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Meanings of breast cancer treatment for lesbian women and their intimate partners

Significados do tratamento do câncer mamário para mulheres lésbicas e suas parceiras

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Abstract

Objective
Among women at risk of developing breast cancer, lesbians tend to have their health needs neglected, which calls for the development of strategies that are sensitive to their specific demands. This qualitative study aimed to understand the meanings that lesbian women with breast cancer and their intimate partners attribute to the treatment.

Method
This is a qualitative, descriptive-exploratory study with a cross-sectional design, grounded in gender studies as the theoretical framework. Participants included seven women (four with a breast cancer diagnosis and three intimate partners). Episodic narrative interviews were conducted individually using a topic guide. Transcribed data were coded through thematic analysis, with emerging themes interpreted within the gender studies framework.

Results
Six themes described the meanings that women with cancer constructed for their treatment and eight themes outlined the meanings assigned by their companions.

Conclusion
The treatment was experienced with distinct meanings by patients and their intimate partners, yet all converged on the perception of the experience as a limiting situation – one that not only tested their tolerance for pain and frustration but also forced them to confront the fragility of the human condition.

Keywords: Breast cancer; Breast neoplasms; Homosexuality, female; Sexual and gender minorities; Women's health.

Resumo

Objetivo
Dentre as mulheres com risco de desenvolver câncer de mama, as lésbicas tendem a ter suas necessidades de saúde negligenciadas, o que requer a criação de estratégias sensíveis às suas

demandas específicas. O objetivo deste estudo qualitativo foi compreender os significados que mulheres lésbicas com câncer de mama e suas parceiras íntimas atribuem ao tratamento.

Método
Estudo qualitativo, descritivo-exploratório e transversal, ancorado nos estudos de gênero. Participaram sete mulheres (quatro pacientes com câncer de mama e três parceiras íntimas). Foram realizadas entrevistas narrativas episódicas individuais, utilizando um guia temático. As entrevistas foram transcritas na íntegra e submetidas à análise temática. Os dados transcritos foram codificados para identificar temas emergentes e analisados à luz do marco teórico-conceitual dos estudos de gênero.

Resultados
Seis temas descreveram os significados que as mulheres com câncer construíram para o tratamento e oito temas delinearam os significados atribuídos pelas companheiras.

Conclusão
O tratamento foi vivenciado com significados distintos pelas pacientes e suas parceiras íntimas, mas todas convergiram na percepção da experiência como situação-limite, que além de testar a tolerância à dor e à frustração, as levou a confrontar a fragilidade da condição humana.

Palavras-chave: *Câncer de mama; Neoplasias da mama; Homossexualidade feminina; Minorias sexuais e de gênero; Saúde da mulher.*

Breast cancer is the leading cause of cancer death in women in Brazil. In 2022, 73,610 new cases were estimated. For this reason, breast cancer is one of the diseases most feared by women (Instituto Nacional do Câncer, 2022; Rossi & Santos, 2003; Santos et al., 2013; Silva & Santos, 2010; B. F. Souza et al., 2014; Vidotti et al., 2013). However, among women at risk of developing breast cancer, some tend to have their health needs neglected by health services, particularly younger women and lesbian women, which requires the health system to formulate specific strategies to reach these populations (Boehmer et al., 2013; Wheldon et al., 2019).

For a long time, the question of sexuality after breast cancer remained a taboo and was little discussed between professionals and patients (Boehmer, Ozonoff et al., 2014; C. Souza, Santos et al., 2021). It is now obvious that, as in other aspects of medical care, the issue of sexuality must be raised by professionals to inform patients of the impact of treatments, identify their needs, prevent, and treat any complications, as well as addressing the topic of sexual orientation (Boehmer, Ozonoff et al., 2014; Jahn et al., 2019; C. Souza & Santos, 2024).

However, it was observed in the Brazilian context that the questions about sexuality and sexual orientation are not even included by health professionals in the routine consultation (D. B. Santos et al., 2016; Vieira et al., 2013), which reinforces the invisibility of lesbian women in health services (Cabral et al., 2019; C. Souza & Santos, 2021, 2023). Thus, in health practices, professionals, without being fully aware of this process, end up endorsing the assumption that all women assisted have hetero-oriented sexuality (Secretaria de Políticas para as Mulheres, 2014).

Studies with heterosexual couples show that the partners had a significant role in facing the problems related to the oncologic treatment, showing feelings of understanding, friendship, affection, and respect for their partners, leaving them the time they needed to recover and helping them to effectively circumvent the obstacles imposed by surgery (Catania et al., 2019; Cesnik & Santos, 2012; Cesnik et al., 2013; D. B. Santos, Ford et al., 2014; C. Souza, Santos et al., 2021; Vieira et al., 2014). These results indicate that studies on the possible transformations in conjugal intimacy due to the impact of breast cancer and its treatments focus almost exclusively on heterosexual women (D. B. Santos et al., 2016; D. B. Santos, Santos et al., 2014). Therefore, the intimate partners investigated in research on perceptions of changes in sexual life and issues related to love relationships after breast cancer are generally limited to men (Hirschle et al., 2018; C. Souza & Santos, 2021; Yoshimochi et al., 2018).

According to gender studies the discourses that oppress lesbian women establish as correct and legitimate that the basis for the harmonious functioning of any society is heterosexuality. One of the many ways to reinforce heteronormativity is to maintain lesbian existence as an invisible possibility (Rich, 1980). Traditionally, women's lives have been regulated by social institutions – such as the nuclear family, religion, and the state – through mechanisms like motherhood and economic exploitation, among others, which have been reinforced by legislation, the media, and censorship. If the lesbian does not disguise herself, she may face discrimination (Rich, 1980; Scott, 1986).

In the field of healthcare, the normative conceptions of gender and sexuality affect how the subjects are linked to health services and the ways they exercise care practices. In the institutional context, gender inequalities contribute to the constitution of the public that benefits from the actions offered, to the detriment of others, with few health services offering an inclusive LGBTQIA+ space (Leal et al., 2024; M. A. Santos et al., 2024; Secretaria de Políticas para as Mulheres, 2014; Souto & Moreira, 2021; C. Souza & Santos, 2023; C. Souza, Oliveira-Cardoso et al., 2021).

In the context of oncology, it is necessary to identify the female vulnerabilities that are present in the search for health services. It is necessary to investigate the social and cultural aspects that support the structures of health-disease-care representations. Women with dissident sexual orientation tend to be invisible by health professionals (Duman & Yildirim, 2022; C. Souza & Santos, 2021, 2024). They are often either seen without regard for their sexual orientation and gender identities, or regarded as women who deviate from heteronormative expectations. In both cases, these women receive care that fails to meet their actual health needs and lacks cultural sensitivity and differentiation (Secretaria de Políticas para as Mulheres, 2014).

Studies found that some lesbian women, when seeking treatment for breast cancer, experienced in the health system some contexts of exposure to situations that reinforce their vulnerability, which can trigger adverse health outcomes and therefore impact their quality of life (Jennings et al., 2019; C. Souza, Britowe et al., 2024; C. Souza & Santos, 2021; Wheldon et al., 2019). A provisional conclusion, which can be drawn from examining the evidence in the literature to date, is that ensuring comprehensive care for women with breast cancer is extremely relevant, as the situations, vital events, and feelings that the patient and his/her partner experience during the process of diagnosis, treatment, and rehabilitation are very complex (Inocenti et al., 2016; Rossi & Santos, 2003; M. A. Santos & Souza, 2019; Silva & Santos, 2008; C. Souza & Santos, 2021; Vidotti et al., 2013).

These findings need to be better understood by new research that focuses on specific aspects that have been little investigated, such as the illness experiences in the context of sexual orientations that differ from heteronormativity. In this sense, this study aimed to understand the meanings that lesbian women with breast cancer and their intimate partners attribute to the treatment.

Method

This is a qualitative, descriptive-exploratory and cross-sectional study. Qualitative research perspective seeks to assist the understanding of meanings, experiences, beliefs and representations, valuing different perspectives of participants and taking into account their biopsychosocial aspects (Flick, 2009).

Participants

Seven women who self-identify as lesbians participated in the research, four of whom were diagnosed with breast cancer and three were intimate partners, regardless of the time of union.

Participants were located based on contacts in social networks and support groups for breast cancer. Two potential participants declined the invitation: Nina's wife and another woman who stopped responding to the researcher's messages.

The participants were selected based on the following criteria: self-identify as lesbian; age of 18 or older; having been diagnosed with breast cancer (in the case of patients) or being their intimate partner; being in clinical conditions to grant the interview. The exclusion criterion was women who presented marked difficulties in understanding and communicating.

The number of participants was determined by the criterion of theoretical saturation (Fontanella et al., 2011). According to Rego et al. (2019), the number of participants to be included is influenced by the specificity of the sample. If the samples are very specific, it is likely that the informants have quite homogeneous characteristics, which may lead to smaller samples. Therefore, very high levels of specificity may favor the use of small samples, as occurred in this research.

Instruments

Sociodemographic Data Form: This instrument addressed general sociodemographic and clinical data.

Critério de Classificação Econômica Brasil (Brazilian Economic Classification Criterion): This instrument aims to characterize the participants in terms of purchasing power and their position in the social hierarchy (Associação Brasileira de Empresas de Pesquisa, 2016).

Semi-structured Interview Script: For data construction, episodic narrative interviews were conducted, which focus on understanding the research participants' accounts of facts, episodes and events, which proved to be relevant to the understanding of the phenomenon studied (Flick, 2009). The interview script was developed from a review of scientific articles on the theme (C. Souza & Santos, 2021).

Procedures

To constitute the research corpus, participants were located based on contacts in social networks and support groups for breast cancer; then, recruitment was based on indications from other women who were supposedly eligible, obtained from the participants ("snowball" method). Other search strategies and access to potential participants (contact with LGBTQIA+ groups, as well as with hospitals) were also used so that the sample could cover a diversity of people and not remain restricted to the researcher's social group.

Interviews were conducted with each woman, separately, except for a couple, Débora and Helena, who attended together in both interviews. All interviews were conducted in Portuguese, from November 2017 to May 2018 in a face-to-face situation and recorded with the participants' consent. Data collection was carried out in a preserved environment. Preliminarily, the researcher came into personal contact with the eligible women, explaining the research objectives and requesting their collaboration. If the patient agreed, the researcher got in contact and scheduled a meeting at the participant's preferred location. On that occasion, the interview with the partner was scheduled.

The interviews lasted between 77 and 331 minutes, later transcribed, and analyzed in the perspective of the inductive thematic analysis (Braun & Clarke, 2006). This technique proves particularly useful for organizing dense descriptions of a topic of interest through the creation of themes. The themes constructed were emergent in nature ("bottom-up"); that is, they were

not defined by the researchers as a priori theoretical categories; rather, they emerged inductively according to the research objective. The interviews were read thoroughly and coded by two experienced members of the research team, taking general aspects relevant to answering the research objective as a guide. The six recommended methodological steps were followed: 1) Familiarization with the data; 2) Generating initial codes; 3) Searching for themes; 4) Revising the themes; 5) Defining and naming the themes; 6) Producing the report.

The theoretical framework for analysis comprised recent research on breast cancer and lesbian experience, extracted from systematic review (C. Souza & Santos, 2021), involving issues of female sexuality and gender relations (Rich, 1980; Scott, 1986).

The study was approved by the Research Ethics Committee of the Faculty of Philosophy, Sciences and Letters at Ribeirão Preto from the University of São Paulo (FFCLRP-USP), CAAE: 65391517.4.0000.5407, following the ethical procedures regarding the volunteers and the institution, according to Resolution No. 466/12 (Conselho Nacional de Saúde, 2012). Participation in the research was voluntary, and the participants formalized it by signing the informed consent form. All names used in this work are fictitious and were chosen by the participants themselves.

Results and Discussion

The joint presentation of the results and discussion ensures better visualization of the information and the analysis of the categories, illustrated by means of the speech excerpts, which corroborate the discussion. The results will be presented and discussed in two stages. In the first, the interviews with women with breast cancer will be analyzed: Débora, Nina, Yele and Frida. In the second stage, the statements of the female partners will be analyzed: Helena, Marília and Fernanda. Table 1 presents the sociodemographic data of the participants.

Table 2 presents some clinical data of the participants related to their trajectory with breast cancer.

Table 1
Sociodemographic characteristics of the participants (Ribeirão Preto, Brazil, 2018)

Name (fictitious)	Age (years)	Time with partner	Occupational status	Education	Family income	CCEB
Débora	37	1 year	Production operator and bartender	Complete HE	R$ 3.000	B2
Helena	22	1 year	Law student	Incomplete HE (studying)	R$ 3.000	B2
Nina	53	30 years	Occupational therapist	Complete HE	Preferred not to inform	Preferred not to inform
Yele	38	6 months	Barber	Complete HE	R$ 2.000 to R$ 3.000	B1
Fernanda	43	6 months	Chemist	Complete HE	R$ 1.0000	A
Frida	51	13 years	Administrative officer	Complete HS	R$ 3.000 to R$ 3.500	B1
Marília	59	13 years	University professor	Complete HE	R$ 13.000	A

Notes: CCEB: *Critério de Classificação Econômica Brasil* (Brazilian Economic Classification Criterion); HS: High School; HE: Higher Education.

Table 2
Clinical characteristics of participants affected by breast cancer (Ribeirão Preto, Brazil, 2018)

Name (fictitious)	Age at diagnosis (years)	Time since surgery (years)	Type of surgery	Complementary treatments
Débora	33	4	Modified radical mastectomy	Chemotherapy and radiotherapy
Nina	51	2	Modified radical mastectomy	Chemotherapy and hormone therapy
Yele	33	5	Modified radical mastectomy	Chemotherapy, radiotherapy, and hormone therapy
Frida	48	3	Quadrantectomy	Chemotherapy, radiotherapy, and hormone therapy

Analysis of the Interviews Conducted with Women who Have Had Breast Cancer

The thematic analysis allowed the construction of the following thematic axes: hair loss, living with pain, breast removal, breast reconstruction and support from intimate partners.

Regarding the consequences of treatment, the first significant loss was hair loss due to antineoplastic chemotherapy. Débora explained that hair loss was not a problem for her: "(...) I felt very beautiful bald. I took several photos, yeah... I went out, even with my bald head (...). I thought I became more feminine (...)". On the contrary, Frida reported that she suffered with hair loss but realized that it was not everything after the initial impact.

> Then I had to take it [hair prosthesis] out. Then I cried (...). [After] I always came [to work] with makeup, but I was always bald (...). Then you see that it [hair] is nothing, right? That you have other resources. (Frida, 51 years old, Marília's girlfriend)

Coping with hair loss by lesbian and heterosexual women who have had breast cancer varies according to each person's situation and personality. Many women claim that hair loss did not affect their femininity. The most important for them is that they were alive. On the other hand, hair is meant as one of the greatest symbols of femininity in Western culture, and its loss can be felt as a very traumatic experience, which impacts the self-image of women with breast cancer (Dua et al., 2017; Trusson & Pilnick, 2017; Wheldon et al., 2019).

The two participants gave different directions for hair loss. Débora was perhaps not so focused on expectations regarding the female appearance. Therefore, she could see beauty in a look that deviates from the standards imposed on women, stating that she did not think she was less feminine or less beautiful because she lost her hair. Frida, perhaps having internalized more of these arbitrary standards of beauty and femininity, initially resorted to the prosthesis to try to keep the hair.

Nina and Yele commented more on the reaction that other people had when they saw them without hair. The first reported that she got married when she was bald, receiving much support at that moment: "And I was in a turban [in her wedding], because I was completely, completely bald (...). And then, the people, everyone... a lot, cheering a lot for us (...)". The second explained that hair loss was not a hindrance so that she could relate to someone else: "(...) I met my ex-girlfriend (...) and she fell in love with me. I was bald, feeling sick (...) and she wanted to be with me (...)".

It was seen in the literature that social support, whether from friends, family members, or even from health services, helps women who have had breast cancer to deal with hair loss (Dua et al., 2017; Trusson & Pilnick, 2017). Such support seems to have been perceived by Nina and Yele. No similar studies were found involving women of sexual minorities.

To undergo cancer treatment is to learn to "live with pain". The four participants affected by cancer reported having experienced diffuse pain throughout the body during the long treatment period. Débora mentioned intense pain and Yele said that she felt little pain. Nina and Frida commented that pain was one of the side effects of hormone therapy.

> (...) All joints hurt. It was one of the strongest side effects [of hormone therapy] (...). Then you get like this... I get tired and have joint pain, you say: "(...) To live like this? No, I will stop taking it [hormone therapy]. (Nina, 53)

> (...) The pain in my legs was too much. (...) When I went to the gynecologist [...] he said that tamoxifen does this. (...) If they had given me the option of choosing [the medication], I would have changed it. (Frida, 51, Marília's girlfriend)

A study conducted in the United States indicated that women who had breast cancer feel pain above the national average for an American adult (Schreier et al., 2019). All participants who had breast cancer reported that they experienced pain at different levels and locations, during treatment and after. Again, no similar studies were found involving women of sexual minorities.

Although women are often told that the side effects of medication tend to decrease over time, the literature shows that the intensity of side effects self-reported by patients increases significantly over time (Moon et al., 2019). Boehmer et al. (2013) found in their research with lesbian and heterosexual women who had breast cancer that the former had greater physical disabilities after surgery, radiation treatment, and hormone therapy. Nina and Frida commented on the recurrence of side effects of hormone therapy, especially regarding the pain, and expressed the desire to discontinue the medication.

Regarding "removing the breasts", Débora, Nina, and Yele reported feelings of sadness when they learned that they would be without their breasts. Frida, on the other hand, chose not to have a mastectomy, even though it was a medical recommendation:

> (...) I felt bad even when I had the surgery, I ran my hand and saw that I didn't have it, you know, I went in with a breast and left without a breast. So, then the shock came, you know. (Débora, 37, Helena's girlfriend)

> He [doctor] said '(...) I can't save any quadrant from your breast. We will remove everything (...)'. I was very sad, because I wanted my breast (...) and the fact that I was homosexual, one thing caught my attention, because when I was younger, I said 'Oh, I'm going to take my breasts off', I don't want my breasts. When I had cancer, I had the opportunity not to have it, I wanted it. (Yele, 38, Fernanda's girlfriend)

> She [doctor] turned like this: 'So, yeah... start thinking about removing the whole breast (...), you see, Angelina Jolie took both of them'. I was like this [sarcastically]: 'Yeah... if you squeeze her breast, milk will even come out because it's so perfect (...). Then I said: 'No, I will not take it out as long as I have a little hope of not taking it out' (...). (Frida, 51, Marília's girlfriend)

Throughout her life and during her socialization process, women are oriented to realize that the female body is different from the male. The breasts are one of the markers that most show this difference in the eyes of the other. Thus, when a chronic-degenerative disease such as cancer reaches this organ-emblem of femininity, the sick woman, regardless of sexual orientation, can mean mastectomy as an aggressive and mutilating process, in addition to representing a direct attack on her self-esteem and sense of body aesthetics (Inocenti et al., 2016; Rodrigues et al., 2022; C. Souza & Santos, 2021; Wheldon et al., 2019).

It can be said that Débora, Nina, Yele, and Frida perceived mastectomy, whose objective is the removal of the tumor mass, as an aggressive and mutilating process, which impacted their self-esteem and body identity (Inocenti et al., 2016; Rodrigues et al., 2022), so much so that Frida chose to have a more conservative surgery, even knowing that this means a resection of the tumor with a lower safety margin, which increases the risk of recurrence. Besides, Frida and Nina were also categorical in maintaining control over their bodies, even though society sees women's bodies as submissive (Cavaler & Beiras, 2022). The first decided not to remove the breasts and the second chose for non-breast reconstruction instead of letting the professional decide what would happen to their bodies (Inocenti et al., 2016).

Study with sexual minority women who chose not to undergo breast reconstruction found that most of those who refused gender labels before treatment felt more comfortable in their bodies after mastectomy. Other participants found that this choice of treatment gave them a new

sense of clarity or comfort in relation to their gender identity (Brown & McElroy, 2018; Wheldon et al., 2019). Yele reported that when she was younger, she had the desire to remove her breasts, but when breast cancer brought the possibility of fulfilling that desire, Yele, to her own surprise, did not want to stay without the breasts.

Regarding "breast reconstruction", Débora reported that she is not satisfied with her reconstruction: "(...) In the future, I intend to look for a surgeon to make it, I don't know, a little more... pleasant. I don't think it looks very natural (...)". Yele, on the other hand, appeared to be satisfied with breast reconstruction nowadays: "So, in the sequence, when he [doctor] put [the prosthesis] there is that situation of indignation 'why me?'. But today I deal with it very well (...)".

Reconstruction surgery can restore a woman's self-esteem and the feeling of being whole again, helping to rebuild her self-image after mastectomy, in addition to helping to overcome the consequences of the disease (Cammarota et al., 2019; Inocenti et al., 2016; Volkmer et al., 2019). However, the way a woman sees her body before and after the changes caused by cancer can influence how she sees herself after reconstruction. Thus, this surgery can also be seen as another mutilation that leaves marks on women and maintains the stigma they previously felt (Inocenti et al., 2016; Volkmer et al., 2019). Currently, breast reconstruction seems to be viewed positively by Yele, while Débora seems to see it as a surgery that has left new scars.

Furthermore, as many women feel pressured by arbitrary beauty ideals, it would not be uncommon for women who removed their breasts and put on prostheses to experience difficulties in liking their new breasts if they did not correspond to the ideal female body (Hirschle et al., 2018; C. Souza & Santos, 2021). These ideals may have pressured Débora and Yele to put on prostheses and at the same time influenced in the non-satisfaction that Débora felt with the reconstruction, since the reconstructed breast often does not correspond to the beauty ideal of the society (Hirschle et al., 2018; Inocenti et al., 2016).

Nina, on the other hand, chose not to do the reconstruction because she would not like to undergo another painful surgery:

> (...) It took a series of people to be quiet, right, friends to be quiet because I did not do reconstruction, "(...) Oh, aren't you going to do reconstruction? Ah, because you have no husband", I said, "(...) It is my decision, it makes no sense, because I am a lesbian". (...) I do it or I don't do it, it's my body. (...) Because it has serious risks. And because (...) I don't need to have a thing in terms of format, because you don't feel anything (...). (Nina, 53)

Nina's speech reveals the belief that people have in a "female domesticity", where the heteronormative society and focused on the man acts on the body of the women, making them submissive, disciplined, and docile (Cavaler & Beiras, 2022). It is as if men and institutions (in this case, health) could decide whether reconstructive surgery would take place or not, regardless of the woman's will. This results in mechanisms for controlling and self-control of female sexuality, including those in which men have no participation (Rich, 1980; C. Souza & Santos, 2021).

It seems that Nina found heteronormative biases not only in health services but also in her social group, which fails to see non-reconstruction as a possibility for treatment. Nina's friends believed that not being married to a man was what made the participant decide for the non-reconstruction, disregarding the fact that Nina could make this decision on her own. However, these statements did not prevent the participant from making the decision she thought was most appropriate.

Studies have shown that lesbian women perform mastectomy without having reconstructive surgery (Brown & McElroy, 2018; Wheldon et al., 2019). Five themes were identified related to breast

reconstruction attitudes of lesbian women: rejecting being defined by their body image, privileging the feeling over their appearance, believing that being without the breast attracts the attention of others less, perceiving their social context as support to non-reconstruction and feeling pressured by social norms to undergo reconstructive surgery (Wheldon et al., 2019).

For Nina maintaining the sensitivity of the breast region is more important than the question of appearance (Volkmer et al., 2019). The participant mentioned that her wife would support her in any decision she made regarding the reconstruction, but her friends rejected the idea of not having reconstructive surgery. In Débora and Yele's cases, mentioned above, there is a possibility that they feel more pressured by social norms and end up undergoing surgery.

All four participants commented on how their "partners offered them support" during and after cancer treatment. Débora said that Helena often praised her: "(...) I have scars, you know, like any surgery leaves us, you know, and she [Helena] says that this is a sign of a winning person". Nina explained that her wife's support was physical and emotional: "(...) She was very present in everything, in everything. In strength, to help me... everything, physically, help me in the bath, help me emotionally, right? And staying by my side (...)". Frida said that Marília worried about her mood: "She [Marília] was very much a partner. Yeah... she did not let me be in a bad mood at all (...). She wow... she was everything. She helped me a lot". Yele mentioned that Fernanda helps her with the side effects of cancer treatment:

> (...) Chemotherapy left me an inheritance, which is the trapped intestine. So, for example, this weekend I was very sick with pain in my belly. (...). She [Fernanda] went there [pharmacy] and bought medicine, bought fruit (...). [Fernanda] stayed by my side all the time (...). (Yele, 38, Fernanda's girlfriend)

Lesbian women who had breast cancer rarely reported having noticed a lack of support from their partners. Notably absent were reports about partners who did not participate in discussions related to cancer, an issue that received much focus in the context of heterosexual women. In general, the perception of support and harmony of the intimate relationship with the partner had a critical impact on the psychological well-being of the women affected (C. Souza, Britowe et al., 2024; C. Souza & Santos, 2021; White & Boehmer, 2012). All participants reported that their partners supported them a lot during and after the treatment, both concerning the emotional as well as with practical care.

In addition, partners help to redefine and cope with their girlfriends' breast cancer by responding to their needs both at the time of diagnosis as well as several years later when survivors continue to face memories of their disease and recurrence fears (C. Souza & Santos, 2021; White & Boehmer, 2012). Débora and Yele mentioned moments when they received support from their girlfriends after having cancer. Nina and Frida brought support that occurred during their cancer treatment.

Analysis of the Interviews Conducted with the Affective Partners

The thematic analysis allowed the construction of the following thematic axes: shock, strength, fear of recurrence, own changes, sexuality and companionship. Two participants described their partner's cancer diagnosis as a "shock". Helena explained that she did not know what to do when she found out that Débora was with metastasis: "(...) Now the new [cancer], at first for me it was that 'My God what am I going to do?' and now it continues with this 'My God what am I going to do?'". Marília said that, despite the shock, she thought that everything would be alright: "Well, when I found out, I really took a shock, right? But since it was breast cancer, we always have the idea that everything is going to be alright".

Breast cancer is a disease that deeply affects not only the woman, whether they are lesbian or heterosexual, but all the people who are part of her social relationships (White & Boehmer, 2012). Spouses reported that the feelings they experienced after their wives' diagnosis were: uncertainty, shock, anger, denial, anxiety, depression, fear, isolation, among others (Catania et al., 2019). Helena and Marilia's speeches show how the two were affected by her girlfriends' diagnosis and the shock of discovering the disease.

Helena brought up the "strength" she noticed in her girlfriend when Débora had to face the treatment and explained that, if it were with her, she would not be able to go through this situation: "Ah, I look at her [Débora] and wonder where she gets her strength from. Because if it were me, I would have quit treatment (...). I don't have half the strength she has for this kind of thing". It is important to remind sexual minority women of their great psychological resilience and ability to face and negotiate sexual stigma, which possibly helped in more effective breast cancer management (Boehmer et al., 2013, Boehmer, Glickman et al., 2014). It seems that Helena can see this resilience in her girlfriend.

Marília commented that she is "afraid of" Frida's "cancer recurrence": "I believe she is afraid of the disease coming back, and so am I, okay? We talk about this from time to time, right? (...) I also, from time to time, think – I try not to think, right?". Fear of cancer recurrence is common among the partners of lesbian and heterosexual women who have had breast cancer, and the survivor's fear is affected by the caregivers' fear of recurrence, which shows that interventions with caregivers are likely to benefit patients (White & Boehmer, 2012; Catania et al., 2019).

Two participants talked about the "changes" they had noticed "in themselves" when accompanying their partners who had cancer. Fernanda said that she believes that cancer changes the meaning of life of the person affected and that Yele brought this new look also to her life: "(...) And I think that cancer changes the meaning of life for the person. And I think she [Yele] brought a lot of this to me too (...)". Marília said she learned to be more tolerant during her partner's treatment: "I worked a lot on the issue of tolerance. (...). I think I had to work very hard on this issue of tolerance. Because Frida already has a very difficult personality, right?".

Finding positive meaning after facing breast cancer, such as a greater appreciation of life, can be an important resource for coping with the disease and its difficulties, and can lead to an increase in positive coping strategies (Hamama-Raz et al., 2019). It seems that Fernanda sees this positive coping in Yele and in herself. Moreover, study found that spouses of women with breast cancer had to change their behavior to avoid conflicts with their wives (Neris et al., 2018), which seemed to be the case with Marília.

Marília also brought up that the "sexuality" is affected after the treatment of breast cancer: "(...) Because after Frida started doing the treatment, these hormonal issues (...). And there was a libido that was [sound of something decaying], do you understand? Down there". Fernanda, on the other hand, said that she did not perceive difficulties regarding this issue: "(...) I didn't see any difference [regarding sexuality]. She [Yele] even commented that normally after cancer, women tend not to get lubricated, it doesn't excite, you know (...). But in Yele's case it is quite different".

In the studies on sexual functioning and breast cancer in lesbian and bisexual women, researchers found that having a history of cancer did not explain the risk of sexual dysfunction or sexual satisfaction. However, cancer status did explain sexual frequency, desire, lubrication, arousal, and pain (Boehmer et al., 2013; Boehmer, Ozonoff et al., 2014). These difficulties were indeed perceived by Marilia in her relationship with Frida, but Fernanda did not perceive any difference regarding sexuality.

Furthermore, two participants talked about "accompanying their partners" in several moments. Marília said she stayed with Frida during quiet times: "(...) So, what you can do is to stay there, to be with her. (...) Even being together, quiet, without saying anything, the silence, right? Communicating only through silence (...)". Fernanda stated that she accompanies Yele during physical exercises and when she must take medicine.

> (...) What I accompany is that sometimes she has pain in the prosthesis, she always has to exercise, she has to take medicine, so she has a differentiated limitation. All this [...] I adapted, but in a very natural way (...). Then there are the medicines, you can't forget to take them (...) . (Fernanda, 43 years old, Yele's girlfriend)

The literature has shown that the partners of lesbian and heterosexual women with breast cancer are able to offer support and comfort to their wives, as well as help with practical and instrumental tasks, such as dressing asepsis (Inocenti et al., 2016; C. Souza & Santos, 2021). It is extremely important for the physical and psychological improvement of patients that spouses care for their wives in the moments after surgery and are sources of support and understanding during moments of vulnerability (Inocenti et al., 2016).

Marília and Fernanda showed that they act as a source of support and as someone who provides care for their partners, either by being more tolerant with the girlfriend who had breast cancer, being there for her in times of suffering and silence, accompanying her in physical exercises, or remembering her to take the medications.

Conclusion

The women who have had breast cancer perceived the disease as a very difficult and painful period in their lives, whose treatment brings physical consequences that are irreparable and affect their body image. The partners of these women also perceived breast cancer as a long and painful disease for the patients, but they could see positive changes in themselves while dealing with their girlfriends/wives condition. Thus, it is understood that cancer has changed not only the women affected, but the companions as well.

All patients reported that they faced the consequences of the physical changes resulting from the treatments for cancer, such as pain in different parts of the body and the feeling of deep sadness when they learned of the possibility of losing the affected breast. They worried, at the beginning of the treatment, about the mastectomy and about how their bodies would look after the surgery. All four patients also valued the support received from their partners during the long course of treatment, highlighting that the girlfriends/wives made changes and adaptations in their routine in order to provide more support and comfort to the patients, besides helping them with different practical and instrumental tasks.

It was noticed that, for the partners of the women affected by breast cancer, the disease is meant as something surprising, in the sense that the partners never imagined that their wives could one day be affected by breast cancer, but also in the sense that it is such a challenging disease that brings with it a new way of seeing the world. The treatment, on the other hand, are seen as consequences of the disease that also allowed some transformations of the meanings built about the marital relationship: the wives/girlfriends reported having developed a greater tolerance, a new way to face life and a new way of being together during the treatment of their partners.

Thinking about the seven participants, it can be said that the diagnosis of breast cancer is seen as a shock, to a greater or lesser extent, for the women who have had the disease and for their

intimate partners. In terms of differences, we can observe that the women who had breast cancer highly valued the physical consequences of the oncologic treatment, such as hair loss, total or partial removal of the breast and acute and chronic pain. The companions, alternatively, reported more the psycho-emotional consequences of the disease, noticing their partners' strength and fighting spirit; they also mentioned concerns about the future and the possibility of recurrence. Thus, based on the participants' experiences, it can be said that the diagnosis and treatment of breast cancer are experienced differently by each participant, but that all of them perceive this stage as a limiting situation, which tests the threshold of tolerance to pain and frustration, as well as facing the fragility of the human condition.

This study has some limitations, such as the sampling method and sample size. Also, the research was restricted to the region of Brazil with the highest socioeconomic development, so lesbian women who did not have access to health care were not included. Another possible limitation is the fact that the research did not expand to other people who are part of the significant social network of couples, including health professionals, to capture how social support can work as mitigating factors of the negative impacts triggered by both the experience of breast cancer and the confrontations waged by LGBTQIA+ people in health services. Therefore, future research may explore these aspects.

Despite the limitations, this study results can encourage initiatives of prevention and health promotion, as well as contribute to substantiate health policies and strategies of intervention and rehabilitation, which expand the possibilities of inclusion of lesbianities in breast cancer scenario. As potential implications of the results obtained, it can be mentioned that examining the meanings attributed to the oncologic treatment by lesbian women with breast cancer may encourage the development of interventions and programs that help this population to face their negative experiences, including the health services setting. Programs focused on interventions to be implemented with couples can favor the elaboration of adverse experiences, opening spaces to promote the resignification of potentially disturbing experiences. Thus, we hope to contribute to the construction of health equity in the LGBTQIA+ field.

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