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PERFIL SOCIOECONÔMICO, DEMOGRÁFICO E INDICATIVO DE DEPRESSÃO EM MULHERES SUBMETIDAS À MASTECTOMIA NO PÓS-OPERATÓRIO TARDIO

SOCIOECONOMIC, DEMOGRAPHIC PROFILE AND INDICATIVE OF DEPRESSION IN WOMEN UNDERGOING MASTECTOMY IN THE LATE POSTOPERATIVE PERIOD

PERFIL SOCIECONÓMICO, DEMOGRÁFICO Y INDICATIVO DE LA DEPRESIÓN EM LAS MUJERES SOMETIDAS A MASTECTOMÍA EM EL POSTOPERATORIO TARDÍO

Jaciara Tiago Antunes Alvarenga[1], Nayara Paula Fernandes Martins Molina[2], Grazielle Riceto Dias Silva[3], Lilane Maria Alves Silva[4], Leiner Resende Rodrigues[5]

ABSTRACT

Objective: to describe the socioeconomic and demographic characteristics and evaluate the indicative of depression in 30 women undergoing mastectomy in late postoperative period. **Method**: quantitative and cross-sectional survey conducted at the Clinical Hospital of the Federal University of Triângulo Mineiro, Uberaba – MG. The Beck Depression Inventory was used; and for the general characterization, an instrument was developed by the authors. **Results**: the mean age was 63.4 years; most widows; with schooling between 1 to 4 years; two sons; family composition of 2 and 3 persons; residents in their own home; Catholic religion; most part retired or pensioner; 01 minimum wage income. As for the health variables: no history of mental illness; no psychological treatment; with no difficulty to perform household chores; no breast reconstruction. The average of Beck Depression Inventory was 15.3±11.04 points. **Conclusion**: the study contributed to elucidate the sociodemographic and health characteristics of women undergoing mastectomy in late postoperative period.

Descriptors: Mental health; Depression; Nursing; Mastectomy; Postoperative Period.

RESUMO

Objetivo: descrever as características socioeconômicas e demográficas e avaliar o indicativo de depressão em 30 mulheres mastectomizadas no pós-operatório tardio. **Método**: pesquisa quantitativa e transversal, realizada no Hospital de Clínicas da Universidade Federal do Triângulo Mineiro, Uberaba – MG. Utilizou-se o Inventário de Depressão de Beck; e para a

[1] Enfermeira pela UFTM. E-mail: jaciera_@hotmail.com
[2] Enfermeira. Doutora em Atenção à Saúde. UFTM. E-mail: nayara.pfmartins@gmail.com
[3] Enfermeira. Mestre em Atenção à Saúde pela UFTM. E-mail: graziellerd@yahoo.com.br
[4] Enfermeira. Mestre em Atenção à Saúde pela UFTM. E-mail: graziellerd@yahoo.com.br
[5] Enfermeira. Doutora em Enfermagem Psiquiátrica. Professora Associada do Departamento de Enfermagem em Educação e Saúde Comunitária do Curso de Graduação em Enfermagem. Universidade Federal do Triângulo Mineiro (UFTM). E-mail: leiner.r.rodrigues@gmail.com

caracterização geral, instrumento elaborado pelas autoras. **Resultados**: a média de idade foi 63,4 anos; maioria viúvas; escolaridade entre 1 a 4 anos; dois filhos; composição familiar de 2 e 3 pessoas; residentes em casa própria; religião católica; maior parte aposentada ou pensionista; e renda de 01 salário mínimo. Quanto às variáveis de saúde: sem antecedente de doença mental; não realização de acompanhamento psicológico; sem dificuldade para executar tarefas domésticas; sem reconstrução da mama. A média no Inventário de Depressão de Beck foi 15,3±11,04 pontos. **Conclusão**: destaca-se a importância do acompanhamento dessas mulheres por meio de um cuidado holístico, individualizado e humanizado.
Descritores: Saúde mental; Depressão; Enfermagem; Mastectomia; Período Pós-Operatório.

RESUMEN
Objetivo: describir las características socioeconómicas y demográficas, y evaluar lo indicativo de la depresión en 30 mujeres mastectomizadas en el postoperatorio tardío. **Método**: estudio cuantitativo y transversal realizado en el Hospital Clínico de la Universidad Federal de Triángulo Mineiro, Uberaba - MG. Se utilizó el Inventario de Depresión de Beck y para la caracterización general, un instrumento desarrollado por los autores. **Resultados**: la edad media fue de 63,4 años; la mayoría de las viudas; la escolarización entre 1 a 4 años; dos hijos; la composición familiar de 2 y 3 personas; residentes en su propia casa; la religión católica; su mayor parte se retiró o pensionado; y 01 ingreso de salario mínimo. En cuanto a las variables de salud: sin antecedentes de enfermedad mental; sin tratamiento psicológico; sin dificultad para realizar las tareas del hogar; sin reconstrucción de mama. La puntuación media en Inventario de Depresión de Beck fue de 15,3 ± 11,04 puntos**. Conclusión**: el estudio contribuyó a dilucidar las características sociodemográficas y de salud de las mujeres sometidas a mastectomía en el postoperatorio tardio.
Descriptores: Salud mental; Depresión; Enfermería; Mastectomía; Postoperatorio.

INTRODUCTION

Mastectomy is a surgical procedure used to treat breast cancer, which is the type of malignancy that most affects women, with the exception of non-melanoma skin cancer. It consists of the removal of the breast or mammary gland, skin and nipple-papillary complex and may be associated with axillary dissection and removal of the pectoral muscles.[1]

As a result of tissue removal, women in late operative phase, as well as in the immediate postoperative period, may have pain, limited range of motion and lymphedema.[2] However, in the late phase, the difficulties are more related with self-care, productivity and leisure (this includes having low or average self-esteem)[3] and impaired routine (keep home, drive a car, write and type, use public transportation, doing laundry, go shopping, cooking, maintain sexual activity, having family

outings, participate in social activities, physical activity and perform craft activities).[4] In addition, there is often need for change of function or the type of productive activity and decreased income.[4]

As it is a mutilating treatment, mastectomy is responsible for causing in women a negative perception regarding their body image, what causes problems regarding the sexual function and commitment of their symbolic representation - femininity and motherhood.[5] These modifications and alterations in the sense of self-esteem and feminine feeling can increase the incidence of depressive symptoms.[6] Depressive symptoms affects up to 25% of women who undergo mastectomy.[7]

The World Health Organization[8] considers depression a serious public health problem and estimates that 151 million people are victims of it. Just as all the stages that the woman undergoes, since the diagnosis of breast cancer, the postoperative period also generates strong emotional impact and brings the need for coping and adapting to the new situation and assimilation of losses, as with surgery woman is at greater risk of developing depressive symptoms.[9] Through this scenario of possible emotional fragility, and also the reduced attention given to women in the late stages of mastectomy, compared with the immediate postoperative period, it is appropriate to carry out this study.

Given the above, the objectives of this study were to describe the socioeconomic and demographic characteristics of women with mastectomies in the late postoperative period and evaluate the presence of indicative of depression in these women.

METHOD

This is a quantitative, descriptive and cross-sectional research, carried out with women undergoing mastectomy surgery, in the period from 1 January 2000 to 31 December 2012, stipulated period taking into account the need of the population to adjust to the late postoperative period (from six months), at the Clinical Hospital of the Federal University of Triângulo Mineiro, Uberaba - MG. They were included. The sample of 67 women was calculated with 95% confidence level, in a population of 80 women undergoing mastectomy, who were in the late postoperative period. These

figures were collected from medical records of the Clinical Hospital mentioned above, with the sample being selected randomly.

The instrument used was developed by the researchers themselves, which was concerned with the socioeconomic, demographic and health issues in general (history of mental illness, conducting psychological counseling and breast reconstruction).

To evaluate the indicative of depression, the Beck Depression Inventory[10] was used, which is an instrument that aims to track the presence of depressive symptoms in individuals of a study. It has 21 questions that assess and classify depressive attitudes and symptoms that reflect the present state of the subject. Feelings such as sadness, suicidal thoughts, pessimism, self-deprecation, self-accusation, failure, guilt, loss of self-satisfaction, irritability, punishment, episodes of crying, indecision, social isolation, inhibition to work and distorted body image. The total score ranges from 0 to 63 points.

Data were collected through interviews at the residence of the women selected, in the period from May to October 2015, by researchers (*stricto sensu* undergraduates and graduates from health care area) previously trained. The scheduling of the interviews was conducted through telephone contact, in order to arrange the best day and time for it. Subsequently, the interviews were evaluated by the field supervisor (responsible teacher) regarding the filling and consistency of the items to guarantee its quality control.

The losses considered were: 11 deceased, 21 who moved from the city of Uberaba (MG), 13 who were not found after three attempts and 5 who refused to participate in the survey, coming to a final sample of 30 women.

Statistical analysis was performed using the percentage and distribution of absolute frequencies for categorical variables and mean and standard deviation for numerical variables, using the application *SPSS "Statistical Package for Social Sciences" 17.0.*

The project was approved by the Research Ethics Committee of the Federal University of Triângulo Mineiro, under number 698.178, and the interview was only initiated after approval and signing of the Free and Informed Consent Form.

RESULTS

From the women interviewed, the average age was 63.4±8.98, with a minimum of 50 and maximum of 85 years. The average time of performing mastectomy surgery was 8.3 years. The highest percentage reported they were widows (40%), having education between 1-4 years (43.3%), having two children (40%), family group composition of 2 (30.0%) and 3 (30.0%) people, and bing Catholic (63.3%), as shown in Table 1.

Table 1 - Distribution of frequencies of the sociodemographic characteristics of women in the late postoperative mastectomy, Uberaba - MG, 2015.

Variables	N	%
Marital Status		
Single	02	6.7
Married	10	33,3
Widow	12	40.0
Divorced	05	16.7
Stabel union	01	3.3
Education (years of study)		
No education	01	3.3
1 to 4	13	43.3
5 to 9	08	26.7
10 to 12	06	20.0
13 years or over	02	6.7
Number of children		
None	1	3.3
01	02	6.7
02	12	40.0
03	06	20.0
04 or more	09	30,0
Composition of family group		
01	05	16.7
02	09	30.0
03	09	30.0
04	04	13.3
05	03	10.0
Religion		
Catholic	19	63.3
Spiritist	04	13.3
Jehovah's Witness	01	3.3
Evangelical	06	20.0

Most women do not have any remunerated activity, they only did it before mastectomy surgery (56.7%), and

among those who have remunerated activity (16.7%), the majority (60%) have weekly workload of 20 to 40 hours. Regarding the participation in the economic life of the family group, the highest percentage of these women does not work, is retired/pensioner and helps with family (46.7%). Most women with mastectomies in the late phase has gross income of 01 minimum wage (73.3%) and the type of housing is predominantly is their own home (83.3%).

The highest percentage had no history of mental illness (70.0%), has not had any psycological counseling before or after breast cancer (43.3%), Table 2. However, among those who said they underwent psychological counseling, the highest percentage (36.7%) reported having done it after the surgery, following those who had therapy after discovering cancer (16.7%), with only 3.3% referring therapeutic treatment before discovering breast cancer.

It is noteworthy that women maintained household chores just as before mastectomy surgery (90.0%), did not show any degree of difficulty with household tasks (40.0%) and did not undergo breast reconstruction (73.3%), according to data in Table 2.

Table 2 - Distribution of frequencies of aspects related to mental health and performing of household tasks of women in the late postoperative mastectomy, Uberaba - MG, 2015.

Variables	N	%
History of mental ilness		
No	21	70
Yes	09	30
Psycologial counseling		
No	13	43.3
Yes	17	56,7
Maintenance of household chores just as before mastectomy surgery		
No	03	10.0
Yes	27	90.0
Degree of difficulty in performing housekeeping		
No	12	40.0
Yes	15	50.0
Ignored/not answered	03	10.0
Breast reconstruction		
No	22	73.3
Yes	08	26.7

The mean score on the Beck Depression Inventory was 15.3±11.04 and median, 13 points.

DISCUSSION

Most women participating in this study were widows (40%). In a similar study, the predominant marital status was of married women (70%), with lower age group (41-50 years)[11], an age at which women normally live with a partner. In the present study, older women are prevalent, with mean age of 63.4 ± 8.98 years.

Frequently, marital relationship may suffer distancing in this period and end up affecting the emotional of these women, leaving them more vulnerable.[12] On the other hand, husband can, very often, acquire the role of the primary caregiver, becoming more attentive and helpful after mastectomy surgery, also having a key role in the grieving stage due to the removal of the breast, helping her coping with this problem.[13] In both cases, nursing should guide both the woman and her partner to share their feelings towards mastectomy, working the changes caused by the disease in married life.[13]

The level of predominant education was from one to four years of study (43.3%), which refers to data expressed in literature, in which prevails the incomplete elementary school.[4.14] Schooling may interfere with health care, since the more time of study, the higher the education and consequently the greater understanding on the health/ isease process.[12] Based on this, the multidisciplinary team should promote health education, encouraging self-care.

The present study showed as two the number of children of the largest percentage of women who underwent mastectomy (40%), with these data being similar to the research conducted in Mato Grosso.[11] It is highlighted that the support offered by family members is important, both at the time of the discovery of the disease, as in all other phases which involves from the surgery to the post-operatory after mastectomy, causing the woman to receive support from their basic needs to the performance of their roles.[15]

The highest percentage of the interviewed showed composition of the family group of two (30%) and three (30%) people. Many times, those who take care of the women with mastectomy is the family, making it a challenge for the parties, because it involves interpersonal relationships, showing that caring suffers

meaning influences and, consequently, ducts. Often the access of families to subjective questions in women with mastectomies is much more effective than the health professional[16]Making the family a health team ally in the care process.

Concerning religion, all women reported having a religious belief in which seek support. In the present study the Catholic religion was predominant (63.3%) being in accordance with data provided by other authors.[12] Religious beliefs are one way for women to seek forward forces the threatening character of breast cancer, for through them, face the suffering and social stigma, dealing with an everyday where the disease imputes psychosocial brands.[17]

Concerning the work, most women in the mastectomy late postoperative period did not exercise more paid work, just prior to surgery (56.7%), expected fact due to the age where they are (mean 63.4 ± 9.0 years), consistent with the retirement. These data discerns a study conducted in northeastern Brazil where most women kept the same job after mastectomy surgery (61.6%), a situation that can be attributed to the age in which they find themselves (50 to 59 years - 47.6%). However, it is noteworthy that 62.5% required function change to continue working.[4]

Regarding participation in the economic life of the family group, 46.7% of women who underwent mastectomy did not work in the late postoperative period, were retired or pensioners and contributed to the family, antagonizing previous study, which reports that the largest percentage (50%) of women with mastectomies worked and were civil servants. This may possibly be suggested by age group in which the largest percentage of them was in, 41-50 years, younger and still economically active.[11] It is noted that the presence of physical limitations resulting from mastectomy may result in the abandonment of the formal labor market favoring the inclusion in the informal market, in order to supplement the family income, lagged by job losses.[12] In this new reality, nursing must show qualified to meet the health needs of these women, seeking to guide the rehabilitation of routine activities.

Most women with mastectomies in late postoperative said owning predominant gross income of a minimum wage (73.3%) and home (83.3%). These data are in agreement with other studies of

the subject, as conducted in Salvador - Bahia, whose population consisted of 98 women who underwent mastectomy and reported that 67.3% of women reported income less than or equal to the minimum wage.[2] Similarly, a study with 62 patients in a hospital in Rio de Janeiro showed that 30.6% of women received up to a minimum wage.[14]

Most women did not have a history of mental illness (70%) and the highest percentage not held up with psychologist at any stage of surgical treatment (43.3%). Other research, however, brought a higher percentage mastectomy women who received counseling postoperatively (45%), followed by women who received counseling before and after surgery (30%) and 25% who received it in no time.[11]There is a great demand for professional psychologist towards these patients; but its performance is still early days in the hospital field and together with the health professionals themselves.[11] Nursing should establish multi-link through the production and dissemination of knowledge about the feelings of these women in the postoperative period and providing assistance to these women, focusing on the increase in all segments of life, especially the changes in psychosocial aspect, helping in the rehabilitation in the current lifestyle and role playing.[15]

Most women in this study performed household chores just as before mastectomy surgery (90%) and did not present any difficulty to perform them (40%). In another study, the activity to keep the home was cited by 70.4% of women as moderately good performance, with score 7, from 1 to 10 (unable to hold up extremely well), coinciding with the present study.[4]

It is important to point out that depending on the extent of mastectomy women can be affected in the movements they performs with arms, reflecting in the tasks of their daily lives and in their role as housewives. Therefore, performing certain activities becomes difficult or even impossible, depending on the degree of motor impairment caused by mastectomy in the affected arm.[17]

These data demonstrate the importance of nursing care in identifying the needs of women, their symptoms, causes and impact of these in their daily lives, encouraging and stimulating functional performance in the absolute

level, encouraging autonomy and independence, respecting their limitations.[4]

Most of the surveyed women did not perform breast reconstruction (73.3%). Although women wanted the reconstruction , they did not to have it due to lack of information; for not knowing that they can have the breast reconstruction immediately after mastectomy; for not wanting to undergo another surgery due to fear, pain and suffering; because of the culture in which she is inserted; and because of the indication for the surgery is different for each patient.[15] Likewise, a Portuguese study showed that of 69 women undergoing mastectomy, 80% abstained from the breast reconstruction.[6] Such a decision not to perform breast reconstruction could have implications on the perception of quality of life and self-esteem of women, negatively impacting the emotional aspect, compared with those who underwent breast reconstruction, as shown by a study conducted in São Paulo, with 22 women who underwent mastectomy.[18] It is suggested as nursing care for these women to develop actions that clarify their questions regarding breast reconstruction procedure, guiding them and providing comfort and safety in relation to the issue and decision making.

In the present study, the average score of the Beck Inventory corresponded to 15.3±11.04 points. Lower score was obtained in a study that recruited 65 women after 6 months of mastectomy (mean 8.6±6.0).[19] In another study, 69 women who underwent mastectomy obtained mean of 11.71±10.11 points. Although the authors have not specified the time of mastectomy performance, there was a significant difference when compared the scores with the women of the group without diagnosis of breast cancer (mean 3.23 ± 2.95, $p \leq 0.001$).[6]

Obtaining low scores in depression indicative may be suggested by the mean time of performing mastectomy surgery, 8.3 years, presented in this study. A research conducted with eight women in the postoperative period (three mastectomized and five with breast conservative surgery), in Americana - SP, elucidates that the greater the time of diagnosis and treatment, the lower the levels of depressive symptoms. Such findings may be related to coping resources used by patients affected by breast cancer described above, such as

faith, family and marital support, together with the health team assistance and psychological support received throughout the process.[9]

The age range in which women were is another factor to be considered. Two thirds of them were already older adults and it is believed that the quality of life and psychological suffering significantly improve with age for women with mastectomies, a fact that is associated with the change of values generated by the disease, such as better use of time and life.[5] This finding demonstrates that nursing care should be performed in order to assist the patient in full, with an emphasis on changes in the psychic field of these women. Therefore, it is necessary that the professional master the technical and scientific knowledge, which implies a constant search for knowledge.[20]

There is the need for nurses to intervene with interactively and humanized care with the multidisciplinary team of professionals who care for and assist women, thereby creating an environment in which the patient feels comfortable to voice their desires, doubts about coping the disease and other feelings experienced by her, in order to identify possible post-mastectomy diagnostics.[20]

CONCLUSIONS

The study found that the higher percentage of women who underwent mastectomy in the late postoperative period had a mean age of 63.4±8.9 years, were widows, with 1-4 years of education, two children, family group composed of 2 and 3 people and Catholic religion.

The predominant economic characteristics of the mastectomized patients in the late postoperative period were women with no remunerated activity, just before the mastectomy surgery. Among those who worked, the weekly workload were from 20 to 40 hours. In general, women were retired or pensioners and contributed to the family, had gross income of a minimum wage and live in their own home.

Concerning the aspects related to mental health and fulfillment of household chores, there was a higher percentage of those who had no history of mental illness, did not undergo psychological counseling before or after breast cancer surgery, kept the household chores just as before

mastectomy surgery, did not present any difficulty to perform the tasks and did not undergo breast reconstruction.

The average score in Beck Inventory of women with mastectomy in the late postoperative period corresponded to 11.04±15.3 points.

The limitation of research is linked to the fact that it is a cross-sectional study, besides presenting a small sample population, indicating the need for further studies to better understand and evaluate the life of mastectomized patients in the late postoperative period, still rarely addressed.

It is essential to know a particular population profile so that measures can be established, aiming at a suitable structure, in conjunction with a monitoring of the nursing actions that seek to assist the human being as a whole, in order to provide a holistic, individualized and humanized care. In face of the results achieved, the study may help to elucidate the sociodemographic and health characteristics of women with mastectomies in the late phase.

REFERENCES

1. Ministério da Saúde (Brasil). Controle do câncer de mama: documento de consenso [Internet]. Rio de Janeiro: INCA; 2004. [citado em 10 maio 2015]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/Consensointegra.pdf
2. Silva ACC, Anjos AT, Mascarenhas IR. Perfil epidemiológico de mulheres que realizaram mastectomia em uma unidade referência em Salvador – Bahia. Rev Bras Saúde Funcional 2014; 1(1):31-41.
3. Gomes NS, Silva SR. Avaliação da autoestima de mulheres submetidas à cirurgia oncológica mamária. Texto & Contexto Enferm. 2013; 22(2):509-516.
4. Brito JS, Marcelino JFQ. Desempenho ocupacional de mulheres submetidas à mastectomia. Cad Ter Ocup UFSCar. 2014; 22(3):473-485.
5. Majewski JM, Lopes ADF, Davoglio T, Leite JCC. Qualidade de vida em mulheres submetidas à mastectomia comparada com aquelas que se submeteram à cirurgia conservadora: uma revisão de literatura. Ciênc Saúde Colet. 2012; 17(3):707-16.
6. Seara LS, Vieira RX, Pechorro PS. Função sexual e imagem corporal na mulher mastectomizada. Rev Int Androl. 2012; 10(3):106-12.
7. Ribeiro FE, Palma MR, Araujo MF, Egydio CA, Peixoto LN, Pelai EB et al. Perfil físico e emocional de mulheres pós-cirurgia de câncer de mama. Colloq Vitae. 2014; 6(2):102-108.
8. World Health Organization. Salud mental y desarrollo: poniendo el objetivo en las personas con problemas de salud mental como un grupo

vulnerable [Internet]. Geneva: World Health Organization; 2010 [citado em 10 jun 2015]. Disponível em: http://apps.who.int/iris/bitstream/10665/84757/1/9789962642657_spa.pdf
9. Santichi EC, Benute GRG, Juhas TR, Peraro EC, Lucia MCS. Rastreio de sintomas de ansiedade e depressão em mulheres em diferentes etapas do tratamento para o câncer de mama. Psicol Hosp. 2012; 10(1):42-67.
10. Gorestein C, Andrade L. Validation of a portuguese version of the Beck Depression Inventory and the State Trait Anxiety Inventory in Brazilian subjets. Braz J Med Biol Res. 1996; 29(4):453-57.
11. Caporossi JAM, Ribeiro HS, MorinigoT, Campos A, Fabrizío L. Mastectomia e a incidência de transtorno de estresse pós-traumático. Psicol Saúde Doenças. 2014; 15(3):800-15.
12. Sousa ALV, Ana GS, Costa ZMB. Análise da qualidade de vida em mulheres mastectomizadas atendidas no ambulatório do HBDF. Comun Ciênc Saúde. 2014; 25(1):13-24.
13. Gasparelo C, Sales CA, Marcon SS, Salci MA. Percepções de mulheres sobre a repercussão da mastectomia radical em sua vida pessoal e conjugal. Ciênc Cuid Saúde. 2010; 9(3):535-42.
14. Haddad NC, Carvalho ACA, Novaes CO. Perfil sociodemográfico e de saúde de mulheres submetidas à cirurgia para câncer de mama. Med. HUPE-UERJ. 2015; 14(1):28-35.
15. Ibiapina ARS, Maia JM, Silva LDC, Fernandes MA, Costa Filho AAI, Fernandes RO. Aspectos psicoemocionais de mulheres pós-mastectomizadas participantes de um grupo de apoio de um hospital geral. Rev Interdiscip. 2015; 8(3):135-42.
16. Fernandes AFC, Bonfim IM, Araújo IMA, Silva RM, Barbosa ICFJ, Santos MCL. Significado do cuidado familiar á mulher mastectomizada. Esc Anna Nery Rev Enferm. 2012; 16(1):27-33.
17. Silva SED, Vasconcelos EV, Santana E, Araujo SJS, Valente T, Oliveira JB et al. Câncer de mama uma doença temida: representações sociais de mulheres mastectomizadas. Rev Eletrônica Gest Saúde. 2012; 3(2):731-42.
18. Furlan VLA, SabinoNeto M, Abla LEF, Oliveira CJR, Lima AC, Ruiz BFO et al. Qualidade de vida e autoestima de pacientes mastectomizadas submetidas ou não a reconstrução de mama. *Rev* Bras Cir Plást. 2013; 28(2):264-69.
19. Giardini A, Pisoni C, Giorgi I. ICF, quality of life, and depression in breast cancer: perceived disability in disease-free women 6 months after mastectomy. Support Care Cancer. 2013; 21(9):2453-2460.
20. Soares SGSC, Albuquerque JOL. Intervenção do enfermeiro no tratamento quimioterápico de mulheres com câncer de mama. Saúde Foco. 2014; 1(1):29-45.

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