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“The Support I Need”

Women’s Experiences of Social Support After Having Received Breast Cancer Diagnosis and Awaiting Surgery

KEY WORDS

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Social network
Social support

Background: Social support is associated with a better adjustment to breast cancer, whereas inadequate social support increases psychological distress. However, the period between diagnosis and surgery is particularly stressful, and few studies have addressed the significance of social support in this period. **Objective:** The purpose of this study was to describe women’s individual experiences of social support after having received a breast cancer diagnosis and awaiting surgery. **Methods:** A qualitative descriptive design was used. Individual semistructured interviews were conducted the day before surgery with 21 women aged 41 to 73 years with newly diagnosed breast cancer at a Norwegian university hospital. **Results:** Methods of qualitative meaning condensation analysis revealed 5 themes: available support, information and advice, care, having confidants, and balancing distance and closeness. Knowing that both family and healthcare professionals were available and caring gave a sense of security. Social support gave strength, although too much could be experienced as difficult and frightening. The women needed a balance between distance from and closeness to their social network. Both professional information and someone professional with whom to talk personally were essential. **Conclusions:** Social support is an important resource for women with breast cancer but can be a double-edged sword as the network’s offered support can sometimes be a burden. **Implications for Practice:** Healthcare professionals could call each patient, encourage the patients to call if they want, and, if preferred, offer face-to-face consultations for women with breast cancer awaiting surgery. This contact should be a supportive, informative, and confidential available resource.

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Breast cancer is the most common cancer in women in Norway, representing 23% of all female cancers, and mainly affects women older than 50 years.¹ Social support plays a key role in how women with breast cancer adjust to their diagnosis and treatment.²⁻⁴

■ Background

Social support is a multidimensional concept and has mainly been conceptualized from a quantitative structural perspective of social networks, such as the number of persons and the formal relationships with them, or from a qualitative functional perspective of social support, such as the perceived content and availability of relationships with significant others.^{5,6} The qualitative functional support refers to the quality or function served by the structural support components and is mainly divided into the provision of instrumental, emotional, and informational support.^{5,7} The beneficial effects of social support have, among other things, been explained as serving as a “buffer” against the adverse effects of stressors under conditions of high stress.⁸

Several studies have concluded that social support, the size of the social network, and women’s integration within it are relevant in adjustment during the breast cancer trajectory.^{4,9-11} Yet social support is not an unequivocal phenomenon.^{12,13} Women with breast cancer with a limited social network or inadequate social support from their network are at increased risk of psychosocial distress,¹⁴ anxiety and depression,^{11,15} and cancer progression.⁶ Women who were socially isolated resulting from poor support prior to diagnosis had a higher risk of mortality from breast cancer.¹⁶ Prediagnosis levels of social integration appeared to explain more of the variance in the quality of life of breast cancer survivors than treatment or tumor characteristics.⁹ Receiving support from family and friends characterized by reassurance, comfort, and help with problem solving in the period following diagnosis was a resource in the search for meaning in the cancer experience.¹⁷ The perceived availability of social support also improved the psychological and physiological functioning among women confronting a breast cancer diagnosis,^{14,18} particularly in women with low optimism after breast cancer treatment,¹⁹ and was even related to better breast cancer prognoses.¹⁰

Several factors influence the effectiveness of the support, such as whether it comes from family, friends, colleagues, or health professionals.^{4,20,21} Other women with breast cancer were also reported to provide important support.²² How the support is experienced is, among other things, influenced by the type of relationship and the setting in which the support is given.^{11,13} Previous studies have reported that women with newly diagnosed breast cancer who had relationship problems or no confidants were more likely to develop depression and anxiety during the first 5 years after diagnosis.²³ Different types of social support are suggested as being valuable to cancer patients at different points in their disease and treatment.²⁴⁻²⁶ Emotional support seems especially important in the period around surgery and recovery,^{3,13,27} whereas informational sup-

port seems more important than emotional support in the diagnostic period of breast cancer.^{24,26}

In summary, these studies have documented that social support is associated with a better adjustment to breast cancer and that inadequate social support increases psychological distress.^{2,10,11,14} However, the need for social support and other kinds of support during the breast cancer trajectory varies.^{3,24,25} In order to facilitate the adjustment to breast cancer, studies on women’s support needs throughout the cancer experience are still required,²⁷ particularly in the pre-treatment period.²⁸ A qualitative approach seems best suited to gain in-depth information about women’s individual experiences of and need for social support. To our knowledge, most qualitative studies on women’s preoperative experiences of social support have been conducted postoperatively, implying disadvantages such as recall bias. This study therefore has been conducted preoperatively and aims to describe women’s individual experiences of social support in the period between having received their breast cancer diagnosis and awaiting surgery.

■ Methods

Sample and Setting

A qualitative descriptive design was used. A convenience sample of 21 women with newly diagnosed breast cancer awaiting primary surgery was recruited from a day-surgery unit at a Norwegian university hospital. The participants received the invitation to participate with the information about the date of surgery. The selection criteria used were as follows: scheduled for primary surgery, older than 18 years, and able to speak and write Norwegian. All had similar ethnic and cultural backgrounds and came from 1 geographical area. The sample size was determined by data saturation—the point at which no new information is obtained and redundancy is achieved.^{29(p357)} Because no new essential information was forthcoming after the 21st interview, the data collection was therefore discontinued at that point. The period between diagnosis and surgery varied from 1 to 3 weeks. All interviews took place in the hospital 1 day before surgery and before preoperative individual information was given out.

Data Collection and Analysis

Data were collected between February 2006 and February 2007. The interviews varied in length from 50 to 120 minutes. A semistructured interview guide was developed based on our previous research.^{30,31} Informants were asked about their experiences of social support between diagnosis and surgery, that is, “How have you experienced social support in this period?” “What have you experienced as being the most important aspect of social support?” During the interview, the themes mentioned by the women were opened up. The interviewer’s impressions of interview atmosphere and nonverbal communication were recorded immediately after each interview.

Following Kvale's³² guidelines, meaning condensation analysis was carried out on 3 levels: self-understanding, common-sense understanding, and theoretical understanding. At the first level, the transcribed interviews were read to acquire a sense of the whole. The meaning units were identified, and data were condensed. Self-understanding occurred as the women's statements were condensed in line with the researchers' understanding of the expressed meanings. At the second level, transcriptions were read several times to achieve a common-sense understanding, a broader comprehension of the expressed meaning. The different themes were identified and transformed into meaningful units, then coded into major themes. At the third level, theoretical understanding implied discovering a deeper meaning where the mutual relationships between the whole and the parts became clearer. These themes were discussed in relation to relevant theoretical concepts and research. The qualitative data analysis software QRS-NVivo 7 (<http://qrsinternational.com>) was used.

Trustworthiness

The trustworthiness of the data was established by using the guideline set.³² The interviews were conducted, recorded, and transcribed verbatim by the first author. All the authors analyzed the data independently. Throughout the analysis process, the findings were discussed by all the authors to reach agreement. If doubts arose, we went back to the data and reassessed the meaning of the statements. Memos were written during the analysis to ensure that impressions, ideas, and reflections were not lost.

Ethical Considerations

The study was approved by the Regional Ethical Board. All participants were given verbal and written project information and gave their written informed consent. The women's needs for emotional protection were respected by not dwelling too deeply on threatening issues. An arrangement was made with the outpatient clinic to offer the women follow-up consultations with professionals if needed. No one requested it. Most participants spontaneously reported having benefited from the interviews.

■ Findings

Demographics

The women's mean age was 54 years, ranging from 41 to 73 years. Sixteen were married or cohabiting, 1 was single, 1 was widowed and 3 patients were divorced. Seventeen lived with somebody (spouse/partner/children); 16 had children. Nineteen were in full-time or part-time employment, and 2 had retired. Five women had completed lower secondary school education, 9 had completed upper secondary school, 6 had attended university colleges, and 1 patient had a university degree.

Themes


Five themes regarding social support emerged: available support, information and advice, care, having confidants, and balancing distance and closeness. The themes are described and illustrated with quotes in the Table.

AVAILABLE SUPPORT

"Available support" implied support that was available either in person or via the telephone, which was essential, regardless of whether it was actually used. Most women had many available social supporters. Knowing that family, friends, colleagues, and healthcare professionals were available if needed was important for all. However, for most women, their close family was considered to be the most important available support resource. To have family nearby was reassuring: "What matters most is having my family around me, even if we're not together all the time, just knowing that they are available," said one woman living alone. Having family available could give strength and stop women crying. A married woman living with her family said, "In this situation, I've felt stronger than usual as long as I have my family around. When I'm alone, my tears flow." Support received at work was emphasized by several women: "Knowing that I have a lot of support from both my superiors and colleagues helps." Others mentioned family, friends, and colleagues; as a divorced woman with teenage children expressed, "The network means everything now. I have a lot of friends who have said to me: 'Just call any time, we are there.' Even colleagues at work have said, 'If you need to talk with anybody, just come.' I know I can call my sister and my brother. I have talked a lot with them on the phone."

Most of the women also perceived the hospital as an available support system but primarily in terms of medical information and treatment: "I could have contacted the hospital if I wanted to. I feel that I have available support." One woman with several previous hospitalizations had great trust in the hospital: "I feel that I have a support system—there are doctors who take me seriously and do whatever they can to help me." Those with no previous hospitalizations also expressed confidence: "I experience the system as very professional, it gives me security. I have received information and have been told what will happen and been given the date for surgery. I feel I've got all the information I could possibly need." Another said, "I felt very well taken care of even when I was here for a biopsy, and I was told that I could contact the nurse if I wanted to. I really can't see how they could have taken better care of me."

Following surgery, available support from family, friends, colleagues, and healthcare professionals was also important. Some needed support during sick leave, which was a new and troubling situation for some: "I need to feel that I won't be alone during the day when on sick leave despite my friends being at work," said a working woman who had never been on sick leave before. A physical presence or easy availability was essential. One working woman who was afraid of the consequences of the diagnosis said, "It's good to know that I have both neighbors and a friend where I live, someone who is more or less at home, whom I can contact in case I should

 **Table • Description of Each Theme Illustrated with Representative Quotes**

Themes	Description of Themes	Quotes
Available support	Support that is available either in person or via the telephone, regardless of it actually being used	<p>What matters most is having my family around me, even if we're not together all the time, just knowing that they are available.</p> <p>The network means everything now. I have a lot of friends who have said to me, "Just call any time, we are there." Even colleagues at work have said, "If you need to talk with anybody, just come."</p> <p>I know I can call my sister and my brother. I have talked a lot with them on the phone.</p> <p>I'm sure the hospital will be supportive if there's anything that bothers me.</p>
Information and advice	Knowledge, explanation, counseling, and guidance from health professionals	<p>I need the comfort this knowledge gives me. The healthcare people's expertise is more reliable than what my family knows.</p> <p>It was good to be able to repeat questions. The nurses had time for me. I wasn't interrupted.</p> <p>It felt good to talk to a nurse who explained and provided information when you needed it. The social network you have is important, but if you don't have that, the health professionals become invaluable. Clinical experts help to sort out what is real from what is my imagination.</p>
Care	Understanding, respect, comfort, being prayed for, empathy, and love	<p>It feels good to know that many people are thinking of me when I have to go through this. It feels good and gives me strength. The support gives me a sense of security; to know they appreciate and love me.</p> <p>My brother has always had problems talking about feelings. But now he phones me and says he thinks of me and prays for me. It feels good that he says this.</p> <p>Just to phone someone and say that I'm sad or I'm very happy or something like that; to be there with me and for me despite my mood at that moment; that they manage to hear my story 3 times just because I need to tell it 3 times.</p> <p>The practical aspect of support is one thing, but that somebody can 'see me' is another.</p>
Having confidants	Someone to talk personally and intimately with	<p>Social support means a lot. For me, it means having someone to talk to. I feel there are only a few people I can talk intimately with now. I don't want to share this with everyone. I focus on my closest family. It's their support I really need.</p> <p>I would prefer someone I know personally at the hospital. When I haven't talked with them before, it's difficult to expose myself. So when I have called, I've asked only about practical issues.</p> <p>I know him very well. I was pleased that my doctor explained more. I felt very calm when I left.</p>
Balancing distance and closeness	Finding the balance between being close to one's social network and securing a certain distance from it, in order to receive enough but not too much social support and care	<p>I have a lot of friends and family members who are attentive, wish me good luck, and think of me. I'm not alone. But I need to handle it in my own way.</p> <p>I like to have somebody around, but at the same time I like to be alone too.</p> <p>I don't like too much consideration and sympathy; I can't cope with it. It's too much attention on me. I prefer to do things on my own.</p>

be very ill.” The particular support that the hospital could provide was essential regardless of family support. One older woman who was married and had other family members living close by said, “I want good information from health-care professionals but also to have somebody to talk with at the hospital if I need it.” Many also mentioned the hospital as a postsurgery support resource: “I’m sure the hospital will be supportive if there’s anything that bothers me.”

However, not only having support available but also having support in terms of a continuous physical presence was important. One of the oldest women who lived alone said, “Since the diagnosis, I dislike being alone. I want to have somebody with me all the time, but I can’t command anybody.” Most of the patients preferred receiving their diagnosis by their physician via the telephone at an appointed time. Some experienced shock and emotional numbness upon receiving the diagnosis of breast cancer regardless of how prepared they believed they were to receive the news. Support in terms of a physical presence when receiving the breast cancer diagnosis was emphasized by women of different family status. One married woman said, “It’s good to have a husband or a good friend there to hear what the doctor says. You’re not able to absorb everything yourself.” According to a woman living alone, “I couldn’t cope with being alone. I took my car and drove to my daughter-in-law’s.” Another woman living alone without anyone to access said, “I would have preferred somebody to be there physically with me when I was told the diagnosis, to share the blow.”

INFORMATION AND ADVICE

Information and advice implied receiving knowledge, explanations, counseling, and guidance from health professionals. After being given the diagnosis by the physician, further information from healthcare professionals was still important for some participants, independent of age, marital status and education. One woman said, “I need the comfort this knowledge gives me. The healthcare people’s expertise is more reliable than what my family knows.” Some women, particularly those who were shocked by their cancer diagnosis, were too upset to be able to remember the information given by their physician. Those who later called the hospital nurse for counseling found it essential that reiterated questions were answered by the nurses patiently: “It was good to be able to repeat questions. The nurses had time for me. I wasn’t interrupted.”

Healthcare informational support was also valuable in helping to discriminate between fantasy and reality, particularly when limited network support was available: “It felt good to talk to a nurse who explained and provided information when you needed it. The social network you have is important, but if you don’t have that, the health professionals become invaluable. Clinical experts help to sort out what is real from what is my imagination.” However, some were afraid of disturbing the health personnel and uncertain of the expectations connected to their patient role: “I don’t want to disturb. Physicians and nurses are busy; they don’t attend only to me. I don’t know what is expected of me in a situation like this.” Another said,

“It would be much easier for me if the initiative had come from the hospital.”

CARE

“Care” encompassed understanding, respect, comfort, being prayed for, empathy, and love. It could be received from family, friends, colleagues, and healthcare professionals. It was regarded as very important: “I need care above all; the fact that somebody loves me and says something nice to me.” “Care” did not necessarily imply being physically present; often, care was conveyed via telephone calls, text messages, and e-mails. “The best support is to know that somebody is there and cares about me.” Knowing that family and friends loved, respected, and were thinking of them gave many women mental strength and security: “It feels good to know that many people are thinking of me when I have to go through this. It feels good and gives me strength. The support gives me a sense of security; to know they appreciate and love me.” For some, knowing that significant others prayed for them felt good. Some of the women became particularly emotionally close to some of their family members during this period. A woman whose family did not express emotions easily felt that she got what she needed in her difficult situation: “My brother has always had problems talking about feelings. But now he phones me and says he thinks of me and prays for me. It feels good that he says this.” According to another with a somewhat emotionally distant relationship with her father, “This is the first time my father has said that he loves me.”

To have someone willing to listen and to “be oneself” with, without having to pretend great strength, was also experienced as important. One woman said, “Just to phone someone and say that I’m sad or I’m very happy or something like that; to be there with me and for me despite my mood at that moment; that they manage to hear my story 3 times just because I need to tell it 3 times. The practical aspect of support is one thing, but that somebody can ‘see me’ is another.” According to another, “Just being allowed to be sad and to say ‘I just can’t take it!’ That I am allowed to be selfish for a period.” One woman, who usually provided support and care to her family members, rather than received it, said, “It is good to lean on a shoulder without having to ask for it. I’m used to being strong and a comfort to others.”

Unexpected consideration and care from their closest family members, friends, and colleagues were particularly positive experiences. Some women received more attention and consideration than usual: “My sister has contacted me more often than usual. It feels good.” Unexpected consideration from friends and colleagues in terms of flowers and gifts was also valuable: “It is lovely that some people think of me more than usual, sending me e-mails, giving me flowers.” Another said, “My colleagues gave me some very beautiful crystal angels. I really treasure them.” Being contacted by their social network and not having to contact them were an important element within the experience of being cared for. However, some women felt that both family members and others, suddenly and for no reason, withdrew from contact, as the following quotes

indicate: "When you see them, they cross the street. They don't know what to say. It's comparable to death. I used to say 'It's not the plague.'" An older woman, cohabiting but with a limited network and often feeling alone, said, "It's a very difficult situation. Those I meet are silent as if I have something contagious. They must think that they shouldn't disturb me. It's not necessary to ask me about my cancer, just to take care of me and not avoid me. It feels good to be contacted."

Healthcare professionals' specialized knowledge and clinical skills combined with their ability to communicate and provide care and reassurance were important: "It is important that nurses and doctors are skilled and give me care and comfort." Being contacted by the hospital was an important feature in the women's experience of caring. One was afraid she had been forgotten by the hospital, and she needed care and comfort during the terrible waiting time: "A telephone call would have 'opened up' into something you really needed but hadn't managed to do anything about. You don't have the ability to fight; you're at somebody else's mercy. A telephone call would have shown that somebody really cared for me and recognized that I was still here."

HAVING CONFIDANTS

"Having confidants" implied having people to talk personally and intimately with. To have confidants was described as essential for all. However, who the confidant was is varied. The women had varying degrees of closeness to their family members, friends, and others. For some, only the closest family fulfilled the role of being confidants: "Social support means a lot. For me, it means having someone to talk to. I feel there are only a few people I can talk intimately with now. I don't want to share this with everyone. I focus on my closest family. It's their support I really need." Sharing experiences and talking personally and intimately with close friends were also important. It also eased the burden of family members: "I have to 'use' my friends; if not, it will be too much for my husband."

However, some of the women preferred to confide in someone outside their family, people who were not too emotionally involved: "It's easier to open up to someone more distant." Some wanted to talk personally with healthcare professionals, although for some women talking personally on the phone to healthcare professionals whom they perhaps had never met was difficult: "It's difficult on the phone." Another said, "I would prefer someone I know personally at the hospital. When I haven't talked with them before, it's difficult to expose myself. So when I have called, I've asked only about practical issues." Some, both young and old, contacted their family doctor whom they knew and who was familiar with their medical history to talk personally face-to-face: "I know him very well. I was pleased that my doctor explained more. I felt very calm when I left." Another said, "It made me feel good. I knew I would receive support." One woman, who was very scared by her diagnosis and did not want to frighten her family and needed to talk with an emotionally neutral confidant, said, "I had to contact my family doctor. I had a 'breakdown.' I couldn't get things done at home, I felt overwhelmed by everything."

BALANCING DISTANCE AND CLOSENESS

"Balancing distance and closeness" implied finding the balance between being close to one's social network and securing a certain distance from it, in order to receive enough but not too much social support and care. As mentioned earlier, almost all the women experienced support in terms of caring and encouragement as essential. However, most of the women needed a balance between distance from and closeness to their social network. For some, it was difficult to accept support and care from family and significant others. This pertained to women with very different life histories and situations. One woman, who had been the eldest of many siblings and always been used to being "the strong one," said, "My problem is accepting and handling care. It is so unfamiliar." Another divorced woman who was used to handling difficult situations said, "I have a lot of friends and family members who are attentive, wish me good luck, and think of me. I'm not alone. But I need to handle it in my own way." According to another, "I probably don't 'open up' to care. I think it is my personality." Some felt that their partners/spouses treated them as if they were fragile or dying. One woman said, "I don't want too much care because I think it will go well. I'm still here. When the day comes when it is not OK, then there is a reason for them to provide care for me." Another found the support "overprotective" and overwhelming: "My husband is so caring I think it is simply too much of a good thing." Another said, "If I received any more care, it would appear overwhelming." For some, it was difficult to have time alone to reflect in solitude upon their diagnosis and new life situation. One of the women, living alone but with many close friends, said, "I was invited to a dinner by somebody every day for 2 weeks. What I need is to 'land' and get a feeling for what this is really about." Some were even ambivalent toward support: "I like to have somebody around, but at the same time, I like to be alone too."

Consideration and sympathy from others could also be demanding and frightening: "They were so encouraging that I felt I had to smile and be a hero. But what I really wanted to say was that I was still frightened." Others' sympathy, pity, and compassion made some feel scared and vulnerable and made them think that their prognosis was poor: "If I get too much comfort, I get nervous and scared." Another said, "If they say 'poor you' and 'this is terrible,' then I start to cry." Consideration from others could also be experienced as commiseration: "I don't like too much consideration and sympathy. I can't cope with it. It's too much attention on me. I prefer to do things on my own." Receiving flowers created feelings of commiseration as well: "My daughter-in-law gave me a bunch of flowers. I don't want commiseration and too much attention." Some of the women did not like cancer-related information and focusing upon the diagnosis. One woman said, "They mustn't focus upon that when they phone me. It's not what I want to talk about." Another said, "I get so much cancer information from people who are not professionals. It wears me out, although it is well intended." Getting support and information from other breast cancer patients was generally experienced as positive. However, a woman said, "I was invited to call a woman with breast

cancer to hear her story. I didn't want to. Why do I have to listen to their stories? I'm not sure it's relevant to me." Despite being in need of support, some had to balance their own and their family's needs for support: "My family needs comfort, but I need to get some comfort too."

■ Discussion

Available Support

This qualitative study gives information on different aspects of women's experiences of social support—their similarities as well as their variations. Our findings revealed that most women had good social supporters. Having support available, particularly from family members and also from friends and healthcare professionals, was important. Having a continuity of support following surgery was also emphasized. Support from both colleagues and superiors at work was highly valued and has been reported as a crucial component of well-being.^{12,28,33}

Our participants felt reassured that their good supporters would be available if needed, which can be comforting in itself and is documented as an important resource for women with breast cancer.^{4,34} Our participants reported that simply knowing that someone was available contributed to feelings of mental strength. However, an important finding in our study was that not only the perception of available support but also having close persons physically present all the time was important for some of our participants, particularly when receiving the diagnosis. According to Brake et al,³⁵ women with breast cancer preferred the company of main confidants when receiving the diagnosis, and their presence has been shown to "buffer" the perceived experiences of stress. Unfortunately, the physical presence of supporters was difficult to obtain, particularly for those living alone.

Information and Advice

Our findings revealed that professional information and advice were important components of social support. The need for further information appeared to be motivated partly by a distrust of one's memory and a fear of negative fantasy in the stressful situation and partly by a distrust of information from nonprofessional sources.

Healthcare professionals are the most important source of information during the diagnosis and treatment phase.^{21,27,36} Most of our participants felt that they received less individual information than desired. Fortunately, those who called the hospital nurses for information experienced that the nurses provided adequate information, helped to discriminate between fantasy and reality, and took sufficient time to listen. Patients clearly need professional information and expert advice that match their individual needs.^{13,21,37} The threat perceived by patients following diagnosis strongly influenced their needs and experiences.^{38,39} Nurses are seen as a key source of information, assist individuals in interpreting information given by others,²⁰ and offer advice and additional information to that

provided by the doctors,¹⁸ which helps to reduce uncertainty.⁴⁰ However, despite their need for professional counseling and support, and despite being urged to call whenever they wanted to, many of the women were reluctant to contact the clinic. They did not want to disturb or be a burden by using the professionals' time and resources. They also were uncertain as to what was expected of them as patients.

Care

We found that our participants wanted to be seen, understood, respected, and valued as individuals. Simply knowing that others "were there for them" was central. According to Helgeson,⁵ emotional support refers to care and having people available to listen, sympathize, provide reassurance, and make one feel valued and loved. This is exactly what was expressed by these women. Women diagnosed with breast cancer have been reported to need care and support from their families, friends, and healthcare professionals^{2,13}; to enhance their mental well-being⁴¹; and sense of inner strength and security.^{13,34} Likewise, our findings also showed that feelings of emotional closeness, of knowing that significant others valued, loved, prayed for, and thought of them, not only demonstrated care and gave feelings of security but also provided mental strength. Despite their need for care, we found that some participants experienced that family and friends tended to avoid them, as reported previously.⁴² To see people around them avoiding them gave our participants the feeling of having a stigmatizing and fatal disease, of being ignored, and of a withdrawal of care that imposed an extra burden on them.

Our findings revealed that professional knowledge and clinical expertise in combination with relational qualities such as care and comfort were important. Interpersonal sensitivity is key in the caring process and is characterized by empathic insight into another's suffering.⁴¹ According to Salonen et al⁴³ and Liao et al,⁴⁴ follow-up telephone consultations may help healthcare professionals to understand patients' emotional reactions and give support. An important finding in our study was that follow-up phone contact at the initiative of healthcare professionals after the patients had received their diagnosis would have demonstrated individualized care and that the patients had not been forgotten.

Having Confidants

Having confidants was central to our participants' social interactions, as also reported previously among women with early breast cancer.^{23,45} In contrast to other studies that have shown that expressing concerns and sharing feelings are more beneficial with people within their inner circle,^{4,41} we found that talking personally face-to-face and expressing emotions to people outside family and to friends who were not too emotionally close were also essential. Talking to healthcare professionals who are experts in the field was important, but talking personally on the phone to healthcare professionals whom the women had never met was difficult. Some contacted their family doctor to talk personally face-to-face—family doctors know patients

over longer periods and have a more comprehensive knowledge about their patients' life situation and emotional strengths.⁴⁶ Such face-to-face consultations can build trust, encourage patients to express their emotions, and decrease anxiety.⁴⁴ Similarly, face-to-face consultations encouraged our participants to express emotions and alleviated fears and concerns.

Balancing Distance and Closeness

Balancing distance from and closeness to their social networks was important for our participants. Social support is linked not only to the structure of the network but also to the patients' capacity to contact resources^{11,31,47} and, as we also found, to their ability to use these resources. Those with self-confidence and reliable social networks knew when to call upon social support and were more likely to have social support available.⁴⁸ We also found that some of our participants did not need much social support but preferred to handle the situation in their own way. This attitude might also have been influenced by our participants' perception of their own personal resources and coping abilities.¹² Caring is preceded by the recipients' need for, and openness to, caring.⁴¹ Our findings also revealed that some of the women wanted their social supporters to provide care only when they were really in need of care, whereas others had problems "opening up" to care. Some experienced the support offered as being "overprotective" and intrusive. Their ambivalence could be misunderstood by their social network as being avoidance behavior, resulting in confusion between the patients' needs and the supporters' assumptions about those needs.²⁷

Encouragement, consideration, and sympathy from others could paradoxically be experienced as difficult and frightening, as if extensive concern expressed expectations of a fatal outcome. However, some of our participants experienced that some people tended to encourage them too much and be too optimistic and cheerful when they wanted to express other feelings. Instead of perceiving the support as well-intentioned encouragement, some of our participants perceived the support as trivializing and as ignoring their need to express fear and concern. Moreover, some of our participants found that family members and friends provided too much information and advice. Supporters who offered unsolicited explanations and advice blocked the sharing of thoughts and emotions.⁴⁹ Our findings revealed that advice from other cancer patients was also unwanted and could be frightening. In this sense, support also taxed our participants' resources. Some gave priority to their family members' need for social support instead of being supported themselves. This could be burdensome and difficult and also taxed our participants' resources.³⁹

Limitations

The participants had similar ethnicity and culture and came from only 1 geographical area. Using personal interviews could further skew the sample toward participants who found it easy to talk about their situation with strangers. It is also possible that the most anxious patients may have declined to participate and

that a more varied sample would have yielded different results. Because of the cross-sectional design, the current study was not able to capture changes over time.

Implications for Practice

In general, healthcare professionals should offer support, care, and advice on an individual basis to promote women's adjustment when facing the diagnosis of breast cancer. Based on our findings, we can tentatively suggest that healthcare professionals could call each patient during their waiting period and also encourage the patients to call if they wanted to. If needed or preferred, they could also offer confidential face-to-face consultations. This contact could act to support and inform patients in general, as well as help those in need of particular support and professional help, including a neutral confidant. Because having a significant person accompanying patients receiving the diagnosis may help to alleviate anxiety, the clinic could suggest this. It is important to consider both the positive and negative aspects of the women's experiences of social support while adjusting to their diagnosis. Healthcare professionals could encourage women to express what they actually want regarding social support from their social network, according to their individual needs. The results of this study may enhance healthcare professionals' awareness of the considerable individuality within these women's support needs.

Conclusion

Social support was important for all of these women, but the support provided had to be adjusted to each woman's needs—which were individual. The social network offered support, but this could sometimes also represent a burden. Health professionals were considered an important source of social support. By understanding and being sensitive to these women's experiences and challenges in their social networks, nurses and other healthcare professionals could offer more individualized support and care to women in this vulnerable and important period.

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