

"Redefining Time: Psychological Intervention for Women and their Caregiver with Breast Cancer in Palliative Care"

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Abstract: A proposal for a 6-session psychological intervention plan is presented, based on Cognitive Behavioural Therapy (CBT) and Dignity Therapy, for a convenience sample of women with breast cancer in Palliative Care, which considers the specificities of this population and will seek to promote their well-being and quality of life. Following the philosophy of Palliative Care, an intervention focused on the person with the illness and their family was conceptualized to promote acceptance of death and manage the quality of life with dignity. The intervention plan (observational study) includes not only the individual with the disease but also their caregiver, recognizing the interconnectedness of their experiences. The emphasis on topics like breaking the "Conspiracy of Silence," caregiver support, and grief management reflects a deep understanding of the multifaceted nature of palliative care.

BREAST CANCER

This paper presents the development of a psychological intervention plan, lasting six sessions, aimed at women and their caregiver with breast cancer in Palliative Care, considering the specificities of this population and promoting their well-being and quality of life. Following the philosophy underlying Palliative Care, an intervention centred on the person with the disease and their family was conceptualized to promote the acceptance of death and the celebration of life.

Cancer is a disease that manifests itself when the formation and division of cells in the human body are affected (Simões, 2016). In a normally functioning organism, the formation of new cells occurs simultaneously with the elimination of dysfunctional cells (Soares et al., 2023). When new cells are formed without the proper elimination of older cells, a tumour forms, which can be benign or malignant (Soares et al., 2023). The presence of a malignant tumour, also called neoplasia, characterizes oncological disease (Soares et al., 2023). Unlike other diseases, such as infectious or inflammatory diseases, which result in the destruction of tissues and cells, in neoplasms the formation of new tissues is observed (Simões, 2016).

Cancer is the second leading cause of death in the world, with an average incidence of more than two million cases annually, affecting both sexes

equally (World Health Organization - WHO, 2022). However, there is a higher prevalence of certain types of cancer in men, such as lung, prostate and colon cancer, while in women, breast and cervical cancer stand out (Soares et al., 2023).

In 2022, in Europe, 557,532 new cases of breast cancer were registered, of which 8,954 occurred in Portugal (WHO, 2022). That same year, 2,211 people died from this disease in the country (WHO, 2022). In the Autonomous Region of Madeira, Portugal, in 2021, 46 women over the age of 30 died (National Institute of Statistics, 2021). Among women aged between 45 and 65, it was found that they accounted for 20 of the 46 fatal cases recorded in Madeira, Portugal, in 2021 (INE, 2021). In 2022, in this same age group, there were 3,636 deaths in Portugal out of a total of 8,954 diagnosed cases (WHO, 2022).

Women between 45 and 65 years old belong to Generation X, experienced profound social changes, both technologically and culturally (Soares et al., 2023). This generation is characterized by dedication to work, ambition, a sense of self-efficacy and autonomy. In the personal context, protection in relation to the family and the effort to balance work functions with family responsibilities stand out, playing multiple roles in the different areas of their lives (Soares et al., 2023). This generation will be the focus of the intervention plan developed in this work (with six sessions and six women and their caregivers).

There are different types of breast cancer, the main differences of which are related to the state of development, anatomical location and connection with hormonal factors (Nascimento et al., 2024). The most common breast neoplasms include ductal carcinoma in situ, invasive ductal carcinoma, lobular carcinoma in situ, and invasive lobular carcinoma (Nascimento et al., 2024).

Ductal carcinoma in situ and invasive ductal carcinoma develop in the breast ducts. The first is a non-invasive form with no tendency to metastasize. In contrast, the second has invasive characteristics, causing the rupture of the ducts and spreading cancer cells to other regions. In turn, lobular carcinoma in situ and invasive lobular carcinoma originate in the lobules of the breast, responsible for milk production, with invasive lobular carcinoma being the type most prone to metastasis (Nascimento et al., 2024).

In men, breast cancer represents approximately 1% of cases worldwide, with invasive ductal carcinoma being the most frequent, corresponding to 86.6% of cases (Reis, 2019). The appearance of this neoplasia in men is often associated with genetic mutations in the BRCA1 and BRCA2 genes, responsible for controlling the cell cycle, as well as Klinefelter or Cowden Syndrome (Meireles, 2013). Changes in the breast or nipple are common symptoms of breast cancer and can be identified by appearance or palpation (Liga Portuguesa Contra o Cancro, 2024). The most common signs include lumps in the breast or axillary area, increased nipple sensitivity, scaly appearance, redness and swelling of the breast, secretion or loss of fluid from the nipple, and retraction of the nipple (Liga Portuguesa Contra o Cancro, 2024).

Since the main manifestations of breast cancer involve changes in the breast and nipple, women must be familiar with their bodies. Although the breast changes the menstrual cycle during breastfeeding and menopause, self-knowledge allows us to distinguish normal changes from pathological changes (Nunes, 2008). Breast cancer is considered a heterogeneous disease, as multiple factors influence it. However, some risk factors increase the likelihood of developing this disease (Nunes, 2008). Age, family history, exposure to stress, early menarche, late pregnancy, use of oral contraceptives and hormone replacement therapies

are some of the main factors identified (Nunes, 2008).

In addition to environmental and physical factors, psychological factors also play a relevant role in the development of breast cancer, with an emphasis on stress (Bauer, 2004). Stress is associated with the suppression of the immune system, including cellular immunity, which makes the individual more susceptible to pathologies. Thus, high levels of stress significantly influence tumour growth (Bauer, 2004). Social support, coping strategies and internal locus of control are considered protective factors in the response to stress (Nunes, 2008). Regarding protective factors against breast cancer, Marques (2023) suggests that a diet low in saturated fats, regular physical exercise, protection against radiation and the absence of alcohol consumption can reduce the likelihood of incidence.

DIAGNOSIS AND TREATMENT

Survival in cases of breast cancer is directly associated with early diagnosis, allowing more aggressive and mutilating interventions to be avoided (Águas et al., 2022). Therefore, adherence to screening programs is essential to safeguard the highest possible quality of life, even when diagnosed. The most widely used method for diagnosing breast cancer is mammography, which uses X-rays to identify changes in breast tissue (Águas et al., 2022). According to the World Health Organization, women over 50 should undergo this exam once every two years, even in the absence of symptoms, as a preventive measure. Other frequently used tests include ultrasound and magnetic resonance imaging (Liga Portuguesa Contra o Cancer, 2024). Additionally, it is common to perform a biopsy, which consists of collecting a sample of tissue or fluid from the breast to analyze the presence of cancer cells (Liga Portuguesa Contra o Cancro, 2024).

The choice of treatment depends on the severity of the disease and the type of cancer cells identified (Liga Portuguesa Contra o Cancro, 2024). The most common treatment is chemotherapy, which uses chemical agents to destroy tumour masses. It can be administered in different ways, such as primary, adjuvant, induction or palliative. In the

case of palliative chemotherapy, the objective is exclusively to alleviate symptoms, improve pain control and promote quality of life (Maughan et al., 2010). Other options include surgery, radiation therapy, and hormone therapy, which are often combined to achieve better results (Maughan et al., 2010).

PALLIATIVE CARE

Palliative Care is provided both inpatient and at home for people with incurable diseases or with high severity in an advanced stage (Neto, 2020). Its main objective is to promote the well-being and quality of life of the person with the disease and their family by alleviating physical, psychological, social and spiritual suffering. These services use person-centred treatments and Care, promoting their autonomy, dignity and comfort (Neto, 2020). In Palliative Care, the underlying philosophy is the affirmation of life and the acceptance of death, using therapeutic measures that aim at well-being and pain control. The person with the disease is spared from invasive and aggressive treatments that do not aim to improve their quality of life (Neto, 2020).

Quality of life can be defined as a person's perception of their position in the different areas of their life based on their values, objectives and expectations, among other factors (Ferreira et al., 2008). Thus, it is considered that quality of life is not only related to physical well-being but also social and psychological well-being (Ferreira et al., 2008). Contrary to what is often stigmatized, Palliative Care is not only intended for people in the last days or weeks of life. Although there are cases of people in the terminal phase – with only a few days to live – these services are also aimed at people with advanced illnesses and life prognoses of more than 12 months (Neto, 2020). A diagnosis of advanced breast cancer has a significant psychological, social and emotional impact on the person with the disease (Turner et al., 2005). This diagnosis is given to women who are in stage IV of the disease, with no prognosis for a cure.

Among the most common challenges faced by these women are uncertainty about the future, loss of autonomy due to lack of energy and changes in routine, fear of disease progression and death, and lack of honesty on the part of family and friends when addressing the issue of the disease and the impact of the diagnosis on the family (Turner et al.,

2005). The feelings of grief and injustice regarding the diagnosis, as well as other existing concerns, must be explored and worked on in order to reduce negative emotions such as anger, frustration, fear, anxiety and depressive symptoms. This approach allows providing the emotional support needed to promote a better quality of life (Turner et al., 2005).

According to the Portuguese Order of Psychologists, working in multidisciplinary teams is an essential practice in Palliative Care, with the aim of increasing comfort and reducing the suffering of the person with the disease (Ordem dos Psicólogos Portugueses, 2019). Psychologists are part of these teams, playing an essential role in emotional regulation, alleviating suffering and promoting a sense of dignity. This work also includes supporting other health professionals and ensuring comprehensive and person-centred intervention (Ordem dos Psicólogos Portugueses, 2019). In addition to individual intervention, one of the main focuses of Palliative Care is the adaptation of the person and their family to the diagnosis of advanced disease since this constitutes a great source of suffering (Martinho et al., 2015). The psychologist, in this context, acts as a mediator between the family and the person with the disease, promoting effective communication that respects the user's autonomy and dignity (Martinho et al., 2015). Comprehensive identification of each person's sources of stress is crucial, given that the end-of-life process is highly individual and does not allow for generalizations (Ordem dos Psicólogos Portugueses, 2019). However, there are common factors that require special attention, such as:

- Promoting emotional expression and thoughts around sensitive topics, such as death, prognosis and illness.
- The attribution of meaning and significance to life.
- Relief of psychological and spiritual suffering (Martinho et al., 2015).

THE CAREGIVERS

The suffering of the family or primary caregiver of a person with an illness can be as intense as that of the person. Involvement in caregiving is often so demanding that it makes it difficult for the caregiver to care for themselves (Neto, 2020). Petronilho (2010) and Pereira et al. (2023) report that around 70% of informal caregivers report high levels of stress and difficulties in reconciling professional responsibilities with the Care provided to the sick person. Effective adaptation of family members to the role of caregiver has a significant impact on the well-being of the caregiver, the person with the disease and on hospitalization rates in health institutions (Pereira et al., 2023; Paiva et al., 2023). Therefore, caregivers must be considered throughout the entire intervention process (Petronilho, 2020). Raising awareness of the importance of self-care is an essential starting point for improving the well-being of the caregiver and, simultaneously, of the person with the disease since caregiver exhaustion is often a criterion for hospitalizing the person being cared for (Neto, 2020).

THE MOURNING PROCESS

Grief is the process of adjustment that occurs after a significant loss. The way the person manages this process defines the type of grief experienced (Pimenta & Capelas, 2019; Santos & Soares, 2024; Santos & Soares, 2024a). In a normal grieving process, there is a gradual acceptance of the loss as a reality, accompanied by a perception of the positive aspects associated with the event (Pimenta & Capelas, 2019; Santos & Soares, 2024b). In the case of anticipatory grief, there is emotional preparation for a loss that has not yet happened, but which is predicted to be imminent (Fernandes et al., 2016). On the other hand, preparatory mourning refers to a practical or instrumental preparation for the loss that is to come (Fernandes et al., 2016).

Prolonged or complicated grief is characterized by the inability to adapt to the loss, often resulting in stagnation in one of the phases of grief, which generates high emotional discomfort (Fernandes et al., 2016; Santos & Soares, 2024). Psychological intervention that promotes a peaceful death and working with the family of the person with the

illness to prepare for the loss are shown to be protective factors against complicated grief (Pimenta & Capelas, 2019; Santos & Soares, 2024).

THEORETICAL MODELS

The psychological intervention plan aimed at women aged between 45 and 65, diagnosed with advanced-stage breast cancer and in Palliative Care, is theoretically supported by Cognitive-Behavioral Therapy (CBT) and Dignity Therapy. Cognitive-behavioural Therapy plays an essential role in psychological intervention in Palliative Care by promoting the identification of negative thoughts, feelings and the flexibility of beliefs that cause emotional and behavioural suffering (Castro & Barroso, 2012; Soares, 2024). In this sense, the intervention plan includes the identification of dysfunctional thoughts, core beliefs, relaxation techniques and guided imagination, with the aim of reducing symbolic pain and psychological suffering of people with advanced disease conditions (Castro & Barroso, 2012).

Dignity Therapy is a psychotherapeutic approach that aims to deal with existential pain and promote dignity and purpose in life in patients with advanced diseases (Barbosa et al., 2016; Leal & Soares, 2024). One of the main goals of this model is to create a legacy that allows the person to preserve a "continuity of self", promoting discussion about life issues considered important and ensuring that they are remembered after their death (Barbosa et al., 2016).

Adding to the growing evidence (and the fact that it is linked to Beck's Cognitive Behavioral Therapy), the close connection with the act of caring and altruism, Gilbert's Compassion Focused Therapy (CBT) has assumed itself as the choice of explanation for the therapeutic intervention (Murfield et al., 2020; Reis et al., 2018; Pereira et al 2023). It is based on sensitivity to suffering, in oneself and others, and its relief or prevention through understanding. It aspires for individuals to look at themselves and others in a compassionate, appropriate, and kind way so that their behaviours can follow the same continuum with an adaptive nature. It aims at balancing the three systems of affect regulation: (1) defense-threat; (2) resource-

seeking and reward; and (3) affiliation. It focuses on and proposes the beneficial activation of the affiliation system, seeking that the individual, instead of a posture marked by guilt and criticism, assumes an attitude of compassion. Compassion focuses on three attitudes to be trained: (1) kindness (instead of a judgmental posture) based on not being critical in times of suffering; (2) shared humanity (instead of isolation), referring to the awareness that we all experience difficulties; (3) and full attention (instead of excessive identification), referring to a balanced recognition of experiences. The first phase emphasizes the importance of the process being co-constructed, and of psychoeducation. This is followed by the formulation of the case, in which an attempt is made to understand the behaviours that stand out most in the individual's behavioural repertoire (paying attention to early experiences, fears related to others and oneself, safety strategies, and unintended consequences). This form of therapy is characterized by Compassionate Mental Training (CMT), which involves the desire to balance sensitivity, overactivity, and conflict between defence-threat and resource-seeking systems and rewards by stimulating the affiliation system, allowing the individual to generate alternative thoughts and adopt caring and helping behaviors towards others and themselves.

The intervention plan includes not only the individual with the disease but also their caregiver, recognizing the interconnectedness of their experiences. The emphasis on topics like breaking the "Conspiracy of Silence," caregiver support, and grief management reflects a deep understanding of the multifaceted nature of palliative care.

“REDEFINING TIME” INTERVENTION PLAN (FOR 6 WOMEN AND THEIR CAREGIVERS)

With the intention of meeting the needs of women between 45 and 65 years old with advanced breast cancer and in Palliative Care, an intervention plan is proposed with six individual sessions, each lasting 50 minutes for women and their caregiver in palliative care. This is an observational design.

In advanced disease conditions, such as those observed in Palliative Care, cognitive changes may occur due to the toxicity of radiotherapy and chemotherapy, which may compromise the effectiveness of psychological intervention. Therefore, it is essential to assess cognitive abilities when including the person in the plan (Purcino, 2016; Leal & Soares, 2024). Factors such as significant change in reasoning and memory were considered, as they can limit the processes of reflection and integration of conclusions obtained during psychological monitoring. That is the reason session 0 is for screening cognitive functioning and clinical assessment motivation for entering the intervention plan.

SESSION 0: CLINICAL ASSESSMENT AND INTERVIEW

The objective of this initial session is to get to know the person and their expectations regarding the psychological intervention process. The general objective of the intervention plan will also be explained, checking whether it is suited to the needs of the person with the disease.

With an estimated duration of 90 minutes, the session will be attended by the person with the disease and their primary caregiver, involving the latter as an integral part of the process, which may facilitate acceptance and commitment to the intervention (Leal & Soares, 2024).

Initially, the person's availability and genuine interest in participating in the plan will be assessed, respecting their dignity and decision-making autonomy (Soares, 2024; Leal & Soares 2024). The level of realism of the person's and caregiver's expectations will also be analyzed, especially in relation to the prognosis, since unrealistic expectations can make it difficult to adapt to reality (Ordem dos Psicólogos Portugueses, 2019).

During this session, the psychologist will assess the quality of communication between the person and the caregiver, as well as the level of information that both have about the disease. Sleep quality and possible depressive symptoms will also be assessed, and if necessary, a referral will be made to a physician on the multidisciplinary team for additional intervention.

Cognitive functioning and the disease stage, influence eligibility for the inclusion on the intervention plan. So, in order to assess cognitive functioning, the Mini-Mental State Examination (MMSE) will be applied, lasting approximately 10 to 15 minutes (Costa, 2019). In addition, the Self-Perception and Relationships Tool (S-PRT) will be used to measure the quality of life and subjective well-being of the person with the disease (Atkinson et al., 2004), an instrument that will also be used to assess the impact of the intervention plan.

SESSION 1: THE CONSPIRACY OF SILENCE

When faced with a diagnosis of advanced disease, it is common for family members and health professionals to avoid discussing sensitive topics, such as the progression of the disease, its endpoint and prognosis, due to the discomfort and suffering that these issues can cause. This "protective silence" can be perceived as a way of protecting both the person with the disease and their family members, but in practice, it can generate isolation and anxiety (Paganini et al., 2024; Leal & Soares, 2024).

The objective of this session is to break the Conspiracy of Silence present in communication between the person with the disease and the caregiver, promoting a more transparent relationship, acceptance of the diagnosis and facing reality (Paganini et al., 2024). The session will last

50 minutes and will involve both the person with the illness and the primary caregiver. What the person with the disease knows about their diagnosis and what they want to know about the prognosis will be explored, respecting their denial, if that is their choice (Leal & Soares, 2024). In addition, the feelings and emotions associated with communicating this information to the family and caregiver will be identified.

For the caregiver, psychoeducation will be provided on the negative impacts of the Conspiracy of Silence, which can contribute to isolation, anxiety and frustration of the person with the disease when realizing what information is being hidden. This process aims to raise caregiver awareness of the importance of clear and honest communication at the end of life. The caregiver's feelings about addressing these topics will be validated without judgment, and the psychologist will act as a mediator to facilitate dialogue about these emotionally charged issues.

At the end of the session, a logbook will be presented to the person with the disease, as a way of expressing feelings, anxieties and positive emotions daily, promoting self-reflection and re-signification of events (Leal & Soares, 2024).

Additionally, the caregiver will be guided on the importance of self-care and will receive a weekly monitoring table based on the Strategic Plan for the Development of Palliative Care (2021-2022 Biennium, see Figure 1) to record their progress in self-care activities.

	I took Care of my relationships	I did physical exercise	I talked about my feelings	I accepted help	I distributed tasks	I looked at myself	I cried and smiled
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							

Figure 1: Weekly Self-Care Tracking Chart

SESSION 2: SYMBOLIC PAIN – PSYCHIC

In Palliative Care, it is common for the pain felt by people with illness to be not only physical but psychological and spiritual. We call this non-physical pain symbolic pain (Pimenta, 2006). Cancer patients with advanced disease experience intense chronic pain for long periods. For this reason, even when physical pain is not present in such an acute way, there is fear and anxiety related to the expectation of when this pain will return, which corresponds to psychic pain (Pimenta, 2006; Leal & Soares, 2024). To alleviate psychic pain, it is necessary to decondense the factors that make it perpetuate and intensify. For this session, cognitive-behavioural techniques will be used so that the person with the disease can identify the emotions that are related to certain core beliefs present in these factors. The session will be individual and last 45 minutes.

The condensation of psychic pain is the product of an accumulation of factors, such as fear, sadness and guilt felt by the person with the illness, which cumulatively end up becoming a single symptom, such as depression or anxiety. These symptoms also become more intense when the person is unable to identify the causes that lead them to feel this way (Pimenta, 2006). The decondensation of psychic pain will be worked on through the exploration of each of the factors that are causing this emotional discomfort to the person with the illness so that they can identify the emotions associated with the corresponding factors. For this purpose, the downward arrow technique will be used to explore the underlying fears/beliefs and evoke the core beliefs (Conceição & Bueno, 2020) that underlie the existence of thoughts that lead to depressive or anxious symptoms.

So that the session ends without the person being too emotionally activated, the diaphragmatic breathing relaxation technique will also be introduced to provide resources so that the person can better deal with a situation of greater anxiety. The goal is for the patient to be able to control physiological symptoms when anxiety escalates, whether in relation to a moment of physical or emotional pain (Conceição & Bueno, 2020).

SESSION 3: SYMBOLIC – SPIRITUAL PAIN

In addition to psychic pain, symbolic pain is also constituted by spiritual pain, which is characterized by issues related to the meaning of life and the finitude associated with the conception of God or a figure representative of the divine world (Pimenta, 2006).

In this session, spiritual pain will be the main point to be worked on, lasting 45 minutes and individually. For this purpose, mental relaxation and mental imagery techniques will be used in the direct form suggestion and indirect suggestion to access the internal subjective reality and promote changes in the person's thoughts. Suffering is related to the meaning of life and finitude (Pimenta, 2006).

It also seeks to find meaning in their life through direct suggestion and indirect suggestion by creating new meanings regarding their role in their own life. Even though the body is sick, there is still a liveliness of spirit and the possibility of peace amid pain. Through the reflection that these techniques provide, a decrease in negative images regarding the future and an increase in well-being are expected (Pimenta, 2006).

The homework will be to write a "Letter to God" in which they can express all emotions regarding their destiny and use relaxation and mental images trained in the session to work on re-signification of negative images (Leal & Soares, 2024).

SESSION 4: LIFE FOREVER

In the context of Palliative Care, bibliotherapy can enhance positive results in terms of reflection and identification of emotions and meanings (Conceição & Bueno, 2020; Santos & Soares, 2024). This session will last 45 minutes, and the aim is to read and interpret the poem "Life Forever" by Casimiro de Brito (1938) and to be able to reflect on their finitude, purpose in life and usefulness.

"Between life and death, there is only
 The simple phenomenon
 Of a subtle transformation. Death
 is not the death of life.
 Death is not inaction or uselessness.
 Death is but the dark face,
 minimum, in the gestation
 of a journey that never ceases to be. Adventure
 prolonged
 from the basement of time. Projecting yourself
 in the inconceivable ships of the future.
 Death is not the death of life, only
 new forms of life. New
 utility. Another role to play
 on the world's fast-paced stage. New being
 (commerce)
 of the dust) and not belong to oneself.
 New clarity, breathing, shipwreck
 in the incomparable machine of the universe."
 Casimiro de Brito, in "Imperfect Solitude" (1938)

In interpreting the poem, we can see that the author refers to life as something that transcends death, referring to the idea that a person with an illness leaves a legacy that keeps them alive. It calls for the need for a paradigm shift when we look at finitude, since it is an integral part of what it means to be alive. The author refers to a "journey that never ceases to be" because the end-of-life process must be experienced actively and not by nullifying the person with the illness. After interpreting the poem, the person will be asked to write in their diary, at home about its meaning of finitude and the transformation it entails in order to promote self-reflection.

SESSION 5: A PURPOSE

In this session, Dignity Therapy (Leal & Soares, 2024) will be used to encourage the exploration of the meaning of life and the sense of worth of the person with the illness. The session will be 45 minutes long and will be individually. The lack of meaning is one of the factors that most enquiries the dignity of the person, being aggravated by the feeling of uselessness. Legacy is one of the main concerns of people at the end of their lives, as it

ensures a permanent existence after death (Barbosa, 2016).

In this session, the objective is to have the opportunity to reflect on the most significant moments in their life and how they want to be remembered in order to form a legacy. Furthermore, it also aims to encourage reflection on what can still be done with the time available to create a purpose and objectives to be completed in the near future.

After the reflection and discussion promoted, a legacy document will be formalized that covers themes from the life of the person with the disease, such as the most significant moments of their life, what they would like people to know about them and how do they want to be remembered. This document may, or may not be delivered, to a significant person of their choice (Barbosa, 2016). At the end of this session, they will consider other possibilities regarding what they can still do and put them on a list to encourage a sense of purpose (Conceição & Bueno, 2020).

As homework, they will be asked to write a message for the next generation and bring it to the next session. This message will be used to make a short film about breast cancer prevention to combat, not only its impact on societies in terms of health and economy, but with special attention to the need to reduce the ecological footprint resulting from compounds of the chemotherapy treatments necessary to intervene in the disease (Soares et al., 2023).

SESSION 6: "CARPE DIEM"

The last session of the intervention plan is aimed at the person and their caregiver, as in the first session. It will last 50 minutes and will begin with the reading of the message that the person with the disease wishes to pass on to the next generation. A reflective approach to the logbook is desirable – if the person so wishes – or to the evolution of the person's perspective regarding the meaning of life and the acceptance of finitude. In relation to the caregiver, self-reflection will also be carried out in relation to their evolution in terms of self-care and application of effective communication, as well as its impact on their daily life and their relationship with the person with the disease.

In the end, the S-PRT will be applied to evaluate the results of the intervention plan in terms of the quality of life and subjective well-being (Atkinson et al., 2004).

EXTRA SESSION: THE FAMILY IN MOURNING

This session is not part of the intervention plan. However, it should be taken into consideration for adequate monitoring of the families of people with illnesses in Palliative Care (Leal & Soares, 2024). Preparing for grief and gradually accepting this reality can be a protective factor against complicated grief (Pimenta & Capelas, 2019; Santos and Soares, 2024b). Therefore, it is important that family members are supported to achieve better adaptation and preparation for mourning. This session is scheduled to last 90 minutes and will be in a group. This group will consist only of family members of people with illnesses in Palliative Care.

Initially, an exploration of what meanings and expectations families attribute to the grieving process and the death of their loved one is planned. Subsequently, psychoeducation (Conceição & Bueno, 2020) will be carried out regarding the stages of mourning so that there is understanding and support among family members regardless of the stage each member is in. It is important to strengthen the opportunity for growth of family members, associated with respect for human life and the personal evolution that everyone experiences when involved in this process (Pimenta & Capelas, 2019). It will be suggested that, in line with what was done with people with illness, they draw up a list of things they can still do in order to promote a meaningful look at the circumstance and to deal with the loss (Conceição & Well, 2020).

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CONCLUSION

Breast cancer brings with it very specific problems depending on the social and cultural meaning of femininity and beauty, which leads to an impact on women's self-esteem and psychological well-being. The intervention plan includes not only the individual with the disease but also their caregiver, recognizing the interconnectedness of their experiences. The emphasis on topics like breaking the "Conspiracy of Silence," caregiver support, and grief management reflects a deep understanding of the multifaceted nature of palliative care. Advanced breast cancer, on the other hand, raises other questions, such as facing finitude. People with advanced illnesses require a humane and dignified intervention, which is best delivered through Palliative Care services. The philosophy of dying well is what opens doors for people who have lost their meaning in life at the time of diagnosis to find themselves again and live until their last day. Psychological intervention at the level of Palliative Care aims to change the paradigm that a person with an illness stops living because they are dying. By redefining finitude, the meaning of life, and dignity by right, it is possible to intervene in a way that truly provides quality-of-life conditions. The importance of investing in the prevention of cancer and mental illness is urgent. Monitoring caregivers to prevent burnout due to the overload of providing Care and investing in education and self-care is essential to relieving the burden on health services and hospitalizations.

Finally, intervention in this context, regardless of the disease that leads the person to Palliative Care, aims to provide quality of life and well-being by reducing pain and suffering. Psychological intervention, in this context, must still add meaning to pain so that even with the pain, life is worth living.

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