

Volume 8, n 3, 2020

Articles

Idiosyncratic ambivalence: A three-dimensional interpretative model to understand the non-adhesion of women to breast and cervical cancer screening

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Abstract

Health programs offer screening activities for the early detection of cancer in vulnerable population, but record very low participation rates. The authors have a theoretical framework to investigate the complexity of the phenomenon, in the psychodynamic and ethical dimensions, specific to women. In this study, the authors used semi-structured interviews and interpretative phenomenological analysis to explore the meaning-making processes of women who do not practice breast and cervical cancer prevention in Southern Italy neither in the public health-care system, nor in private health facilities. Three superordinate themes have emerged: *taking care of oneself would be to love oneself; difficult contact with a sexual body; at the end, the fate decides*. We highlight three levels in the psychism that underlie the behavior of not doing prevention: body-> affects-> thought. Understanding these psychic level mechanisms permits to support women's health policy, reducing costs and promoting health.

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Keywords:

Breast and cervical cancer screening; Women meaning-making; Interpretative phenomenological analysis; Health care; Risk prevention.

Received: 28 June 2020

Accepted: 25 November 2020

Published: 19 December 2020

Citation: Lemmo, D., Martino, M.L., Nunziante Cesaro, A., Solbakk, K.H. (2020). Idiosyncratic ambivalence: A three-dimensional interpretative model to understand the non-adhesion of women to breast and cervical cancer screening. *Mediterranean Journal of Clinical Psychology*, 8(3).

<https://doi.org/10.6092/2282-1619/mjcp-2563>



1. Introduction

The adhesion of women to screening programs for the prevention of breast and cervical cancer appears to be influenced by a multiplicity of individual, as well as contextual (Plourde et al., 2016), variables related to cultural sociodemographic, cognitive, and psycho-affective aspects (Adolfsson et al., 2012; Facchin & Saita, 2017; Martino & Freda, 2016; Vernet & Henry, 2007).

Breast cancer is the leading cause of female death and is the most frequently diagnosed cancer in all age groups, with a 5-year survival rate of 87%. Cervical cancer is ranked second among the tumors in the world that affect women, with a higher incidence in the group below 40 years old. The main etiological factor is represented by the human papillomavirus transmitted sexually (AIRTUM data – ISTAT, 2018).

The screening programs offer mammography for women aged 50 to 69 every 2 years and for women aged 25–64 for the Paptest/HPV test every 3 years. Although breast and cervical cancer screening programs have the potential to detect a potential cancer before it is clinically apparent with signs or symptoms, as the European Guidelines declare, the acceptance of cancer screening remains controversial, recording very low participation rates among women, both in the public health-care system, and in private health facilities (Report ONS, 2017).

The literature has very much highlighted that a diagnosis of cancer is considered a critical event associated with physical and psychological effects (Martino et al., 2019; Villani et al., 2016). Cancer has a specific and peculiar nature because of the difficulty of recognizing a unique stressful. It has internal triggering processes and temporal continuity in terms of hereditary or possible relapse (Gurevich et al., 2002; Mehnert & Koch, 2007). Anxiety and depression symptoms are common in a wide range of chronic medical conditions, influencing the patients' quality of life (Catalano et al., 2018; Fantinelli et al., 2019; Marchetti et al., 2017; Marchini et al., 2018; Martino et al., 2019; Quattropiani et al., 2018a, 2018b; Rahnea-Nita et al., 2019), as well as dysfunctional metacognitive beliefs could be a relevant factor involved in the development of negative emotions, influencing the adherence to medical treatments. The psychological trauma, which may occur as a result of such a severely distressing event, in case of cancer starts from the communication of the diagnosis and continues during the different phases of treatment. In the more specific area of early diagnosis, studies reveal that lack of screening information, marital status, socioeconomic level, and age of women are not the only variables affecting the implementation of preventive behavior. Studies about the subject (Biondi et al., 1996; Payne et al., 1999; Ricci Bitti et al., 2000; Rummans et al., 1998) emphasize that the intention to undergo screening (Ackerson & Preston, 2009; Marlow et al., 2015; Zani & Pietrantonio, 2000) depends on the subjective risk and vulnerability perception to the disease (Galdon et al., 1997), as well as on personal reflections on health, coping styles, and social influences (Garotti et al., 2003).

Some researches focusing on emotional factors (Consedine et al., 2004) emphasize the importance of women's experiences at the screening center (Harcourt et al., 2014) in relation to the doctor and the emotional costs associated with the specificity of the diagnostic tests also

related to disgust/shame, embarrassment surprise and fear about cancer (Blomberg et al., 2008; McBride et al. 2020; Silverman et al., 2011; Teng et al., 2014).

The concern for cancer, moderated by the perception of being able to control the situation (Langer & Rodin, 1976; Paganucci & Siani 2002; Scheier & Carver, 1987) and the acquisition of clear information provided by doctors (Rimal & Real, 2003), seems to promote a preventive activity, whereas high levels of concern seem to be a barrier for all women, regardless of personal risk (Andersen et al., 2003). Finally, at a cognitive level, women's beliefs seem to differ from the medical model: if health professionals perceive women who don't participate in oncological prevention as behaving in a risky manner, women themselves perceive the test as a risk that threatens their "status quo" of health and state that it is preferable not to know (Tessaro et al., 2006).

1.2 Theoretical issues: Towards an ethical and psychodynamic framework for oncological prevention

Health psychology has sought to develop conceptual tools in order to describe the way people perceive their health or risk status and deal with their own health problems, i.e., modeling choice behavior and decision-making processes (Bertini, 2012; Braibanti, 2008; Zani & Cicognani, 2000).

The main epistemological frames of the abovementioned studies are cognitive and psychosocial, based on models centered on health beliefs (Becker & Maiman, 1975), i.e., on the motivations to protect oneself (Rippetoe & Rogers, 1987); on reasoned action and planned behavior; and on risk assessment, sense of self-efficacy, and locus of control. However, in this theoretical framework, the empirical work carried out and the results obtained so far do not provide clear indications of the range of variables and their correlations that influence the non-adhesion of women to screening programs.

This seems to make partial the look on the phenomenon that instead would require an enlargement of perspective and a theoretical re-conceptualization that takes into consideration ethical and psychodynamic aspects. In this work, the authors combine health psychology with an ethical and psychodynamic perspective, suggesting a broader theoretical framework that allows for its complexity.

In accordance with Duberstein and Masling (2000), we believe that it is essential to link health research with unique personality traits, intrapsychic conflicts, and mental representations concerning illness and health care.

In particular, we think it is necessary to consider that in the human psyche, next to the libidinal part, there is an aggressive part able to proceed both against the other and against oneself (Abraham, 1924; Ferenczi, 1929; Freud, 1920; Menninger, 1938), in opposition to what is prescribed by responsibility and love for the Self and the Other (Levinas, 1991). Furthermore, literature highlights that this aggressive part, connected to narcissism, can translate into a profound sense of omnipotence for which the subject believes that nothing can happen. In psychodynamic terms, this means keeping false protective ideas of integrity and absoluteness, refusing to admit the finitude of existence, sheltered therefore from the anguish of death (Bacqué, 2014; De Masi, 2002) and from the traumatic illness experience (De Luca et al., 2019; Martino et al., 2019a, 2019b, 2019c, 2019d; Quattropiani et al., 2018). In addition to these intrapsychic aspects, it is necessary to consider in a gender perspective (Bekker, 2003; Rollero, 2014) that women are encouraged to take care of their bodies, to become protagonists of their own health, to take on this responsibility, and to undergo medical examinations in the absence of symptoms, thus exposing oneself to the risk of discovering a sick body (Reich, 2009) in the intimate and unspeakable body parts, which symbolize female sexual identity (Chasseguet-Smirgel, 2005; Dejours, 2004; Ferraro & Nunziante Cesàro, 1985; Parat, 2000). To this adds a phenomenological dimension of “patientness,” i.e., what does it imply in practical terms to respect patients’ idiosyncratic perceptions of their situation and the choices they make and thereby their autonomy? In the medical ethics literature (Solbakk, 2019, 2020), thousands of pages have been written about patients’ rights to self-determination concerning decisions pertaining to health and disease. *“Morally speaking this implies accepting that when we fall ill most of us shrink a bit compared with our normal selves, in the sense that our attention is more directed to our own fears and forms of suffering than to the needs of those near and dear to us, including for many patients problems of the unspeakable kind mentioned above. This is exactly the way Aristotle describes the moral horizon of the comic figure. If this represents a plausible perception of ‘patientness’, then it also becomes important to accept and respect the way patients might perceive and experience their situation, that is, not always in the way the predictable, judicially impeccable and rationally immaculate sort of person might react, but as a form of existence where the seemingly execrable and ridiculous dimensions of their lives occupy centre stage”* (Solbakk, 2015, p. 15).

We think that concentrating on women’s health and on the early diagnosis of breast and cervical cancer is an opportunity to focus on women rather than an attempt to take control of the female body and of the meanings women hold concerning their bodies, their health, the potential risks, and their approach to the health-care system.

Only a few qualitative studies suggest, through focus groups and semi-structured interviews, experiences and perceptions related to adherence to breast and cervical cancer screenings (Al Dasoqui et al., 2013; Canales & Geller, 2004; Head & Cohen, 2011; Manjer et al., 2014; Norfjord

Van Zyl et al., 2018; Oscarsson et al., 2008; Waller et al., 2011; Schoenberg et al., 2013), but a psychodynamic exploration of the refusing experience to participate in breast and cervical cancer screening programs is lacking.

A qualitative approach of interpretative phenomenological analysis (IPA; Aasen & Skolbekken, 2014; Newberry, 2011; Smith, 1996; Smith & Osborn, 2001; Smith et al., 2009) is appropriate in case of highly subjective issues, but sensitive to the social context, such as our issues. The IPA allows to study complex phenomena that involve identifying relational and meaning-making aspects, dealing idiographically with particular processes and individual cases. Recognizing research as a dynamic process, the IPA allows the exploration and understanding of the meaning that the subjects, as experts of a phenomenon, give to their specific experience.

The present study aimed to explore the meaning-making processes of women who (Martino et al., 2018), although defined as being at risk of developing breast and cervical cancer for the age factor, do not adhere to examinations for preventive screening.

Understanding how women prepare themselves for self-care and prevention can have important repercussions in terms of clinical intervention in support of health promotion and awareness-raising interventions on female cancer prevention.

2. Methods

2.1 Participants and data collection

IPA studies are conducted on small samples as the phenomenological approach attempts to explore the participant's personal experience, trying to say, in an idiographic way, something in detail about a particular group of interest rather than jumping to generalizations.

The sample is therefore intentional in the sense that it is made up of a specific and rather homogeneous group within it for which the research demand is significant. In our case we are interested in the experience of those women who, albeit at an age at risk, declare that they do not practice cancer prevention, either in public or private facilities.

The eligibility criteria were age 40 to 69 years, did not undergo preventive examinations for more than 3 years, homogeneous sociocultural level, good knowledge of the subject area, and lack of hereditary as a risk factor for breast cancer. The group of participants was composed of eight women from the Alts (Breast Cancer Fight Association) and the Department of Humanities of the University of Naples Federico II. The characteristics of each participant are presented in Table 1.

Women's participation was voluntary; they provided informed consent and privacy policy.

Table 1. The socio-anagraphic characteristics of each participant

Pseudonym	Age (years)	Marital status	Number of children	Occupation
Mrs R.	63	Separated	2	Pensioner
Mrs A.	67	Widowed	1	Housewife
Mrs M.	51	Separated	2	Teacher
Mrs N.	57	Divorced	3	Professor
Mrs C.	69	Widowed	3	Professor
Mrs B.	41	Single	0	PhD Student
Mrs T.	57	Married	2	Teacher
Mrs S.	48	Divorced	2	Clerk

2.2 Measures

The best way to collect data for an IPA study is the semi-structured interview which allows the researcher and participant to engage in a dialogue where the initial questions can be modified in light of the participants' responses and the researcher is able to explore the interesting and important areas that arise. The 4 areas of interest that represent the guide for the interview administered, and the related questions are:

- Taking care of yourself and your health.

What does it mean for you to take care of yourself and your health?

What do you think health can depend on?

- Risk representation.

What does it mean for you to risk or to put yourself at risk?

If you were to think about what could be a risk to you, what comes to your mind?

- Body and femininity.

How would you define the relationship with her body and her femininity?

- Experiences and representations of breast and cervical cancer screening prevention.

What are your experiences and what are your emotions with respect to the two types of exams, breast and gynecological examinations?

The interviews were audio-recorded and subsequently transcribed, thus producing a text corpus on which it was possible to work in the analysis phase.

2.3 Analysis

Our analysis was conducted in line with the IPA method and based on the recommendations by Smith et al. (2009) about analysis which is described as an iterative and inductive cycle (Pietkiewicz & Smith, 2014; Smith, 2007; Tessitore et al., 2019).

After all the interviews had been transcribed, they were read and reread to aid familiarity. Exploratory comments, including descriptive, linguistic, and conceptual aspects, were noted.

We then proceeded, through the hermeneutic circle characterizing the IPA, to the identification of the emerging themes and to the subsequent structuring of the same into super-ordinate themes, analyzing their connections and links.

Emerging themes, which reflected the participants' comments and the interpretation of the analyst, were then identified and labeled, after which they were clustered and organized as potential higher order or superordinate themes. A summary table of illustrative quotes and corresponding line numbers was created for each participant for the purpose of cross-referencing. Finally, the themes obtained from all transcripts were compared and clustered to form a list of superordinate themes, which conveyed the shared experience of the participants. In order to ensure that the themes were grounded in the data, similarities and differences were considered both within and between participants.

Finally, the development of a complete narrative, highlighted by the comments and detailed on the extracted data that take the reader along the theme-based interpretative process (Smith et al., 2009).

The very nature of the interpretative procedure recalls the need for constant supervision, comparison, and reflection on other researchers on what emerges at an advanced stage of analysis, highlighting the importance of triangulation. The supervision allowed to take into consideration the potential influence of the researcher in the research and analysis process, recognized by the methodology itself.

2.4 Findings

Three superordinate themes emerged from our analysis of the data. These themes, and associated subordinate ones, are summarized in Figure 1, and they highlight both shared experiences and subjective experiences on the prevention of female cancers.

2.4.1 Taking care of oneself would be to love oneself

The first superordinate theme compares self-care with self-love, which is often ambivalent. All women express, through an evocative and introspective language, the conflict between *I love*

myself and *I harm myself*, which leads to continuous references to the future or to the “Other” to think about taking care of one’s health.

Taking care of oneself leads women to narrate the general principle of loving themselves and an ideal practice of healthy behaviors that should be implemented. But it is not easy to do, and sometimes, one refuses to do it. The core of the conflict seems to reside in a depressive fund that opposes the joy of life. To take care of oneself and love oneself a life of narcissism and a libidinal investment of self seem necessary.

Taking care of yourself is very difficult, I can do it when I don't have to take care of the others or I'm inclined to neglect myself. It takes a lot of self-love. And I don't always like me. When you really have the will to live, you do everything unless there are other factors like wanting to challenge death. If you avoid doing certain things, there is a background of depression, of self-destruction; it is as if there was not that desire to live that can also be linked to prevention. Wanting to deny the possibility of being able to control oneself, being able to cure oneself is almost a form of wanting to start more towards death than towards life.

Through the expression of the need for an Other that involves you in the possibility of taking care of yourself, women highlight another dilemma: dedicated to the care of children, relationships, home, work, women manage to make space for themselves to dedicate themselves to themselves? Can they allow themselves to be vulnerable and self-oriented? Through the narration of the *subject–object of care*, women trace both the evolutionary passages of self-love, which would seem to be linked to transgenerational transmission, and the deeper needs linked to care (Freda et al., 2016). Women represent themselves primarily as subjects who care for others. One is not a subject of care for oneself nor an object of care by another. To phrase this in the words of Aristotle in his tiny book on tragedy, comedy, and epic literature, women are not comic figures obsessed with themselves and their fares and ridiculous anxieties; rather they are someone to look up to – and notably – exactly because of their other-relatedness and care for others.

In the narratives, women express the need for another (a daughter, a friend, the doctor, the Health Institution) who performs an “Auxiliary Me” function because taking care of oneself is possible if there is another that involves, invites. It may be possible to carry out screening tests if there was a good relationship with the doctor, of “continuous care” such as the one you have with the gynecologist, “companion of your story”. Or it may be possible with other women who would help to exorcise “something unpleasant that could tell you,” as the cancer risk.

I know a lot about taking care of others, but I have never taken care of myself, and no one has ever taken care of me this is perception. Only if the doctor called me and obliged me... so she proves to be wanted

2.4.2 Difficult contact with a sexual body

The second superordinate theme makes it possible to identify the mental representation of women regarding cancer prevention (breast and gynecological examinations) or the experiences of women who have not undergone female screening for more than 3 years. It is a prevention linked to the sexual organs and specific meanings connected also to psycho-sexual identification. First of all, women talk about the sexual places of intrusive and mechanistic investigations. These are *examinations in your own privacy* – the unspeakable parts of yourself – that require you to show your sexual body to another person. In this regard, only in three out of eight women were there accusations against a health context made up of doctors and medical staff who care a little about women and the delicacy of the issue, which for women needs attention and understanding.

Women differentiate between internal organ (uterus, where “we don’t know what happens”) and external organ (breast), but both are understood as aspects of oneself that are at risk to suffer a wound – the illness or the intervention, this time not evolutionary, as in the case of menarche and childbirth.

They are both very intimate areas ... as for the pap test, I have a reluctance ... I experience them a bit like the violence being carried out ... not physical violence but painful violence that is carried out on your body ... the breast crushes you in a press and you feel like a cow.

This superordinate theme forces women to deepen their relationship with their *femininity, neglected and often rejected*. It would seem that one cannot love and care for a body that is not always liked and accepted or that has not been loved and valued by a partner.

I quarreled for so long with my femininity, I kept it hidden ... then I had a marriage that really trampled on my femininity. And then the effort to reconquer as a woman, as a friend, companion, daughter, mother, before there had been a cancellation in this sense. My female growth process coincided with my separation.

2.4.3. At the end, the fate decides

The third superordinate theme seems to resolve all the issues that emerged previously through the reference to fate. If the risk is understood as a consequence of one’s own actions and non-actions, *a challenge is activated not to access the fear* of getting sick because of one’s unhealthy attitudes, a fear that must be kept away from the mind. What calms is given by never having had big problems, the risk does not belong to the experience of the body, for which prevention seems to anticipate mentally too great anguish, that of the tumor, represented as “devastating disease that you should keep away.”

I know there are things that hurt and I do the same, hoping to get away with it. I risk that can happen to me, maybe a lump and then I say “Oh my God to know! After it's too late I know.

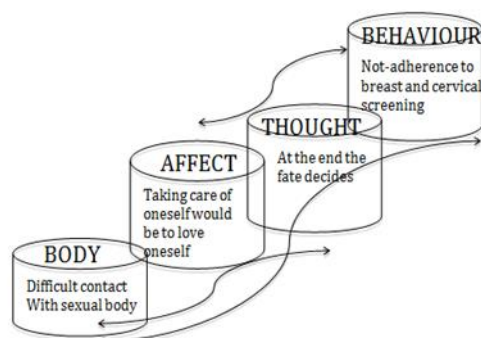
Faced with the vulnerability and loss (of the state of health, of parts of the body, of life) and thinking about the unthinkability of death, the perception of a “destiny” allows a double denial towards external reality and internal reality. *Atropos and the thread of life* is the subordinate theme that expresses the power that women attribute to fatalism in terms of cancer prevention. Fate resembles a mythological divinity, Atropos, the one who cannot be avoided and who was assigned the task of cutting, with shiny shears, the thread that represented the life of individuals, decreeing the moment of death. Women believe that despite prevention, they can get sick 6 months later from a cancer that attacks another area of the body. The inscrutability of the case is felt with such force that it seems only possible to adhere to the causality of living and dying.

We cannot live in fear, however we die. If I knew I didn't have to die maybe I'd do something. But the fact of having to die anyway, this inevitability of the life path, this is a bit fatalistic

Table. 2. Superordinate and Subordinate Themes

Superordinate and Subordinate Themes	Mrs R.	Mrs A.	Mrs M.	Mrs N.	Mrs C.	Mrs B.	Mrs T.	Mrs S.
1. Taking care oneself would be to love oneself 1a) <i>I love myself and I harm myself</i> 1b) <i>Subject-object of care</i>	*	*	*	*	*	*	*	*
2. Difficult contact with a sexual body <i>Screening of sexual zones</i> <i>Neglected and rejected femininity</i>	*	*	*	*	*	*	*	*
3. At the end the fate decides <i>A challenge not to access the fear</i> <i>Atropos and the thread of life</i>	*	*	*	*	*	*	*	*

Fig. 1 A three-dimensional interpretative model about behaviour of non-adhesion of women to breast and cervical cancer screening



3. Discussion

The three superordinate themes that emerged from the attribution of meaning to women around their experience of non-adherence to screening programs are constituted as three levels that underlie the behavior of not doing prevention in the psychism: body-> affects-> thought.

- The first level is the bodily level, the somatic nucleus from which one's own psycho-sexual identity and thoughts originate.

The refusal to undergo screening tests appears to be rooted in the difficult investment of one's own sexual body, the unspeakable thing, too often rejected and neglected, difficult to love and think.

Moreover, in the case of cancer prevention, there is no "body that speaks," which sends symptoms or signs of discomfort, but women should worry about their health in the absence of a visual, tactile, and somatic perception of "something that does not it goes." The experiences told by women clearly show what literature highlights femininity, or something known that was not thought (Bollas, 1987; Nunziante Cesàro, 2014). The possibilities of exposing one's body to medical supervision and allowing others to enter one's own cavity (in this case, the gynecological speculum for investigations) are connected to the deepest of oneself and one's somato-psychic identity (Arcidiacono, 1994). A preventive activity into the sexual places, i.e., unspeakable parts of one's body, would seem so complicated precisely because it psychologically mixes the paths of development of one's femininity, where wounds and losses could become concrete and not merely symbolic due to the risk of cancer.

- The second level is that of affections, needs, and deeper meanings that highlight an area of dilemmas within the woman, attributable to eros and thanatos. Through the narratives of women, we grasp the most problematic aspect of the disposition to take care of oneself and to prevent cancer risk, connected to the most atavistic conflict between life and death drives, where the latter tend both to homeostasis and to unconscious destructiveness. Taking care of oneself, therefore, could be understood as an aspect of a healthy ego narcissism, a comic form of existence, so to speak, while the dimension of the negative narcissism would call for an aspect of libidinal disinvestment towards the I as an expression of the death instinct. This aspect seems to be linked to the need of women for an Other, for example, the Healthcare Institution, which does not leave them alone with a dilemma of choice regarding prevention and encourages them to take care of themselves and to undergo screening, accompanying them in the preventive action. Recognizing the dimension of interpersonal dependence, the narratives highlight the importance of the affiliative bonds for self-care and health because care seems to make sense only in a relationship, an addiction so there must be another who cares of you.

In this regard, the data relating to the marital status of women is interesting: only one has a partner, a husband, at the time of the interview. The other seven women are separated or widows and do not mention current relationships. As if the absence of an emotional and erotic relationship made it even more difficult to take care of yourself.

- The third level is the thought, which leads to the wording of activated defensive strategies, such as that of fatalism. If to think means to have an emotional experience of a concept (Dicè et al., 2020), to think about cancer prevention means to experience emotionally the concept of cancer risk or to think about death. Cancer, understood by Susan Sontag (2002) as a metaphor for contemporaneity, is defined as an organic accident that scourges the human, which cannot be represented metaphorically and perhaps precisely for this reason mystified in cancer equality death. And personal death, alien to the symbolic order, is configured for our psychic apparatus as a traumatic anxiety that must be denied but that each association can rekindle (De Masi, 2002).

As the idea of cancer prevention is associated with the risk of profound vulnerabilities, risk appears to be a refuge for the mind that can defend itself by resorting to a sense of omnipotence and chance, as the only holder of the power of life and death.

We believe that the present study allows us to identify specific constructions of meaning of women who do not undergo screening for breast and cervical cancer prevention.

The superordinate themes that emerged and the psychodynamic interpretative model discussed here allow us to emphasize that the barriers linked to cancer prevention are based on important psychic questions that are stratified starting from a more primitive and sensorial level which is that of the body, crossing the area of fantasies and affectivity connected to taking care of oneself, to screening tests, and to the risk of illness, to then come to a thought that, by contacting the anguish of death, needs to defend itself. The three-dimensional interpretative model allows us to illustrate that non-adherence to screening cannot be understood as a *tout court* behavior, but it can be the expression of a process that crosses all three levels or only one of the psychic questions.

Taking into account these aspects that underlie non-adherence to screening behavior means being able to think of personalized intervention practices aimed at supporting women in taking care of themselves, creating spaces in wherein they can give voice to these unconscious but obstructing levels, accepting disease-induced suffering as a form of comic existence, an existence where the seemingly execrable and ridiculous dimensions of life occupy the center stage.

The authors are aware of the limitations of this study which are related to the lack of generalizability and the specific nature of the context of the results.

4. Conclusion

However, we believe that it is important to increase qualitative studies both on women to whom screening programs are aimed and on younger women to highlight meaningful trajectories related to cancer prevention to build and practice interventions to support women's health.

The highlighting of the obstacles that at various levels in the subjective experience of women oppose the assumption of preventive behavior, allows us to think about clinical intervention practices aimed at working on semiotic connection processes between the different levels of experience involved in this process.

Moreover, these studies can provide suggestions about doctor–patient relationship identifying good practices and contributing to a reorganization of the business system with effective and homogeneous health promotion activities, planning to support the development of advertising policies and projects aimed at the population at risk.

References

1. Aasen, T., & Skolbekken, J.A. (2014) Preparing for and communicating uncertainty in cancer genetic counselling sessions in Norway: an interpretative phenomenological analysis, *Health, Risk & Society*, 16(4), 370-389. [10.1080/13698575.2014.927838](https://doi.org/10.1080/13698575.2014.927838)
2. Abraham, K. (1924). Tentativo di una storia evolutiva della libido sulla base della psicoanalisi dei disturbi psichici. *Opere*. Vol.I. Torino: Bollati Boringhieri.
3. Ackerson, K., & Preston S.D. (2009). A decision theory perspective on why women do or do not decide to have cancer screening: systematic review. *Journal Compilation*, 65(6). <https://doi.org/10.1111/j.1365-2648.2009.04981.x>
4. Adolfsson, A., Granevik, K., & Paulson, K. (2012). The Reasons Why Women Do Not Participate in the Pap Smear Screening and Testing Program in Sweden. *Advances in Sexual Medicine*, 2(3),31-37. [10.4236/asm.2012.23006](https://doi.org/10.4236/asm.2012.23006)
5. Al Dasoqui, K., Zeilani, R., Abdalrahim, M., & Evans, C. (2013). Screening for breast cancer among young Jordian women: ambiguity and apprehension. *International Nursing Review*, 60(3), 351–357. <https://doi.org/10.1111/inr.12025>
6. Andersen, M. T., Smith, R., Meischke, H., Bowen, D. & Urban, N. (2003). Breast cancer worry and mammography use with and without a family history in a population based sample. *Cancer epidemiology, biomarkers & prevention*, 12, 314-320.
7. Arcidiacono, C. (1994). *Identità femminile e psicoanalisi*. Milano: Franco Angeli.
8. Bacqué, M.F. (2014). *Psychob thérapies analytiques en oncologie*. Lavoisier.
9. Becker, M. H., & Maiman L.A. (1975). Social behavioral determinants of compliance with health and medical care recommendations. *Medical Care*, 13, 10-24.
10. Bekker, MHJ. (2003). Investigating gender within health research is more than sex disaggregation of data: A Multi-facet Gender and Health Model. *Psychology, Health & Medicine* 8(2), 231-243. <https://doi.org/10.1080/1354850031000087618>
11. Bertini, M. (2012). *Psicologia della salute*, Milano: Raffaello Cortina.
12. Biondi, M., Costantini, A., & Parisi, A. (1996). Can loss and grief activate latent neoplasia? *Psychotherapy and Psychosomatics*, 65(2), 102-105. <https://doi.org/10.1159/000289055>
13. Blomberg, K., Ternstedt, B.M., Tornberg, S., & Tishelman, C. (2008). How do women who choose not to participate in population-based cervical cancer screening reason about their decision? *Psycho-Oncology*, 17, 561–569. <https://doi.org/10.1002/pon.1270>
14. Bollas, C. (1987). L'ombra dell'oggetto. *Psicoanalisi del conosciuto non pensato*, Roma, Borla, 1989.
15. Braibanti, P. (a cura di) (2008). *Pensare la salute. Orizzonti e nodi critici della psicologia della salute*. Milano: Franco Angeli.
16. Canales, M.K., & Geller, B.M. (2004) Moving in Between Mammography: Screening Decisions of American Indian Women in Vermont *Qualitative Health Research*, 14(6), 836-857. <https://doi.org/10.1177/1049732304265845>
17. Chasseguet-Smirgel, J. (2005). *Il corpo come specchio del mondo*. Milano: Cortina Raffaello.

18. Consedine, N.S., Magai C., Krivoshekova, Y.S., Ryzewicz, L., & Neugut A.I. (2004). Fear, Anxiety, Worry and Breast Cancer Screening Behaviour: A Critical Review. *Cancer Epidemiol Biomarkers Prevention*, 13(4), 501-510.
19. De Luca Picione, R., Martino, M. L., & Troisi, G. (2019). The Semiotic Construction of the Sense of Agency. The Modal Articulation in Narrative Processes. *Integrative Psychological and Behavioral Science*, 53(3), 431-449. <https://doi.org/10.1007/s12124-019-9475-9>
20. De Masi, F. (2002). Il limite dell'esistenza. Un contributo *psicoanalitico al problema della caducità della vita*. Torino: Bollati Boringhieri.
21. Dejours, C. (2004) Il corpo, come esigenza di lavoro per il pensiero. In Debray R., Dejours C. & Fèdida, P. *Psicopatologia dell'esperienza del corpo*. Roma: Borla.
22. Dicé F., Dolce P., Maiello A. & Freda M.F. (2020). Exploring emotions in dialog between health provider, parent and child. An observational study in pediatric primary care. *Pratiques Psychologiques*, 26, 69-84. 10.1016/j.prps.2018.12.001.
23. Duberstein, P.R., & Masling J.M. (a cura di) (2000) *Psychodynamic Perspectives on Sickness and Health*. Amer Psychological Assn.
24. Facchin, F., & Saita, E., (2017). L'impatto psicologico del Papillomavirus: quando la fiducia si ammala, in Acquati, C., & Emanuela Saita, E., *Affrontare insieme la malattia. Il coping diadico fra teoria e pratica*, Carocci, Roma 2017: 87-106
25. Fantinelli, S., Marchetti, D., Verrocchio, M. C., Franzago, M., Fulcheri, M., Vitacolonna, E. (2009). Assessment of Psychological Dimensions in Telemedicine Care for Gestational Diabetes Mellitus: A Systematic Review of Qualitative and Quantitative Studies. *Frontiers in Psychology*, 10(153), 1-15. <https://doi.org/10.3389/fpsyg.2019.00153>
26. Ferenczi, S. (1929) Il bambino mal accolto e la sua pulsione di morte. Tr.it in *Opere* vol IV Milano: Cortina, 2002
27. Ferraro, F., & Nunziante Cesàro, A. (1985). *Lo spazio cavo e il corpo saturato*. Milano: Franco Angeli.
28. Fowler, B.A. (2006). Claiming health: mammography screening decision making of African American women. *Oncology Nursing Forum*, 33(5), 969-982
29. Freda, M.F., González-Monteaudo, J., Esposito, G. (2016) (Eds). Working with Underachieving Students in Higher Education: Fostering Inclusion through Narration and Reflexivity. Abingdon: Oxon; New York: NY; Routledge. 10.4324/9781315659121
30. Freud, S., (1920). Al di là del principio di piacere. In *O.S.F.*, Vol.9. Torino: Bollati Boringhieri, 1977.
31. Galdon, M.J., Andreu Y., & Dura E. (1997). Determinantes psicosociales de la practica de autoexploracion mamaria. *Boletín de Psicología*, 57, 77-96.
32. Garotti, P.L., Candini, L., Ricci Bitti, P.E., & Scioli, A. (2003). Studio sulle credenze e gli atteggiamenti personali in tema di prevenzione dei tumori del collo dell'utero e della mammella. *Psicologia della Salute*, 3, 41-59.
33. Gurevich, M., Devins, G. M., and Rodin, G. M. (2002). Stress response syndromes and cancer: conceptual and assessment issues. *Psychosomatics* 43, 259-281. 10.1176/appi.psy.43.4.259

34. Harcourt, N., Ghebre, R.G., Whembolua, G., Zhang, Y., Osman, S.W., & Okuyemi K.S. (2014). Factors Associated with Breast and Cervical Cancer Screening Behavior Among African Immigrant Women in Minnesota. *J Immigrant Minority Health*, 16(3), 450-456. 10.1007/s10903-012-9766-4
35. Head, K.J.; & Cohen, E. L. (2011). Young Women's Perspectives on Cervical Cancer Prevention in Appalachian Kentucky. *Qualitative Health Research*, 22(4), 476-487.
<https://doi.org/10.1177/1049732311425053>
36. Langer, E.J., & Rodin, J. (1976). The effects of choice and enhanced personal responsibility for the aged. *Journal of Personality and Social Psychology*, 34(2), 191-198. <https://doi.org/10.1037/0022-3514.34.2.191>
37. Lenzo, V., Sardella, A., Martino, G., & Quattropiani, M. C. (2020). A Systematic Review of Metacognitive Beliefs in Chronic Medical Conditions. *Frontiers in psychology*, 10, 2875. [10.3389/fpsyg.2019.02875](https://doi.org/10.3389/fpsyg.2019.02875)
38. Levinas, E. (1991). *Entre nous. Essais sur le penser à l'autre*. Paris: Grasset.
39. Manjer, A.R., Zackrisson, S., & Emilsson, U.M. (2014). On women's ambivalence about mammography screening: support in the decision-making process a potential role for health care social workers? *British Journal of Social work*, 46(2), 480-497. <https://doi.org/10.1093/bjsw/bcu078>
40. Marlow, L., Waller, J., & Wardle, J. (2015). Barriers to cervical cancer screening among ethnic minority women: a qualitative study. *Fam Plann Reprod Health Care*, 0, 1-7. <http://dx.doi.org/10.1136/jfprhc-2014-101082>
41. Martino, G., Catalano, A., Bellone, F., Langher, V., Lasco, C.G., Penna, C., Nicocia, G., Morabito, N. (2020). Quality of life in postmenopausal women: which role for vitamin D? *Mediterranean Journal of Clinical Psychology*, 6(2). <https://doi.org/10.6092/2282-1619/2018.6.1875>
42. Martino, G., Langher, V., Cazzato, V., and Vicario, C.M. (2019a). Editorial: Psychological Factors as Determinants of Medical Conditions. *Front. Psychol*, 10, 2502. <https://doi.org/10.3389/fpsyg.2019.02502>
43. Martino, M. L., & Freda, M. F. (2016). Meaning-Making Process Related to Temporality During Breast Cancer Traumatic Experience: The Clinical Use of Narrative to Promote a New Continuity of Life. *Europe's Journal of Psychology*, 12(4), 622-634. 10.5964/ejop.v12i4.1150
44. Martino, M. L., De Luca Picione, R., Lemmo, D., Boursier, V., & Freda, M. F. (2019b). Meaning-Making Trajectories of Resilience in Narratives of Adolescents with Multiple Sclerosis. *Mediterranean Journal of Clinical Psychology*, 7(2), 1-25. 10.6092/2282-1619/2019.7.2049
45. Martino, M. L., Gargiulo, A., Lemmo, D., Dolce, P., Barberio, D., Abate, V., Avino, F., & Tortriello, R. (2019c). Longitudinal effect of emotional processing on psychological symptoms in women under 50 with breast cancer. *Health Psychology Open*, 6(1), 1-9. <https://doi.org/10.1177/20551029198445>
46. Martino, M.L., Lemmo, D., Gargiulo, A., Barberio, D., Abate, V., Avino, F., & Tortriello, R. (2019d). Underfifty Women and Breast Cancer: Narrative Markers of Meaning-Making in Traumatic Experience. *Frontiers in Psychology*, 10, 618, 1-12. 10.3389/fpsyg.2019.00618
47. McBride, E., Tatar, O., Rosberger, Z., Rockliffe, L., Marlow, L. M., Moss-Morris, R., Kaur, N., Wade, K., & Waller, J. (2020). Emotional response to testing positive for human papillomavirus at cervical cancer screening: a mixed method systematic review with meta-analysis. *Health psychology review*, 1-35. Advance online publication. 10.1080/17437199.2020.1762106.

48. Mehnert, A., and Koch, U. (2007). Prevalence of acute and post-traumatic stress disorder and comorbid mental disorders in breast cancer patients during primary cancer care: a prospective study. *Psychooncology* 16, 181–188. 10.1002/pon.1057
49. Menninger, K. A. (1938). *Man Against Himself*. Harvest Books: Harcourt.
50. Newberry, A.M. (2011). Book Review: Interpretative Phenomenological Analysis: Theory, Method and Research. *Qualitative Health Research*, 21(9), 1298-1300. <https://doi.org/10.1177/1049732311410357>
51. Norfjord Van Zyl, M., Akhavan, S., Tillgren, P., & Asp, M., (2018). Experiences and perceptions about undergoing mammographic screening: a qualitative study involving women from a county in Sweden. *International Journal of Qualitative Studies on Health and Well-being*, 13(1), 152-256. 10.1080/17482631.2018.1521256
52. Nunziante Cesàro, A. (2014). *Chiaroscuri dell'identità. Sessualità, sesso e genere. Una lettura psicoanalitica*. Milano: Franco Angeli.
53. Oscarsson, M.G., Wijma, B.E., & Benzein, E.G. (2008). 'I do not need to... I do not want to... I do not give it priority...! why women choose not to attend cervical cancer screening. *Health Expect*, 11(1), 26-34. <https://doi.org/10.1111/j.1369-7625.2007.00478.x>
54. Paganucci, C., Primi C., & Siani R. (2002). Locus of control sulla salute e screening mammografico. *Psicologia della Salute*, 2, 75-90.
55. Parat, H. (2000). *L'erotico materno, Psicoanalisi dell'allattamento*. Roma: Borla.
56. Payne, D.K., Hoffman, R.G., Theodoulou, M., Dosik, M., & Massie M.J. (1999). Screening for anxiety and depression in women with breast cancer. *Psychosomatics*, 40(1), 64-69. [https://doi.org/10.1016/S0033-3182\(99\)71273-9](https://doi.org/10.1016/S0033-3182(99)71273-9)
57. Pietkiewicz, I., & Smith, J. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal*, 20(1) 7-14. 10.14691/CPJ.20.1.7
58. Plourde, N., Brown, H.K., Vigod, S., & Cobigo, V. (2016). Contextual factors associated with uptake of breast and cervical cancer screening: A systematic review of the literature, *Women & Health*, 56(8), 906-925. <https://doi.org/10.1080/03630242.2016.1145169>
59. Quattropiani, M.C., Lenzo, V., & Filastro, A. (2018). The role of metacognitions in multiple sclerosis: a clinical study and assessment of possible correlation with anxiety, depression and coping strategies. *Euromediterranean Biomedical Journal*, 13(9), 39-45. 10.3269/1970-5492.2018.13.9
60. Rahnea-Nita, R., Paunica, S., Motofei, C., Rahnea-Nita, G. (2019). Assessment of anxiety and depression in patients with advanced gynaecological cancer. *Mediterranean Journal of Clinical Psychology*, 7(2), 11. <https://doi.org/10.6092/2282-1619/2019.7.2214>
61. Reich, M. (2009). Cancer et image du corps: identité, représentation et symbolique. *L'Information Psychiatrique*, 85(3), 247-254. <https://doi.org/10.3917/inpsy.8503.0247>
62. Ricci Bitti, P.E., Candini, L., Garotti P.L., & Scioli A. (2000). Fattori predittivi del comportamento preventivo in tema di tumori della mammella del collo dell'utero. In Reda, M.A. & Benevento, D. (a cura di) *Significato e senso della malattia*. Siena: Tipografia senese.

63. Rimal, R.N., & Real, K. (2003). Perceived risk and efficacy beliefs as motivators of change. Use of the risk perception attitude (RPA) framework to understand health behaviors. *Human Communication Research* 29(3), 370–399. <https://doi.org/10.1111/j.1468-2958.2003.tb00844.x>
64. Rippetoe, P.A., & Roger S.R.W. (1987). Effects of components of protection- motivation theory on adaptive and maladaptive coping with a health threat. *J Pers Soc Psychology*, 52(3), 596-604. <https://doi.org/10.1037/0022-3514.52.3.596>
65. Rollero, C. (2014). Salute in una prospettiva di genere. In De Piccoli N. (a cura di) *Salute e qualità della vita nella società del benessere*. Roma: Carocci.
66. Rummans, T.A., Frost, M., Suman, V.J., Taylor, M., Novotny, P., Gendron, T., Johnson, R., Hartman, L., Dose, A.M., & Evans R.W. (1998). Quality of life and pain in patients with recurrent breast and gynecologic cancer. *Psychosomatics*, 39(5), 437-445. [https://doi.org/10.1016/S0033-3182\(98\)71303-9](https://doi.org/10.1016/S0033-3182(98)71303-9)
67. Scheier, M.F., & Carver, C.S. (1987). Dispositional optimism and physical wellbeing. *Journal of Personality*, 55, 169-210.
68. Schoenberg, N.E., Studts, C.R., Hatcher-Keller, J., Buelt E., & Adams. E. (2013). Patterns and Determinants of Breast and Cervical Cancer Non-Screening Among Appalachian Women. *Women & Health*, 53(6), 552-571. <https://doi.org/10.1080/03630242.2013.809400>
69. Silverman, E., Woloshin, S., Schwartz L.M., Byram, S.J., Welch, H.G., & Fischhoff, B., (2001). Women's Views on Breast Cancer Risk and Screening Mammography. A qualitative interview study. *Medical Decision Making*, 21, 231-240. <https://doi.org/10.1177/0272989X0102100308>
70. Smith, J., (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health*, 11, 261-271. <https://doi.org/10.1080/08870449608400256>
71. Smith, J., (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well Being*, 2, 3-11. <https://doi.org/10.1080/17482620601016120>
72. Smith, J.A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Methods*. London: Sage.
73. Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis. Theory, Method and Research*. London: Sage.
74. Solbakk, J. H., Bentzen, H. B., Holm, S., Heggstad, A.K.T., Hofmann, B.M., Robertsen, A. Alnæs, Anne Hambro; Cox, Shereen; Pedersen, Reidar & Bernabe, Rosemarie de la Cruz (2020). Back to WHAT? The role of research ethics in pandemic times. *Medicine, Health care and Philosophy*. 10.1007/s11019-020-09984-x
75. Solbakk, J.H. (2019) *Bioethics & Human Development*. Taylor & Francis
76. Solbakk, J.H. (2015). What is it to do good medical ethics? On the concepts of 'good' and 'goodness' in medical ethics. *Journal of Medical Ethics*, 41(1), 12-16. <http://dx.doi.org/10.1136/medethics-2014-102310>
77. Sontag, S. (2002). *Malattia come metafora. Cancro e Aids*. Milano: Mondadori.
78. Teng, F.F., Mitchell, S.M., Sekikubo, M., Biryabarema, C., Byamugisha, J.K., Steinberg, M., Money, D.B., & Ogilvie, G.S. (2014). Understanding the role of embarrassment in gynaecological screening: a qualitative study from the ASPIRE cervical cancer screening project in Uganda. *BMJ Open*, 1-9. <http://dx.doi.org/10.1136/bmjopen-2014-004783>

79. Tessaro, I., Eng, E., & Smith J. (1994). Breast cancer screening in older African- American women: qualitative research findings. *American Journal of Health Promotion* 8(4), 286–292. <https://doi.org/10.4278/0890-1171-8.4.286>
80. Tessitore, F., Glovi, F. A., Margherita, G. (2019). Pre- and post-migratory experiences of refugees in Italy: an interpretative phenomenological analysis. *Mediterranean Journal of Clinical Psychology*, 7(3), 1-18. <https://doi.org/10.6092/2282-1619/2019.7.2171>
81. Vernet, A., & Henry F. (2007). Prévention du cancer du sein et facteurs psychosociaux. *Le Journal des psychologues*, 247, 54-57. 132
82. Villani, D., Cogna, C., Toniolo, D., Scanzi, F., and Riva, G. (2016). Engaging elderly breast cancer patients: the potential of eHealth interventions. *Front. Psychol.* 7:1825. doi: 10.3389/fpsyg.2016.01825
83. Waller J, Jackowska M, Marlow L, & Wardle J. (2012). Exploring age differences in reasons for nonattendance for cervical screening: a qualitative study. *BJOG*, 119, 26–32. <https://doi.org/10.1111/j.1471-0528.2011.03030.x>
84. Zani, B., & Cicognani, E. (2000). *Psicologia della salute*. Bologna: Mulino.
85. Zani, B., & Pietrantoni, L. (2000). Donne e salute: un modello per predire l'intenzione ad eseguire il Pap-test. *Psicologia della Salute*, 1, 51-66.



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DOI: 10.6092/2282-1619/mjcp-2563