ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 8 (August 2026)

Between Fear and Hope: A Multiple-Case Study on the Lived Experiences of Women with Invasive Cervical Cancer Diagnosis

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Date Submitted:
February 10, 2026

Date Accepted:
March 26, 2026

Date Published:
August 19, 2026

DOI:
10.5281/zenodo.22023773

ABSTRACT

This qualitative multiple-case study explored the lived experiences of women diagnosed with invasive cervical cancer in Davao del Norte, with emphasis on psychological responses, coping mechanisms, and insights emerging between fear and hope. Three women with Stage IIA2, Stage IIIB, and Stage IV invasive cervical cancer were recruited through referral and criterion-based purposive selection. Data were generated through face-to-face, in-depth interviews, supported by family informants, and analyzed using thematic analysis and cross-case comparison. Across cases, fear of death was a shared experience, while feeling overwhelmed and emotional stress were prominent in Cases A and B. Case-specific experiences included fear of disease and concealment of diagnosis, being misunderstood by others, and, for the participant with advanced disease, functional decline, role disruption, family-centered worry, altered self-image, and treatment-related fear. Coping was shaped by living by faith and acceptance of the life situation across all three cases; positive thinking, family support, and social engagement were prominent in two cases. Major insights included valuing life, strengthening social connections, and cultivating hope for resilience. The findings show that living with invasive cervical cancer is not solely a physical illness experience but a dynamic biopsychosocial and spiritual process influenced by disease stage, personal appraisal, family relationships, faith, social resources, and meaning-making. The study underscores the need for holistic, culturally sensitive, patient-centered nursing care that integrates psychosocial assessment, family and spiritual support, clear communication, and continuity of care alongside medical treatment.

Keywords: *invasive cervical cancer, lived experiences, coping mechanisms, fear and hope, multiple-case study, holistic nursing care*

INTRODUCTION

Cervical cancer is a life-altering illness whose effects extend beyond the physiological burden of disease and treatment. Women diagnosed with invasive disease may experience fear of death, uncertainty, anxiety, depression, altered self-image, disruption of family roles, and concerns about recurrence or disease progression. These experiences may persist during and after treatment and can substantially affect quality of life (Boisson, 2024; Cianci et al., 2023; Zhang et al., 2025). The psychological dimension of cervical cancer is therefore integral to the illness experience rather than secondary to it.

Social and cultural contexts further shape how women understand and respond to cervical cancer. Stigma related to human papillomavirus and assumptions about sexuality can produce shame, self-blame, isolation, and

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 8 (August 2026)

fear of social judgment (Bae & Temkin, 2025; Coleman et al., 2024). At the same time, family relationships, social networks, religious beliefs, and culturally grounded understandings of illness can function as sources of strength. Perceived social support has been associated with lower anxiety and depression, while women with gynecologic cancer also describe continuing needs for emotional, informational, practical, social, and spiritual support (Li et al., 2023; Ljungman et al., 2021).

Women use varied coping strategies throughout the cancer trajectory. Existing studies describe acceptance, positive reinterpretation, social support, spiritual practice, self-management, and meaning-making as important ways of responding to the stress of diagnosis and treatment (Ambikile et al., 2025; Christiansen et al., 2022). These responses can shift as women appraise the seriousness of their condition, available resources, treatment experiences, family responsibilities, and future uncertainty. Such variability is consistent with the Transactional Model of Stress and Coping, which emphasizes appraisal and coping resources, and the Biopsychosocial Model, which recognizes the interaction of biological, psychological, and social dimensions of illness (Engel, 1977; Lazarus & Folkman, 1984).

In the Philippine context, spirituality, family ties, reflection, and social support are important features of cancer coping (Ahmadi et al., 2024). However, the thesis identified limited localized evidence describing how women in Davao del Norte personally experience an invasive cervical cancer diagnosis, particularly how fear, emotional distress, treatment realities, social relationships, and hope intersect over time. A deeper understanding of these experiences is important for nurses and other healthcare professionals because patient-centered care requires attention to emotional and psychosocial needs as well as physical treatment.

This study therefore explored the unique characteristics and lived experiences of women with invasive cervical cancer, the ways they coped with the challenges of diagnosis and illness, and the insights they could share with others facing a similar condition. By comparing three cases across different disease stages and treatment circumstances, the study sought to identify both common patterns and distinctive experiences and to derive implications for holistic, culturally sensitive nursing care.

Literature Review

Psychological Responses to Invasive Cervical Cancer

A diagnosis of invasive cervical cancer can produce an immediate emotional shock that is expressed through fear, confusion, helplessness, anxiety, and uncertainty. Women may worry about prognosis, recurrence, treatment outcomes, and death, and these concerns can be compounded by pain, fatigue, bleeding, fertility concerns, and sexual or body-image changes (Boisson, 2024; Osei Appiah et al., 2021). Psychological distress can therefore arise from both the meaning attached to cancer and the physical realities of living with and treating the disease.

Qualitative evidence has shown that cervical cancer can disrupt physical functioning and biopsychosocial well-being. Herita et al. (2024) described effects involving fear, dependence, stress, and bodily changes, while Agyeiwaa et al. (2024) documented substantial challenges among women living with cervical cancer. Such findings underscore that emotional distress is not uniform: the intensity and form of fear may vary with disease stage, treatment history, prior experiences, responsibilities, and the support available to the patient.

The fear of progression and the burden of advanced disease also affect patients' psychological flexibility and perceived burden (Zhang et al., 2025). For nursing practice, this literature suggests a need to recognize emotional distress early, communicate clearly about illness and treatment, and assess how a woman's concerns about mortality, family, functioning, and identity shape her response to care.

Social Support, Stigma, and Cultural Context

Social relationships can either buffer or intensify the psychological burden of cervical cancer. Li et al. (2023) found that perceived social support was inversely related to anxiety and depression among cervical cancer patients. Family members may provide emotional reassurance, practical assistance, financial help, accompaniment

to treatment, and a sense of belonging. Women with gynecologic cancer have likewise expressed the need for peer support, psycho-oncological care, family support, and assistance with emotional, social, spiritual, and practical concerns (Ljungman et al., 2021).

However, cervical cancer can also carry stigma. Because of its association with HPV and sexual health, women may experience guilt, shame, fear of rejection, and negative social judgments (Bae & Temkin, 2025; Coleman et al., 2024). These reactions can affect disclosure, social participation, willingness to seek help, and self-image. The social environment is therefore not merely a background factor; it can directly influence whether women feel accepted, misunderstood, isolated, or supported.

Cultural and religious meanings also shape responses to illness. Ahmadi et al. (2024) emphasized religion and culture in the coping experiences of Filipino cancer patients. In settings where faith and family are central sources of meaning, spiritual practice, prayer, and close family relationships may become important resources for maintaining hope and emotional stability while patients confront uncertainty.

Coping, Acceptance, Faith, and Meaning-Making

Coping with cervical cancer includes both problem-focused and emotion-focused strategies. The Transactional Model of Stress and Coping explains coping as a process shaped by how individuals appraise a stressful event and the resources they believe are available to manage it (Lazarus & Folkman, 1984). Dirar et al. (2022) similarly described the importance of coping strategies among cervical cancer patients. Because illness circumstances change, coping can also change across diagnosis, treatment, recovery, recurrence, or progression.

Qualitative studies describe acceptance, positive thinking, spiritual faith, social support, and efforts to maintain normality as recurring coping mechanisms (Ambikile et al., 2025; Christiansen et al., 2022). Nastiti et al. (2020) found that acceptance and adjustment can foster renewed hope, while Sharma et al. (2020) emphasized the role of spiritual beliefs in psychological balance, well-being, and goal-setting. Positive thinking may also support resilience and self-acceptance when patients confront uncertainty (Higuita-Gutiérrez et al., 2023).

Meaning-making can emerge from the illness experience itself. Women may come to value life more deeply, strengthen relationships, reassess priorities, and cultivate hope. These adaptive responses do not erase fear or suffering; rather, they illustrate how fear and hope can coexist. This balance is central to the present study's focus on how women living with invasive cervical cancer interpret their condition and continue to find purpose despite its demands.

Quality of Life and Holistic Nursing Care

Cervical cancer can affect health-related quality of life through physical symptoms, sexual dysfunction, altered body image, emotional distress, relationship strain, financial pressure, and disruption of work or family roles (Cianci et al., 2023). Quality of life is therefore multidimensional and cannot be understood solely through clinical indicators. Women may continue to need psychosocial support even when active treatment has ended or when medical outcomes appear stable.

Social support is an important component of quality of life. Li et al. (2024) linked social support with life satisfaction among women with cervical cancer, while other studies emphasize the continuing role of family, healthcare providers, and peer networks. When support is responsive to the patient's actual needs, it can strengthen self-care, emotional adjustment, and active coping. Conversely, insufficient or poorly matched support may leave important needs unmet.

These findings support a holistic nursing approach consistent with Engel's (1977) Biopsychosocial Model. Nurses are positioned to assess physical symptoms alongside emotional distress, social roles, coping resources, spiritual concerns, and family dynamics. The present study applies this lens to the three cases in order to understand how biological severity, psychological appraisal, and social resources interact in women's experiences of invasive cervical cancer.

ISSN: 3116-3475
International Journal
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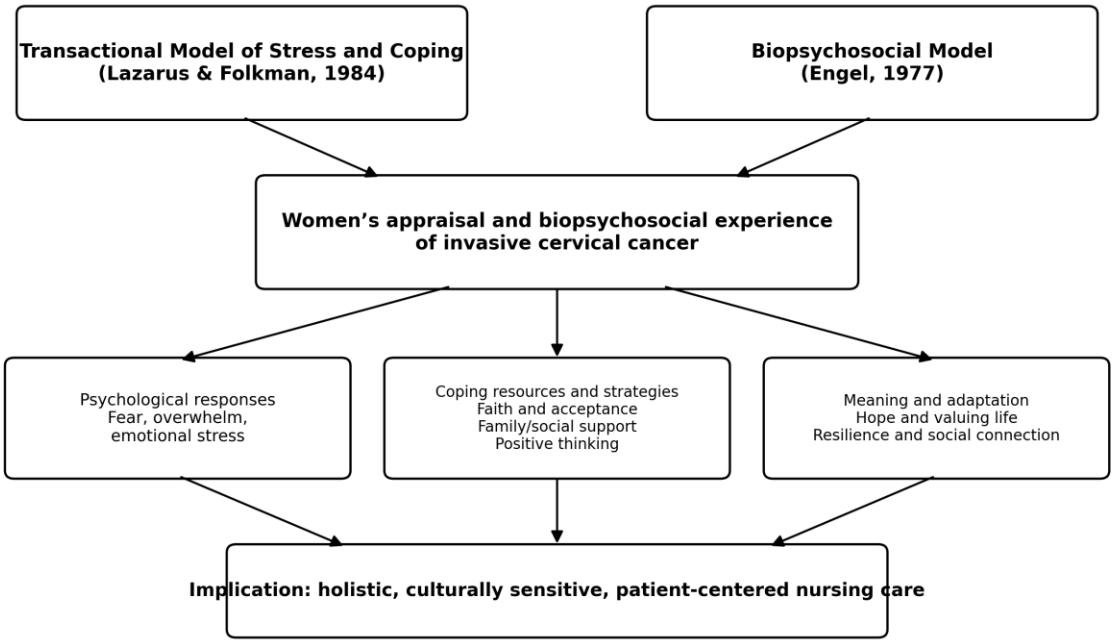
Figure 1. *Conceptual Framework of Fear, Coping, Hope, and Holistic Nursing Care*



METHODS

Research Design

The study used a qualitative multiple-case study design to examine the lived experiences of women diagnosed with invasive cervical cancer, consistent with qualitative case-study principles for examining complex experiences in context (Creswell & Creswell, 2018). The design enabled in-depth examination of each case and systematic comparison across cases to identify common patterns and distinctive experiences related to psychological responses, coping, and meaning. The study was guided by the Transactional Model of Stress and Coping and Engel's Biopsychosocial Model. The analysis remained focused on the participants' accounts rather than on testing causal relationships.

Research Locale

The study was situated in Davao del Norte, Philippines. Eligible participants were women residing in the province who were living with Stage II, III, or IV invasive cervical cancer. Interviews were arranged in mutually agreed, safe, and private locations based on participant convenience and confidentiality. Participant recruitment included outreach through a private cervical cancer support group and referral from eligible participants.

Participants and Sampling Technique

Three women with invasive cervical cancer participated in the study. Referral or snowball procedures were used to identify potential participants, followed by criterion-based purposive selection to ensure that each case met the study requirements. Eligibility included being female and at least 18 years old, having a histopathologically confirmed invasive cervical cancer diagnosis and Stage II, III, or IV disease as defined in the thesis using Bhatla et al. (2021), having lived with the diagnosis for at least one year, residing in Davao del Norte, and being willing to complete the interview. Each participant also had a family informant who provided supplementary observations.

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International Journal
of Education, Research, and Innovation Perspectives
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Case A was a 63-year-old woman with Stage IIA2 cervical cancer who had lived with the diagnosis for seven years and had completed chemotherapy, radiation therapy, and brachytherapy. Case B was a 62-year-old woman with Stage IIIB cervical cancer diagnosed six years earlier; she had undergone radiation therapy, chemotherapy, and brachytherapy, although the treatment course was not fully completed. Case C was a 54-year-old woman with Stage IV cervical cancer diagnosed one year earlier, with metastasis reported to the bone and kidney; she also had a pre-existing condition requiring regular dialysis and had not undergone cancer treatment other than medication.

Research Instrument

The primary instrument was an in-depth interview guide designed to elicit participants' unique characteristics, lived experiences following diagnosis, coping mechanisms, and insights they wished to share with others. The guide supported open narration and follow-up probing while maintaining alignment with the study questions. Interviews also drew on observations and supplementary accounts from designated family informants to enrich the description of each case.

Data Gathering Procedure

Consistent with systematic nursing research procedures (Polit & Beck, 2021), before data collection, ethical clearance was obtained from the Arriesgado College Foundation Inc. Research Ethics Committee. Potential participants received information about the study, eligibility requirements, voluntary participation, risks and benefits, confidentiality, and the right to withdraw. Written informed consent was obtained before interviews. Face-to-face interviews were conducted in private settings and audio-recorded with permission. Interviews were expected to last approximately 45 to 90 minutes. Recordings were transcribed verbatim, translated into English when necessary while preserving meaning, and stored on password-protected devices with identifying information replaced by codes.

Data Analysis

Data analysis was iterative and reflexive. Interview transcripts were reviewed repeatedly, coded, and organized into categories and themes using thematic analysis (Braun & Clarke, 2020; Kiger & Varpio, 2020). Related codes were grouped into themes representing psychological responses, coping mechanisms, and insights. A cross-case comparative analysis was then conducted to identify similarities and differences across Cases A, B, and C. Themes were continually reviewed and refined to preserve the authenticity of participants' accounts and to produce a coherent synthesis of the phenomenon.

Ethical Consideration

The study treated women with invasive cervical cancer as a potentially vulnerable population and applied safeguards for autonomy, privacy, confidentiality, emotional safety, and voluntary participation. Pseudonyms were used in the report, identifying information was removed from transcripts, and participants could pause or withdraw from an interview at any time. The research team used empathetic interviewing and made psychological support available when sensitive discussion caused distress. Credibility and confirmability were strengthened through probing, triangulation, member checking, peer debriefing, cross-checking interpretations, and documentation of the analytical process.

RESULTS AND DISCUSSION

Case Profiles and Unique Characteristics

The three cases represented different stages, treatment histories, illness durations, and functional circumstances. These differences provided important context for interpreting how each participant moved between fear and hope. Case A had the longest time since diagnosis and had completed multimodal treatment; Case B had

ISSN: 3116-3475
International Journal
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also lived with cancer for several years but reported an incomplete treatment course; Case C had the most advanced disease and substantial functional limitations associated with cancer and dialysis.

Table 1. *Profile of the Three Cases*

Case	Age	Diagnosis and treatment context	Years with diagnosis
Case A (Bebang)	63	Stage IIA2; chemotherapy, radiation therapy, and brachytherapy completed	7
Case B (Nene)	62	Stage IIIB; radiation therapy, chemotherapy, and brachytherapy initiated but not fully completed	6
Case C (Lilia)	54	Stage IV with reported bone and kidney metastasis; medication only; regular dialysis for pre-existing comorbidity	1

The profile differences were reflected in the unique characteristics described in the individual cases. Case A's narrative included strong awareness of treatment and survivorship, spiritual signs, inner strength, and a continued tension between fear and hope. Case B emphasized optimism, expressiveness, self-growth, and attention to personal well-being. Case C's advanced illness was associated with a shift from independence to dependence, persistent health concerns, awareness of limited time, and the interpretation of illness through faith and gratitude. These case-specific features support the Biopsychosocial Model by showing how disease severity, psychological outlook, social roles, and available resources jointly shaped the illness experience (Engel, 1977).

Lived Experiences: Fear, Overwhelm, and Emotional Stress

Fear of death was the only core challenge shared across all three cases. Participants described mortality as a real and immediate concern, although the object of fear varied. Cases A and B expressed fear connected with the diagnosis, prognosis, and uncertainty, whereas Case C's fear was strongly connected with advanced illness, hospitalization, survival, and concern for children and grandchildren. Feeling overwhelmed and emotional stress were prominent in Cases A and B. Case A also uniquely reported fear of disease and concealment of the diagnosis, while Case B described being misunderstood by others. Case C showed more pronounced role disruption, functional decline, debilitating symptoms, and family-centered worry.

> *"I was afraid—afraid and full of doubts, constantly asking why, why this had to happen... It was a fear I could not explain." (Case A)*

> *"I have cancer. After that, I felt overwhelmed and hurt, and cried, though it only lasted a few seconds." (Case B)*

> *"I am afraid. I am afraid to die, and I am afraid of being admitted." (Case C)*

These patterns are consistent with studies describing cervical cancer as a source of profound physical and psychological disruption. Agyeiwaa et al. (2024) documented substantial challenges among women living with cervical cancer, while Herita et al. (2024) described effects on body image, functioning, dependence, and biopsychospiritual well-being. Fear of death and emotional stress also parallel findings that women may perceive cervical cancer as life-threatening and may struggle with distress, social disruption, and uncertainty (Chona et al., 2023). The distinctive burden in Case C further illustrates how advanced disease can intensify functional and family-role consequences.

Coping Mechanisms: Faith, Acceptance, Positive Thinking, and Support

Living by faith and acceptance of the life situation were shared across all three cases. Prayer, surrender to God, spiritual trust, and acceptance were described as ways to reduce emotional turmoil and continue facing illness. Positive thinking was prominent in Cases A and B, as were family support and continued social engagement. Case A additionally described healing with courage and advocacy for other people with cancer,

ISSN: 3116-3475
International Journal
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whereas Case C emphasized limited time, present valuing, spiritual surrender, and renewed faith. The differences show that coping was not a single fixed strategy but a set of responses shaped by appraisal, illness severity, and available personal and social resources.

"We truly treasure the present moment now... I always pray and entrust everything to the Lord." (Case A)

"I always stay positive... I just choose to think positively and hold on to the Lord." (Case B)

"I realized that my time here in the world is limited, so I treasure the time I have here." (Case C)

The results align with the Transactional Model of Stress and Coping, in which coping depends on how individuals appraise the threat and the resources they can mobilize (Lazarus & Folkman, 1984). Qualitative research has similarly identified acceptance, emotion-focused coping, social support, and spiritual resources among women confronting cervical cancer (Ambikile et al., 2025; Christiansen et al., 2022; Kulsum et al., 2022). Faith may provide emotional stability and meaning (Sharma et al., 2020), while family support can sustain motivation and assist with treatment and daily needs (Kurniasih et al., 2023). Positive thinking and acceptance did not remove illness-related fear, but they helped participants maintain functioning, motivation, and emotional balance.

Insights: Valuing Life, Social Connection, and Hope for Resilience

The cross-case analysis identified three central insights. Valuing life and strengthening social connections were evident particularly in Cases A and B, while cultivating hope for resilience was shared across all three cases. Case A also emphasized financial support and anxiety about the future; Case B described self-motivation and adaptation to change; and Case C described altered self-image, mortality awareness, preserved but reduced social connection, and fear related to treatment. Together, these insights show that living with invasive cervical cancer can lead to reevaluation of priorities, relationships, identity, and the meaning of time.

Valuing life reflects the participants' recognition of fragility and the importance of meaningful daily living. Christiansen et al. (2022) similarly found that women undergoing cervical cancer treatment develop new perspectives and self-management strategies. Social connection served both as emotional support and as a means of remaining engaged with others; Li et al. (2024) linked social support with life satisfaction among women with cervical cancer. Hope, in turn, functioned as a forward-looking psychological resource. Rao et al. (2025) emphasized the role of hope in reducing psychological distress and supporting resilience. The participants' narratives therefore suggest that hope coexisted with fear rather than replacing it.

Table 2. *Cross-Case Synthesis of Major Themes*

Domain	Theme	A	B	C
Lived experience	Feeling overwhelmed	✓	✓	—
Lived experience	Emotional stress	✓	✓	—
Lived experience	Fear of death	✓	✓	✓
Coping	Positive thinking	✓	✓	—
Coping	Living by faith	✓	✓	✓
Coping	Family support	✓	✓	—
Coping	Acceptance of life situation	✓	✓	✓
Coping	Social life	✓	✓	—
Insight	Valuing life	✓	✓	—
Insight	Strengthening social connection	✓	✓	—
Insight	Cultivating hope for resilience	✓	✓	✓

The cross-case results reinforce the need for individualized nursing care. Shared themes provide a basis for routine psychosocial assessment, but the distinctive themes caution against assuming that all women

experience cervical cancer in the same way. Disease stage, physical functioning, treatment history, family roles, spiritual resources, financial conditions, and disclosure patterns changed the meaning of the illness across cases. Holistic nursing care should therefore combine symptom management with communication, emotional assessment, family involvement, spiritual sensitivity, and referral to psychosocial or palliative resources when indicated.

CONCLUSION

The study showed that women living with invasive cervical cancer experienced a complex movement between fear and hope. Fear of death was present in all three cases, while feeling overwhelmed and emotional stress were prominent in two. Advanced disease brought additional burdens related to physical decline, dependence, family-centered worry, altered self-image, and treatment-related fear. These differences demonstrated that the experience of cervical cancer was shaped by the interaction of disease severity, psychological appraisal, social roles, and available support.

Coping was dynamic and multidimensional. Faith and acceptance were shared across the cases, while positive thinking, family support, and social engagement were important for two participants. The illness also generated insights concerning the value of life, social connection, and hope. The findings indicate that invasive cervical cancer should be approached as a biopsychosocial and spiritual experience requiring more than physical treatment. The study contributes a localized, case-based understanding of how women in Davao del Norte interpret illness, mobilize coping resources, and sustain meaning and resilience despite uncertainty.

Recommendation

Healthcare institutions should strengthen holistic oncology and nursing care by incorporating routine psychosocial assessment, clear patient education, emotional support, family involvement, and culturally sensitive spiritual care into the management of women with invasive cervical cancer. Nurses should be supported through continuing education in oncology, palliative care, therapeutic communication, and psychosocial care so that fear, distress, body-image concerns, family worries, and treatment uncertainty can be identified and addressed early.

Local health systems and policymakers should improve access to screening, diagnosis, treatment, counseling, and supportive services, especially for women facing advanced disease or financial and logistical barriers. Community health centers, advocacy groups, and cancer-support networks should strengthen peer support and anti-stigma education so that women can seek care and disclose concerns without fear of judgment or social isolation.

Families should be included, with patient consent, in education and supportive-care planning because family relationships can strongly influence coping, treatment adherence, daily functioning, and emotional stability. Support should also be individualized because some patients may rely more heavily on internal coping, faith, or personal reflection than on active social involvement.

Future research should include a larger and more diverse group of women from across the Davao Region and other Philippine settings. Longitudinal qualitative studies, phenomenological investigations, and studies using multiple data sources may clarify how coping changes over the illness trajectory. Further research may also examine family support, holistic nursing interventions, palliative needs, stigma, quality of life, and the relationship between disease stage and psychological adaptation.

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