

Abordagens em **MEDICINA:**

ESTADO CUMULATIVO
DE BEM ESTAR
FÍSICO,
MENTAL E
PSICOLÓGICO

3



BENEDITO RODRIGUES DA SILVA NETO
(Organizador)

Atena
Editora
Ano 2021

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APRESENTAÇÃO

A Organização Mundial de Saúde (OMS) define saúde como o estado de completo bem-estar físico, mental e social. Uma definição de certo modo ampla que tenta compreender os principais fatores ligados diretamente à qualidade de vida tais como alimentação, exercícios e até mesmo o acesso da população ao sistema de saúde. Portanto, partindo deste princípio a saúde física, mental e social são algumas das dimensões que determinam o estado de bem-estar humano, e conseqüentemente vão muito além da simples ausência de doenças. O próprio conceito de saúde, aqui estabelecido pela OMS, está relacionado a uma visão ampla e integral do ser humano, que considera aspectos do corpo, mente, ambiente, sociedade, hábitos e assim por diante.

Esse conceito nos conduz ao fundamento da multidisciplinaridade com abordagens que cada vez mais é aplicada e contextualizada nos diversos âmbitos da saúde, haja vista que todas as abordagens e áreas de estudo convergem para o mesmo princípio que é a saúde integral do individuo. A saúde na atualidade se estabelece na interação entre diversos profissionais e requer conhecimentos e práticas de diferentes áreas tais como as ambientais, clínicas, epidemiológicas, comportamentais, sociais, culturais etc.

Deste modo, por intermédio da Atena Editora, apresentamos a nova obra denominada “Abordagens em medicina: Estado cumulativo de bem-estar físico, mental e psicológico”, inicialmente proposta em quatro volumes, com o intuito de direcionarmos ao nosso leitor uma produção científica com diversas abordagens em saúde. Reforçamos aqui também que a divulgação científica é fundamental para romper com as limitações ainda existentes em nosso país, assim, mais uma vez parabenizamos a estrutura da Atena Editora por oferecer uma plataforma consolidada e confiável para estes pesquisadores divulguem seus resultados.

Desejo a todos uma proveitosa leitura!

Benedito Rodrigues da Silva Neto

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QUALITY OF LIFE AND ASSOCIATED FACTORS IN COLORECTAL CANCER PATIENTS

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ABSTRACT: Objective: To analyze the Brazilian and international scientific production on quality of life and associated factors in colorectal cancer patients. **Method:** This is a narrative review carried out in 2015 in the Databases SCIELO, Medline, Pubmed and LILACS, with articles published online and available intact, in Portuguese and English. **Results:** From the textual analyses, three categories were elaborated, to be: Colorectal cancer from the perspective of pathogenesis; Factors that represent a negative impact on the quality of life of cancer patients; e Protective factors and predictors of quality of life of cancer patients. We found that social support and resilience can

act as factors that protect health and strengthen the quality of life patients with colorectal cancer. Emotional stress and the physical and emotional symptoms of the disease contribute to a higher level of stress and lower quality of life among these patients. Final Considerations: Health managers and professionals need to think and execute actions and policies that strengthen the resilience and social support network of patients. Furthermore, studies are needed to evaluate the impact of demographic and clinical factors on the emotional stress and quality of life of these patients, since the delay in diagnosis and staging of the tumor may affect the effectiveness of treatment and the prognosis of patients.

KEYWORDS: Social Support; Psychological Stress; Psychological Resilience; Quality of Life; Nursing, Cancer.

QUALIDADE DE VIDA E FATORES ASSOCIADOS EM DOENTES COM CÂNCER COLORRETAL

RESUMO: Objetivo: Analisar a produção científica brasileira e internacional sobre a qualidade de vida e fatores associados em pacientes com câncer colorretal. **Método:** Trata-se de uma revisão narrativa realizada em 2015 nas bases de dados SCIELO, Medline, Pubmed e LILACS, com artigos publicados online e disponíveis íntegra, nos idiomas português e inglês. **Resultados:** A partir das análises textuais, foram elaboradas três categorias, a ser: Câncer colorretal na perspectiva da patogenia; Fatores que representam impacto negativo à qualidade de vida dos pacientes com câncer; e

Fatores de proteção e preditores de qualidade de vida dos portadores de câncer. Verificou-se que o suporte social e a resiliência podem atuar como fatores que protegem a saúde e fortalecem a qualidade de vida paciente com câncer colorretal. Já o estresse emocional e os sintomas físicos e emocionais da doença contribuem para maior nível de estresse e menor qualidade de vida entre esses pacientes. **Considerações Finais:** Os gestores e profissionais de saúde precisam pensar e executar ações e políticas que fortaleçam a resiliência e a rede de suporte social dos pacientes. Ainda, necessita-se de estudos que avaliem o impacto dos fatores demográficos e clínicos sobre o estresse emocional e qualidade de vida desses pacientes, uma vez que o atraso no diagnóstico e o estadiamento do tumor podem afetar a efetividade do tratamento e o prognóstico dos pacientes.

PALAVRAS-CHAVE: Apoio social; Estresse Psicológico; Resiliência Psicológica, Qualidade de Vida; Enfermagem; Câncer.

INTRODUCTION

Currently, 309,750 new cases of cancer are expected in Brazil, and colon and rectal cancer is among the 10 most incidents, corresponding to 20,540 new cases in men and 20,470 new cases in women. The state of São Paulo leads the forecast of new cases of cancer in Brazil for 2020 (except non-melanoma skin), with 117,130,000 new cases, of which 14,670 new cases of colon and rectal cancer. (INCA, 2020a). It is estimated that, for each year of the triennium 2020/2022, 41,010 new cases of colorectal cancer are diagnosed in Brazil, which corresponds to an estimated risk of 19.63 new cases per 100,000 men and 19.63 for every 100,000 women (INCA, 2020b). Given this panorama of cases of the epidemiological profile of the Brazilian population, cancer becomes increasingly a matter of concern to public health managers, especially due to greater exposure to risk factors related to lifestyle and carcinogens, and it is therefore essential to prioritize actions aimed at the prevention and control of the disease (GUIMARÃES; SILVA, 2012; KIMURA et al., 2020). Risk factors for colon cancer include age, male gender, presence of colonic polyps, individual and family history, and type 2 diabetes. In addition, environmental factors such as diet rich in red, processed and fatty meats, low intake of fruits and vegetables, alcohol consumption, obesity, smoking and sedentary lifestyle (INRA; SYNGAL, 2015; KIMURA, 2016).

Although its remarkable incidence in Brazil, this type of cancer is treatable and often curable when diagnosed early. In general, sporadic colon cancer develops from premalignant lesions (adenomatous polyps) that develop as they vascularize through the intestinal mucosa and grow slowly over time (American Cancer Society, 2014b). Treatment can be performed through surgery, chemotherapy and target cell therapy. Treatment may combine two therapeutic methods simultaneously or in isolation and will depend on the size, location and extent of the tumor, as well as the general health conditions of the individual. In general, a multidisciplinary team promotes treatment and different treatment

approaches are employed, depending on the tumor classification (BUZAID; Maluf; LIMA, 2013; AMERICAN CANCER SOCIETY, 2014B; KIMURA et al., 2020).

Speaking at the World Congress of the International Psycho-Oncology Society (IPOS) held in Rotterdam, The Netherlands, in 2013, and previously reported at the World Congress of the Same Society in 2009 in Vienna, Austria, it was reiterated that, in order to ensure the quality of cancer patient care, it is necessary to integrate the psychosocial domain in the practice of care. Another relevant aspect present in this pronouncement referred to the evaluation of distress as the sixth vital sign that should be included in the care process and incorporated into the basic assessments of temperature, blood pressure, heart rate, respiratory rate and pain (World Psychiatric Association, 2010; Breitbart et al., 2013). The National Comprehensive Cancer Network (NCCN) defines distress as an unpleasant multifactorial emotional experience of a psychological (cognitive, behavioral, emotional), social and/or spiritual nature that can interfere with the individual's ability to effectively cope with cancer, whether in the behavioral, emotional, physical and/or treatment spheres. This feeling can be from a common perception of vulnerability, sadness and fear to major injuries such as depression, anxiety, panic, social isolation and existential and spiritual crisis (Distress Treatment Guidelines for Patients, 2005).

Studies report that the ability to control distress improves the quality of life of cancer patients. The gap between control and quality of life is the precarious knowledge of the most significant/protective factors that effectively impact for better or worse quality of life of these patients in the experience of the disease. It is observed in practice that the health team does not value the possible psychoemotional manifestations presented by the patient and, thus, little appropriates available resources and that actually contribute to a better management of the disease. On the other hand, even patients who experience greater suffering report that they are not severe enough to seek help and intervention for symptom relief (Clover et al., 2014). This result seems to be a challenge to be faced in this journey, because not even patients perceive their own needs, which influences the search for possible sources of support and strengthening.

It is worth mentioning the need to define quality of life. The Mental Health Division of the World Health Organization defined for the first time the concept of quality of life as "the individual's perception of their position in life, in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (World Health Organization, 1997). According to Minayo (2000), quality of life approaches the degree of satisfaction of the individual in family, loving, social, environmental and existential instances. For the same author, quality of life is based on conditions and lifestyle, and is included in the field of sustainable development and human ecology.

In health, Auquier (1997 cited by Minayo, 2000) defines quality of life as a life value mediated by functional deterioration, the social condition caused by the disease, its

severity and treatment and the organization of the care system in the political and economic spheres. Considering the view centered on pathological conditions, quality of life refers to the individual's ability to overcome the difficulties experienced in disease conditions.

Quality of life in oncology was defined (Cella et al., 2002; Salsman, Pearman, Cella, 2013) as the assessment and satisfaction of the individual with their level of functioning in the disease process when compared to the perception of possible or ideal. Aaronson et al. (1993) define quality of life as a concept that includes the assessment of functional status, psychological and social well-being, health perception and symptoms related to the disease and treatment. It is defined as the ability of the individual to develop, under appropriate conditions and with well-being, the same functions usually performed in different spheres of life during the period of illness or treatment, when compared to his pre-disease condition (Dolbeault, Szporn, Holland, 1999). Thus, the quality of life in this study was based on the concept that includes, in addition to the symptoms, the physical, emotional, functional, social and family dimensions.

OBJECTIVE

To analyze the Brazilian and international scientific production on quality of life and associated factors in colorectal cancer patients.

METHOD

This is a narrative review of the literature, characterized as a method of describing the state of the art of a specific subject, from the theoretical and conceptual point of view. It also involves the analysis and interpretation of literature published in books, printed and/or electronic journal articles.

In June 2015, data were collected in the databases: SCIELO - Scientific Electronic Library Online; Lilacs - Latin American and Caribbean Literature in Health Sciences, Medline- Medical Literature Analysis and Retrieval System Online; and Pubmed. We included articles written in Portuguese or English, available online and in full text, with no time frame.

After the initial reading of the titles and abstracts of the materials found, selected those that met the eligibility criteria. Subsequently, the pre-selected articles were read in full, being evaluated again for these criteria. After the selection of the final sample, the following variables were extracted for analysis and construction of this review: Objective, Methodology, Results and Conclusion. These variables were treated by content thematic analysis

RESULTS AND DISCUSSION

Colorectal cancer from the perspective of pathogenesis

Cancer of the large intestine is a treatable and often curable disease when diagnosed early. In general, sporadic cancer of the colon develops from premalignant lesions, called adenomatous polyps, which, when vascularized by the intestinal mucosa, develop and grow slowly over the years (American Cancer Society, 2014b). The most well-established risk factors for colorectal cancer are age, male gender, presence of colonic polyps, individual/family history of colorectal cancer, type 2 diabetes and environmental (diet rich in red, processed and fatty meats, low intake of fruits and vegetables, alcohol consumption, obesity, smoking, sedentary lifestyle and diabetes mellitus) (Inra, Syngal, 2014). Inflammatory bowel disease, such as ulcerative colitis and Crohn's disease, is an important risk factor for colonic neoplasia (Herszényi et al., 2015). Colorectal cancer hardly affects young individuals, with the age group with the highest incidence between 60 and 70 years of age (Jemal et al., 2009; Saragiotto et al., 2013).

The colorectal tumor is mostly of the sporadic type; however, it may also arise as a hereditary syndrome called Family Adenomatous Polyposis Syndrome (FAP) and Lynch Syndrome or Hereditary Non-Polyposis Colorectal Cancer Syndrome (HNPCC) (Saragiotto et al., 2013)

Because it does not produce symptoms in the initial phase of the disease (change of bowel habits, general abdominal discomfort, weight loss without apparent cause, frequent fatigue, hematochezia or melena), colorectal cancer is often diagnosed at a more advanced stage. In asymptomatic patients, diagnosis usually occurs when performing screening tests (occult blood, rectosigmoidoscopy or colonoscopy, double contrast with barium enema and computed tomography of the colon – virtual colonoscopy), which is recommended for individuals over 50 years of age (Filho and Garcia, 2006).

The treatment of this type of tumor is based on different methods: surgery, chemotherapy and radiotherapy (only for rectal cancer) and target cell therapy. The choice of treatment may be a combination of two therapeutic methods at the same time or separately, and will depend on the size, location and extent of the tumor, as well as the general health conditions of the patient. However, the choice for surgical treatment occurs in about 90% of patients with colon cancer. Patients are often treated by a multidisciplinary team and different treatment approaches are employed, depending on the tumor classification (Buzaid, Maluf, Lima, 2013; American Cancer Society, 2014b). Although chemotherapy has benefits to treatment, its effect is not restricted to tumor tissues, also affecting normal tissues, which leads to side effects, including: alopecia, cardiotoxicity, hepatotoxicity, neurotoxicity, pulmonary toxicity, hematological, gastrointestinal changes, reproductive dysfunction, bladder and renal toxicity, metabolic changes, hematological toxicity, allergic reactions and anaphylaxis (BONASSA, 2005; SILVA et. al., 2015). In

addition to these effects, the patient experiences the social paradigm associated with cancer, the fear of death and the social, labor and physical changes involved (KIMURA et al., 2017). Moreover, during the diagnosis and treatment process, colonoscopy stands out as an uncomfortable examination for the patient, which can trigger feelings of vulnerability, shame, fear and pain. In view of this context, it is possible that the adaptive resources of patients are exceeded, leading to stress and reduction in the quality of life of patients (BONASSA, 2005; SILVA et al., 2015; KIMURA et al., 2020).

The staging of colonic neoplasia is due to anatomopathological analysis and follows the system of the American Joint Committee on Cancer (AJCC), known as TNM (distance, extension and involvement of organic organs or tissues) and the Dukes classification. Tumor staging takes place in a classification from 0 to IV (from lower to greater severity), with variations depending on the method adopted. The overall survival rate ranges from 75 to 80% and occurs on average five years for stage II colon cancer, which decreases to 60% for stage III disease (Buzaid, Maluf, Lima; 2013, Saragiotto, 2013).

It is known that multimodal treatment, whether neoadjuvant or adjuvant, brings a real gain for patients with colorectal cancer stages II and III. Despite the benefits of chemotherapy, it is known that its effect is not restricted to tumor tissues, also reaching normal tissues, which is evidenced by the side effects observed. The most reported are alopecia, cardiotoxicity, hepatotoxicity, neurotoxicity, pulmonary toxicity, hematological, gastrointestinal, reproductive dysfunction, bladder and renal toxicity, metabolic changes, hematological toxicity, allergic reactions and anaphylaxis. These effects, when not well evaluated and treated, have a negative impact, reducing the quality of life of their patients (Cordeiro, 2004; Bonassa, 2005; Son, Garcia, 2006).

In the analysis of patients suffering from breast cancer, it is verified that, with the incorporation of multimodal therapy, there was an increase in the number of patients who suffer an impact on quality of life, either in the expression of transient, persistent complaints or even for long periods (Gartner et al., 2009; Bantema-Joppe et al., 2015). In this perspective, in a study conducted with patients collected for tumor resection of the rehest, an impact on quality of life in the functional sphere and sexuality was reported among those under 69 years of age (Schmidt et al., 2005). In a prospective study that analyzed gender differences after rectal cancer surgery, there was a worsening among women in the global and physical health spheres and high scores for fatigue and effort. Among men in the same study, the lack of sexual satisfaction was the most reported complaint. Changes in bowel habit with the presence of diarrhea, fecal incontinence and pain were frequent complaints in patients after colorectal tumor resection (Nikoletti et al., 2008).

Factors that represent a negative impact on the quality of life of cancer patients

Different studies show situations or symptoms that predict the worsening of the quality of life of cancer patients. It is worth remembering that the quality of life in this

study was based on the concept that includes, in addition to the symptoms, the physical, emotional, functional, social and family dimensions.

Because it represents less stigma and differentiates it from psychiatric disorder, the term distress in cancer patients has been frequently used (Distress Treatment Guidelines for Patients, 2005). In the current research, the term stress was used because it represents a conceptual similarity with the term presented and with the theoretical stress framework according to Lazarus and Folkman (Lazarus, Folkman, 1984), which defines as any stimulus coming from the external or internal environment that taxor exceeds the sources of adaptation or coping of the individual. Stressors are stimuli from the disease situation and/or treatment that can interfere with the individual's ability to adapt to present challenges/threats. Given the stress experienced by cancer patients, it is necessary to use different coping strategies, whether they are focused on the problem or emotion, among which social support. This involves a set of formal and formal relationships from which cancer patients receive support to face the problems related to the disease (KOLANKIEWICZ et. al., 2014; KIMURA et. al., 2017; KIMURA et. al., 2019).

Although the emotional stress among colorectal cancer patients seems to be similar to those faced by patients with other types of tumors (Zabora et al., 2001), national and international investigations have focused little on identifying situations of wear and tear among colorectal cancer patients.

From the perspective of stress and disease, in the diagnostic confirmation phase, the perception of safety and well-being of the subject becomes the need to live for long periods with more severe stressor. Thus, in a longitudinal study that analyzed positive emotions and their relationship with physical and psychological symptoms of 215 patients with newly diagnosed colorectal cancer, a maximum period of one year, it was observed that the worsening of physical symptoms influences patients negatively, with more symptoms of anxiety and depressive mood, in a maximum period of three months after diagnosis (Hou, Law, Fu, 2010).

In a population-based cohort study that compared the quality of life of 309 patients with invasive colorectal cancer at least one year after diagnosis with the general population, a slight aggravation of patients was observed in the scores of the physical functional scales, role performance, development of daily activities, cognitive function and overall health. In the analysis of symptoms, there was a greater limitation of patients in the subscales fatigue, dyspnea, insomnia, constipation, diarrhea and financial difficulties (Arndt et al., 2004).

In another randomized controlled study that compared the quality of life of 152 colorectal cancer patients treated with curative intent with the general population, it was found that patients had lower depression and anxiety scores, but worsened quality of life scores of cognitive functional scales, role performance and social activity. It was observed in this analysis that the symptoms of the subscales fatigue, loss of appetite, diarrhea,

nausea and vomiting were the most scored (presented the worst result) for those who were in the phase near the end of treatment (Russel, 2015).

In this perspective of analysis of the quality of life of patients undergoing chemotherapy, a prospective observational study that analyzed 102 colorectal cancer patients evaluated in the initial and final stages of chemotherapy treatment showed that there was no considerable change between the domains evaluated for quality of life in the two stages of evaluation; however, fatigue was the main complaint reported among patients in the final phase of treatment. Also in this study, symptoms of anxiety and depression were described in a significant number of patients in the study in both phases, beginning and end of treatment (Iconomou et al., 2004). With these findings, there was a correlation between depression and poorly adaptive responses to coping with the disease and treatment with emphasis on the harmful effect on quality of life.

One hundred and fifty-three patients with colorectal cancer and ninety-six family members were analyzed in a descriptive cross-sectional study to know the impact on quality of life of operated patients and their relatives/caregivers. In this analysis, it was demonstrated that patients with stoma present decreased physical, social, emotional functionality, role performance and overall quality of life when compared to those without stoma. Similarly, symptoms of fatigue, diarrhea and altered sexual function in men were also the most reported. In both patients and their relatives/caregivers, symptoms of anxiety and depression were more present among ostomized patients (Cotrim, Pereira, 2008).

Following the same theme, however, focusing on couples experiencing colorectal cancer and treatment, a qualitative study was conducted in a sample of patients with advanced colorectal cancer and their respective spouses in order to know the impact that the disease and treatment have on the daily life situations of both. Three categories were formed from the patients' reports: constant visits to health institutions were related to feelings of safety and hope; staying active and controlling daily activities were strategies used in order to maintain normality; and, finally, the reassessment of lived experiences and the feeling of vulnerability were related to the awareness of the time limits of life. Among the spouses, it was reported that living in an altered marital relationship and living in the shadow of a disease makes it difficult to establish future plans (Sjövall et al., 2011).

In the evaluation of stress and the difference between gender of colorectal cancer patients, in an exploratory cross-sectional study with 100 patients undergoing chemotherapy, reports were observed among men of treatment interference in daily routine and worsening of quality of life. Also, in this research, women presented greater perception of stress and greater impact of treatment, especially in the sphere of physical appearance, alopecia and weight gain, which interfere in self-image; other symptoms, such as fatigue, nausea, vomiting and weakness, interfere with daily activities (Benavente, 2011).

There is a strong association in this context between the psychoemotional manifestations of stress and the therapeutic actions in cancer; however, it is observed that

this relationship is not fully understood, because what is observed is that people react in different ways in these situations and mobilize different resistance resources to satisfy the demands imposed by the threatening stimuli with better results in this treatment process.

Protective factors and predictors of quality of life of cancer patients

Data from the literature show protective factors and stress moderators among colorectal cancer patients. In this perspective, social support appears as a strong ally in coping with the disease and supporting patients in the experience of common symptoms during treatment. Similarly, more resilient individuals have a better ability to recover from negative experiences from stressful cancer situations.

The concept of resilience has been proposed by different authors (Molina et al., 2014; Oken, Chamine, Wakeland, 2015). Wagnild and Young (1993) and define resilience as a multidimensional construct and mediator of behaviors, thoughts and actions that favor the individual's ability to deal more successfully with the challenges of life, with emphasis on recovery and emotional stability (Wagnild, 2009).

Resilience studies have different subjects in their approach. Initially, children and adolescents were the most studied (Smorti, 2012; Chen, Chen, Wong, 2014). Others focus on resilience assessment as predictors for intervention (Wallace et al., 2007; Docherty et al., 2013). Others also address resilience in the analysis of family suffering (Greef, Thiel, 2012); few subjects have colorectal cancer patients.

Researchers define resilience in oncology as a characteristic of the individual that gives him a trajectory of stability and low stress or high emotional control in the course of the disease or treatment (Lam et al., 2010). Other authors define resilience as the ability to cope or adapt the individual to the adversities present in the diagnosis or conduction of the disease (Woodegate, 1999). The concept of resilience in oncology has not yet been fully clarified; however, a methodological study of a systematic literature review that analyzed eleven articles of resilience in adult individuals with cancer concluded that resilience is a dynamic process of coping with the adversities imposed on individuals with cancer through diagnosis, treatment, presence of symptoms and stress inherent to the situation itself (Eicher et al., 2015).

The importance of the concept of resilience in health is indisputable. Its relevance in nursing practice is essential, because it allows to know the risk and protection factors imbued with the disease process and to predict individuals with greater capacity for resistance or recovery in the face of the challenges of the disease and treatment (Lima, Araújo, 2012; Smith et al., 2013). Strauss et al. (2007) report that knowing the resilience of the individual allows to outline intervention programs that impact treatment adence, the reduction of symptoms and prevention behaviors to deleterious and undesirable results or the maintenance of healthy habits.

A randomized cross-sectional study conducted with 281 women with newly

diagnosed gynecological cancer that analyzed resilience, positive expressions, meaning cultivation and quality of life observed that more resilient patients had better quality of life. The results of this research also reveal that the most resilient express their emotions better, perceive experiences in a more positive way and better cultivate the sense of meaning through life (Manne et al., 2014).

In the comparison between patients with prostate cancer, 189 undergoing radiotherapy and 236 who underwent surgery, a significant association of psychological aspects of resilience with low level of depression was observed in both groups of patients. It was concluded in this research that the evaluation of resilience can predict depression in patients with prostate cancer and contribute to more effective interventions that help in the ability to cope with stress in diagnosis and treatment for the most depressed (Sharpley et al., 2014).

In a cross-sectional study that investigated the association of distress and the protective factors related to the personality characteristics (resilience and perception of optimism) of 1,425 patients newly diagnosed with prostate cancer, it was found that individuals with higher scores for resilience and optimism are more adapted to coping with the disease and are associated with less distress. In this research, the authors mention the importance of developing intervention strategies (cognitive-behavioral therapy) for those with low scores for personality characteristics, in order to contribute to a better coping with stressors from diagnosis, treatment and the common fear of recurrence of the disease (Orom et al., 2015).

Studies report that resilience increases with age. Thus, in a cross-sectional exploratory study that analyzed 92 colorectal cancer patients with staging II and III, it was observed that resilience is a mediating factor to decrease the presence of anxiety and depression symptoms. Among older patients and men, resilience is a moderating factor for less distress (Cohen, Baziliansky Beny, 2014).

By following the context of the protective sources of cancer patients to emotional stress, social support has been shown in different researches as a coping resource for improving the quality of life of these patients (Helgeson, Cohen, 1996). Cobb (1976) states that social support is a moderating agent of stress and defines it as the information offered to the subject to reinforce his belief and perception to feel cared for, loved, esteemed, valued and belong to a mutual network of obligations. Among the authors who define social support, five categories that describe the concept were found: support resources from other subjects; perception of the scope of support, support and information needs; mutual perception or behavior between the one who supports and what he receives with the intention of well-being of the one who receives support; reciprocity and exchange of resources between those who offer support and what they receive; support offered to the individual from the relationship with other individuals, groups and community (Hupcey, 1998).

Social support is seen as a transactional process that changes according to the demands that the stressful event presents. In this context, Dunkel-Schetter, Folkman, Lazarus (1986) highlight the interaction of the individual and his/her environment in coping with crisis situations. In the individual and middle relationship, the support resources come from different sources – family, friends, religious/spiritual, operative groups and health professionals – in different contexts, which implies feelings of greater security, adoption of healthy lifestyle habits and better health outcomes (O'Mara-Eves et al., 2013).

Although the concept of social support is broad, complex and studied in different contexts and resources, studies report being an indisputable source of support that plays a positive role in the recovery of patients with disease of such severity as cancer (Silva, Melo, Rodrigues, 1999). A sample of 100 breast cancer patients was studied in a cross-sectional study that related symptoms of distress, religious or personal support to quality of life. Linear regression analysis showed that family and friend support is the greatest predictor for better quality of life, regardless of the distress symptoms presented by patients (Manning-Walsh, 2004).

One thousand five hundred and forty-four patients in a period of four to 14 years of follow-up after gynecological cancer, breast, prostate or colon were analyzed in a cross-sectional study. For most patients, the perception of support came from their spouses, mostly, and children, and the greater availability for decision-making and use of health services was found among married patients in the period of two years of follow-up of the disease. In this research, the authors report that the sense of obligation to participate in care, provision of financial resources, inclusion in supplementary health and follow-up in routine consultations seems to be a more common practice among couples (Forysthe et al., 2014).

The meeting with support groups was analyzed in a qualitative study that addressed 36 patients with breast cancer. The results show that participation in these groups allows sharing experiences with those who live similar situations, acquiring knowledge about the disease and treatment, expanding the feeling of trust and developing the skills to better cope with and adapt to the disease and treatment (Cozaru, Papari, Sandu, 2014).

From the perspective of professional support, in an exploratory study with a qualitative approach that interviewed 27 patients undergoing treatment with colorectal cancer diagnosis, the results revealed the expressive role of nurses as an element of support and support for patients in offering information that favors the understanding of the disease, the treatment adopted, predictable symptoms and home care education (Beaver et al., 2010). Williamson, Chalmes, Beaver (2014) reinforce the role of nurses as a support element that favors continuity of care at home with greater patient satisfaction and better outcome in the treatment of colorectal cancer.

FINAL CONSIDERATIONS

Managers and health professionals need to think and execute actions and policies that strengthen the resilience and social support network of patients in view of less emotional stress and improved quality of life. Moreover, based on the problem found regarding clinical aspects, studies are needed that assess the impact of demographic and clinical factors on the emotional stress and quality of life of these patients, since the delay in diagnosis and staging of the tumor can impact on the effectiveness of treatment and the prognosis of patients. Demographic elements, such as the level of education, can be evaluated as elements that hinder the recognition of the disease and the delay in the search for health care.

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