMARKS

Based on the findings, an interrelation between the three categories analyzed is observed. Participants who reported impairments in physical health also described some degree of impact on mental health, including stress, emotional instability, increased anxiety, and, in some cases, depression symptoms. The support network proved essential to minimizing the impacts of these symptoms, providing emotional support, security, and encouragement for continuing treatment. The support offered by family and friends and the relationship with faith and spirituality helped patients cope better with emotional challenges, reducing feelings of fear and loneliness.

On the other hand, patients who did not have a structured support network reported a more solitary experience, marked by intensified feelings of loneliness and insecurity and greater difficulty in facing treatment challenges. These findings reinforce the importance of the support network as a fundamental pillar for the mental health and well-being of cancer patients, highlighting the need for strategies that expand support to those who face the disease alone.

This study contributed to fostering scientific knowledge concerning cancer survivors. It draws attention to the needs of this group and strengthens the importance of adequate and individualized care executed by a multidisciplinary team led by a nurse who is directly connected to the patient, who can manage the care, and who can create personalized care plans for this audience.

REFERENCES

1. Tonorezos E, Devasia T, Mariotto AB, Mollica MA, Gallicchio L, Green P, Doose M, Brick R, Streck B, Reed C, de Moor JS. Prevalence of cancer survivors in the United States. J Natl Cancer Inst. 1 nov. 2024;116(11):1784-1790. DOI: 10.1093/jnci/djae135. PMID: 39002121; PMCID: PMC11542986.
2. Neris RR, Nascimento LC. Childhood cancer survival: emerging reflections on pediatric oncology nursing. Rev Esc Enferm USP. 2021;55:e03761. Disponível em: https://doi.org/10.1590/S1980-220X2020041803761.
3. Urquhart R, Cordoba W, Bender J, Cuthbert C, Easley J, Howell D, et al. Risk stratification and cancer follow-up: towards more personalized post-treatment care in Canada. Curr Oncol. 3 maio 2022;29(5):3215-3223. DOI: 10.3390/curroncol29050261.
4. Alencar NES, Silva GRF, Gouveia MTO e Silva ARV. Fatores associados à qualidade de vida relacionada à saúde de adolescentes. Acta Paulista de Enfermagem. 2022;35;eAPE0189345.
5. Ruidiaz-Gómez KS, Cacante-Caballero JV. Desenvolvimento histórico do conceito de Qualidade de Vida: uma revisão da literatura. Revista Ciencia y cuidado. 2021;18(3):86-99.
6. Martins BG, Silva WR, Maroco J, Campos JADB. Escala de Depressão, Ansiedade e Estresse: propriedades psicométricas e prevalência das afetividades. J bras psiquiatr [Internet]. 2019;(68)32-41.

Disponível em: https://www.scielo.br/j/jbpsiq/a/SZ4xmWDdkxwzPbSYJfdyV5c/?lang=pt.

7. Alvarez KCP, Sales CA. Existential phenomenological view of health care experiences from the perspective of cancer survivors. Rev bras enferm. jul. 2020;73(Suppl 6):e20190811. DOI: 10.1590/0034-7167-2019-0811.

8. Friestino JK, Corrêa CR, Souza AI, Fonsêca GS, Geremia AC, Moreira Filho DC. Qualificação profissional e o câncer infantojuvenil na atenção básica. Acta Paul Enferm [Internet]. 2022;35:eAPE02771. DOI: 10.37689/acta-ape/2022AO02771.

9. Abad A, Abad TM. Análise de conteúdo na pesquisa qualitativa. Alternativas cubanas en Psicología [Internet]. 2022;10(28). Disponível em: https://acupsi.org/analise-de-conteudo-na-pesquisa-qualitativa/.

10. Langdon EJ, Wiik, FB. Antropologia, saúde e doença: uma introdução ao conceito de cultura aplicado às ciências da saúde. Rev latinoam enferm [Interne]. 2010;18(3):459-466. DOI: 10.1590/S0104-11692010000300023.

11. Tong A, Sainsbury P, Craig J. Consolidated Criteria for Reporting Qualitative Research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349-57. DOI: 10.1093/intqhc/mzm042.

12. Minayo, M. C. de S. (2017). Amostragem e saturação em pesquisa qualitativa: consensos e controvérsias. Revista Pesquisa Qualitativa [Internet]. 5(7):1-12. Disponível em: https://editora.sepq.org.br/rpq/article/view/82.

13. Sun M, Liu C, Lu Y, Zhu F, Li H, Lu Q. Effects of physical activity on quality of life, anxiety and depression in breast cancer survivors: a systematic review and meta-analysis. Asian Nurs Res (Korean Soc Nurs Sci). Dez. 2023;17(5):276-285. DOI: 10.1016/j.anr.2023.11.001. Epub 2023 Nov 7. PMID: 37944798.

14. Stein JS, Moreira MC. Perspectivas do cônjuge sobre a doença oncológica do(a) parceiro(a): do trauma à possibilidade de ressignificação. Pensando famílias [Internet]. 2021 [citado em 27 mar. 2025];25(2):48-64. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1679-494X2021000200005&lng=pt&tlng=pt.

14. Moshina N, Falk RS, Hofvind S. Long-term quality of life among breast cancer survivors eligible for screening at diagnosis: a systematic review and meta-analysis. Public Health. Out. 2021; 199:65-76. PubMed; PMID: 34560477. DOI: 10.1016/j.puhe.2021.08.008.

15. Garcia-VIvar C. The use and misuse of the concept of cancer survivor. Cancer Nurs [Internet]. Nov-dez. 2022;45(6):419-420. Disponível em: https://doi.org/10.1097/NCC.0000000000001167.

16. Siwik CJ, Jhaveri K, Cohen JA, Barulich M, Chang A, Levin AO, Goyal NG, Melisko M, Chesney MA, Shumay D. Survivorship wellness: a multidisciplinary group program for cancer survivors. Support Care Cancer. 26 oct. 2023;31(12):655. Doi: 10.1007/s00520-023-08117-3. PMID: 37882860; PMCID: PMC10602945.

17. Collodel-Benetti I, Oliveira WF. Consequências negativas de adoecer e sobreviver ao osteossarcoma no cotidiano de adultos jovens: uma revisão narrativa. Psicol Conoc Soc. 2020;10(3):135-150. DOI: 10.26864/pcs.v10.n3.9.

18. Zang, Lu, Cheng C, Zhou Y, Liu X. Music therapy effect on anxiety reduction

among patients with cancer: a meta-analysis. Front Psychol. 2023;(13):1028934. DOI: 10.3389/fpsyg.2022.1028934.

19. Barba, DMM. A terapia de aceitação e compromisso no manejo dos transtornos psicológicos de pacientes com câncer. Brazilian Journal of Health Review. 2023;6(3):12347-12368. DOI: 10.34119/bjhrv6n3-309.

20. Amorim JN, Cavalcante LA, Rodrigues KC, Pucci SHM. Ideação suicida em pacientes oncológicos. Revista Ibero-Americana de Humanidades, Ciências e Educação. 2022;8(7):978-998. DOI: 10.51891/rease.v8i7.6388.

21. Beserra JHGN, Aguiar RS. Sentimentos vivenciados pela equipe de enfermagem perante o tratamento de pacientes com câncer: revisão integrativa. Revisa [Internet]. Mar. 2020. [citado em 17 maio 2023];9(1):144-155. Disponível em: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-1051392.

22. Rodrigues RL, Schneider F, Kalinke LP, Kempfer SS, Backes VMS. Clinical outcomes of patient navigation performed by nurses in the oncology setting: an integrative review. Rev Bras enferm. 2021;74(2):e20190804. DOI: 10.1590/0034-7167-2019-0804.

23. Campos SO, Scorsolini-Comin F. Coping e redes de apoio de casais sobreviventes ao câncer cervical. Contextos Clín. 2020;13(3):873-895. DOI: 10.4013/ctc.2020.133.08.

24. Oliveira, MR, Mattias RS, Lemos ID, Pinto KRTF, Gomes GNCC, Cestari MEW. A família diante do diagnóstico de câncer de mama sob o olhar da mulher. Rev Pesqui [Internet]. 2018; 932-935. Disponível em: https://seer.unirio.br/index.php/cuidadofundamental/article/view/6267/pdf.

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