



Health Communication Experiences of Cervical Cancer Patient Navigators in Supporting Remission at RSKD

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ABSTRACT

This study explores the experiences of cervical cancer patient navigators in motivating themselves and other patients undergoing chemotherapy and radiation at RSKD to achieve remission. Motivation plays an important role in helping patients develop positive thinking and a strong determination to recover. The study uses a phenomenological approach to understand how survivors interpret their experiences and give meaning to their journey toward remission. Although patient navigation has been widely investigated in high-income countries, empirical evidence on how patient navigators in Indonesia, particularly at RSKD, experience and enact health communication in supporting cervical cancer patients during remission remains scarce. Moreover, Indonesia's unique cultural context, healthcare system, and communication practices may generate distinct communication experiences and challenges that are not adequately reflected in the existing international literature. The research involved two women aged 50–65 years who had previously undergone chemotherapy and radiation and were later declared free from HPV. Both participants currently serve as patient navigators for cervical cancer patients at RSKD. Data were collected using purposive and snowball sampling within a constructivist paradigm. The findings show that achieving remission is not only a medical struggle but also a psychological and social one. The participants experienced pessimism, hopelessness, and social stigma that viewed cancer as a fatal disease. Despite these challenges, they were able to motivate themselves and support other patients through interpersonal communication and shared experiences. Spiritual closeness to God emerged as the main source of strength and resilience in maintaining hope and motivation toward remission.

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1. Introduction

Cervical cancer remains a major global public health concern and is one of the leading causes of cancer-related morbidity and mortality among women. According to the World Health Organization (WHO), cervical cancer is the fourth most frequently diagnosed cancer among women worldwide, with more than 600.000 new cases and over 340.000 deaths reported annually ([Organization, 2024a, 2024b](#)). Despite advances in prevention through human papillomavirus (HPV) vaccination, early detection, and improved treatment modalities, many women continue to be diagnosed at



advanced stages, particularly in low- and middle-income countries where access to health services remains unequal. Consequently, cervical cancer not only poses a substantial clinical burden but also creates long-term psychological, social, and communication challenges throughout the cancer care continuum (Yao et al., 2026; Yu et al., 2022).

Indonesia is among the countries with a high burden of cervical cancer in Southeast Asia. Data from GLOBOCAN indicate that cervical cancer is the second most common cancer among Indonesian women and remains one of the leading causes of cancer-related mortality (Dean et al., 2025). Delayed diagnosis, limited awareness of early symptoms, social stigma surrounding reproductive health, and unequal access to healthcare services contribute to poor treatment outcomes. Beyond medical challenges, communication barriers between patients, healthcare providers, families, and communities often hinder patients' understanding of their illness, adherence to treatment, and psychosocial adjustment (Dean et al., 2025; Liberacka-Dwojak et al., 2024; Zhuang et al., 2025). These conditions highlight the importance of effective health communication in supporting cervical cancer care.

The experience of living with cervical cancer extends beyond diagnosis and medical treatment. Patients frequently experience psychological distress, including fear, uncertainty, anxiety, depression, diminished self-esteem, and concerns about disease recurrence. Such emotional challenges often persist even after treatment has been completed, particularly during the remission phase, when patients must adapt to life after cancer while coping with uncertainty regarding their future health. Previous studies have shown that psychological well-being during remission significantly influences patients' quality of life, treatment adherence, and long-term survivorship.

Health communication plays a crucial role in addressing these psychosocial challenges by facilitating information exchange, emotional support, shared decision-making, and patient empowerment (Conte et al., 2024; Zhi et al., 2024). Within cancer care, patient navigators have emerged as important communication facilitators who assist patients in understanding medical information, coordinating healthcare services, overcoming healthcare barriers, and providing continuous psychosocial support throughout the treatment journey. In many healthcare settings, patient navigators, particularly cancer survivors serving as peer navigators, also provide experiential knowledge, emotional reassurance, and motivational support that complement formal clinical care (Simamora et al., 2021). Their lived experiences enable them to establish empathetic relationships with patients, thereby strengthening trust and encouraging patients to remain engaged in their treatment and recovery process (Chepngeno & Anyonje, 2023).

Previous studies on patient navigation have primarily examined its effectiveness in improving access to cancer care, reducing treatment delays, increasing adherence to therapy, and enhancing patient satisfaction. Other studies have investigated physician–patient communication, family support, and psychosocial interventions among cancer patients. Although these studies have demonstrated the value of communication in cancer care, they have largely emphasized communication outcomes and service effectiveness rather than the communication experiences of patient navigators themselves. Furthermore, research on health communication has predominantly focused on the stages of diagnosis and active treatment, while relatively little attention has been given to communication during the remission phase, when patients continue to face uncertainty, fear of recurrence, and psychosocial adjustment (Chepngeno & Kiptoo, 2023; Linus et al., 2023).

In addition, empirical evidence regarding how patient navigators in Indonesia experience and enact health communication while supporting cervical cancer patients during remission remains scarce. Existing evidence has been generated primarily from high-income countries whose healthcare systems, cultural values, and communication practices differ substantially from those in

Indonesia. These contextual differences may shape unique communication experiences, interaction patterns, and support strategies that cannot be fully explained by findings from previous international studies. Consequently, understanding the communication experiences of Indonesian patient navigators is essential for developing culturally appropriate health communication strategies for cervical cancer survivorship.

Therefore, this study aims to explore the health communication experiences of cervical cancer patient navigators in supporting patients during the remission phase at RSKD. By examining how patient navigators communicate, provide emotional and informational support, and help patients maintain motivation throughout remission, this study seeks to contribute to the growing body of knowledge on health communication and patient navigation, particularly within the context of cervical cancer survivorship in Indonesia.

2. Theoretical Framework

In this study, the author utilizes several relevant theories and concepts to serve as a foundation for thinking and as guidelines in examining the reality of the phenomenon being studied. These theories and concepts are outlined as follows:

Maslow's Hierarchy of Needs

This theory was proposed by Maslow (1943), a psychologist, as cited by (Sumarwan, 2011). It reveals that there are five human needs based on a hierarchy. These needs start from the most basic and progress to the highest. The five human needs according to Maslow in Fig. 1.

1. Physiological needs, in this case, refer to human needs such as food, water, clothing, air, shelter, and other essentials required for survival. These needs are the most basic.
2. Safety needs, humans require a sense of security, both physically and psychologically. This can include a safe and clean environment, protection from physical and psychological harm, and freedom from violence and threats (Sartre et al., 2022).
3. Social needs, in this context, refer to the need for affection and a sense of belonging. Humans are social beings, so they naturally seek connections and relationships with others in their lives.
4. Esteem needs, these needs typically emerge after physiological, social, and security needs are fulfilled. Everyone wants to be recognized and valued by others.
5. Self-actualization needs, these are at the highest level. Typically, these are the needs of individuals who strive to fulfill personal ambitions and achieve their full potential.



Fig. 1. Maslow's hierarchy of needs

Expectancy Theory

The theory of expectancy is proposed by Vroom (1963), Expectancy theory proposed by Vroom explains that motivation arises when individuals believe their efforts will lead to desired outcomes. People are motivated to choose behaviors that are expected to produce rewards or meaningful results. The theory consists of three main components: expectancy, namely the belief that effort will improve performance; valence, referring to the value individuals place on outcomes or rewards; and instrumentality, which is the belief that good performance will lead to goals.

Motivation refers to the internal drive that directs individuals to achieve goals (Robbins et al., 2015; Robbins & Judge, 2014). It influences the strength, direction, and persistence of behavior. Motivation emerges when needs remain unmet, creating tension that encourages action (Vansteenkiste et al., 2020). In health contexts, motivation is essential for cervical cancer patients because it helps maintain positive thinking, resilience, and quality of life during treatment. Intrapersonal communication is communication within oneself, involving self-reflection, interpretation, and internal dialogue (Cangara et al., 2016). It occurs when individuals process experiences, thoughts, and emotions to make decisions or give meaning to life events. Through intrapersonal communication, cervical cancer patients can develop self-awareness, positive thinking, and motivation to continue treatment and pursue remission.

Interpersonal communication is the exchange of messages between individuals that allows direct feedback and relationship building (Solomon & Theiss, 2021). It is considered effective in influencing attitudes and behaviors because communication occurs directly between communicator and receiver. Effective interpersonal communication involves openness, empathy, support, positivity, and equality (Wiranti, 2023). In the context of cervical cancer patients, interpersonal communication provides emotional support, encouragement, and shared experiences that help strengthen motivation during recovery. Patient navigation is individual assistance offered to patients, families, and caregivers when navigating obstacles in the healthcare system. The role of patient navigation can facilitate timely access to quality health and psychosocial care from pre-diagnosis through each phase of cancer treatment. Cancer mortality rates in Indonesia are expected to continue rising. The results of a study presented by WHO cancer control official Andre Ilbawi, quoted by the Ministry of Health's NCD Prevention and Control Division (P2PTM) on February 5, 2018, state that about 70% of cancer deaths occur in low and middle-income countries (LMICs) (<https://p2ptm.kemkes.go.id>).

Cancer Patient Navigator (NAPAK), according to the official website of the Ministry of Health go.id dated April 10, 2022, is an individual who assists in guiding patients through their diseasetreatment journey within the healthcare system, not representing a medical role. Acting as a patient navigator includes coping with the patient (helping to cope with the stress) of cervical cancer. The assistance provided by patient navigators includes accompanying patients through the stages of examination, diagnosis, treatment, and follow-up for a medical condition. To become a patient navigator, special training is required, not only related to cancer information but also hospital services, donations, the needs of each cancer patient, and knowledge related to Basic Life Support (BHD) Cancer Hospital Dharmais, Roche Indonesia, and Tata Memorial Hospital have agreed on a collaboration to strengthen the capacity of oncology healthcare professionals (general practitioners and/or nurses) to provide cancer patient navigation services (Navigator Pasien Kanker-NAPAK) through a certified training program for trainers (training for trainer). Program NAPAK is introduced to address various obstacles faced by cancer patients, such as long queues and wait times, perceived lack of clear communication, complex administration, and patient distrust in the capabilities and empathy of healthcare professionals.

3. Method

This study uses a qualitative field research approach with phenomenological methods to explore the experiences of cervical cancer patient navigators in motivating themselves and other patients to achieve remission. The constructivist paradigm was applied to understand how participants interpret their experiences and social realities through interaction. The research subjects consisted of two female cervical cancer survivors aged over 50 years who had completed chemotherapy and radiation, were declared free from HPV, and currently served as patient navigators at RSKD West Jakarta. Informants were selected using purposive sampling based on specific criteria, including willingness to participate in the study. Data were collected through observation, in-depth interviews, and document studies from January to June 2025. The researcher directly observed communication between patient navigators and patients undergoing treatment. Interviews were conducted after establishing trust and obtaining informed consent from participants.

Interview recordings were transcribed verbatim and analyzed using thematic analysis. The analysis involved familiarization with the data, open coding, identification of categories, development of themes, and interpretation of the participants' lived experiences. Data analysis used the phenomenological model of Moustakas, involving identification of significant statements, meaning units, textural and structural descriptions, and interpretation of the essence of participants' experiences. To ensure credibility, member checking was conducted by returning interview summaries to participants for confirmation. Data validity was strengthened through triangulation and member checking to ensure the accuracy and credibility of findings.

This research uses the constructivist paradigm because the researcher aims to develop an understanding that aids the interpretation process of a phenomenon or event. The research subjects are three adults who have had near-death experiences. The constructivist paradigm views social reality as holistic, complex, dynamic, meaningful, and with interactive relationships between phenomena. The research is conducted on natural objects that develop as they are, without being manipulated by the researcher, and the presence of the researcher does not affect the dynamics of the objects (Sugiyono & Lestari, 2021).

Referring to the phenomenon being studied, which is the transcendental communication experience of individuals who have had near-death experiences, the method used is phenomenology. Phenomenology seeks to understand how humans construct meanings and important concepts within the framework of intersubjectivity (our understanding of the world is shaped by our relationships with others) (Kuswarno, 2009). Furthermore, (Stephen W. Littlejohn et al., 2012) assumes that people actively interpret their experiences and try to understand the world through their personal experiences. To obtain a picture of the reality of the individual experiences of research subjects with near-death experiences, in-depth interviews are conducted.

4. Result and Discussion

The experience of research subjects and self-motivation in undergoing the stages of treatment until reaching the remission condition.

Encountering the Diagnosis: The Collapse of Normality

The diagnosis of cervical cancer emerged as the first major turning point in participants' lived experiences. Rather than being perceived merely as a medical confirmation of disease, receiving the diagnosis represented a profound disruption to the participants' sense of normality, identity, and expectations for the future. Across all interviews, participants consistently described diagnosis as an unexpected life event that abruptly interrupted their ordinary lives and initiated an emotionally overwhelming process of uncertainty.

The diagnosis did not simply communicate the presence of cancer; it fundamentally altered how participants understood themselves, their bodies, their relationships, and the continuity of their lives. Before receiving a definitive diagnosis, nearly all participants interpreted their early symptoms as common reproductive health problems or natural consequences of aging. Abnormal vaginal bleeding, persistent vaginal discharge, lower abdominal discomfort, and irregular menstruation were initially considered temporary conditions that did not require immediate medical attention. Some participants even believed that these symptoms were associated with menopause or hormonal changes. This initial interpretation contributed to delays in seeking medical examination, illustrating how everyday assumptions about women's reproductive health shaped the participants' early responses to illness.

One participant explained:

"At first I thought it was only menopause. I had bleeding for several months, but I believed it was something normal because of my age. I never imagined that it was cervical cancer."

Another participant similarly recalled:

"I thought it was just ordinary vaginal discharge. I bought medicine from the pharmacy and waited for it to get better. When it didn't stop, I finally decided to visit the hospital."

These narratives demonstrate that the earliest phase of illness was characterized by uncertainty rather than awareness. Participants interpreted bodily changes through the lens of everyday experience instead of perceiving them as symptoms of a life-threatening disease. From a phenomenological perspective, the body was initially experienced as "normally functioning," despite subtle physiological changes that later proved to be indicators of cervical cancer. Consequently, the diagnosis represented not only new medical information but also the collapse of participants' previous understanding of their own bodies.

The moment participants received confirmation of cervical cancer was consistently described as emotionally devastating. Most participants used expressions such as shock, fear, disbelief, crying, confusion, and hopelessness when recalling this experience. For many, the word "cancer" immediately evoked associations with suffering, death, and the possibility of leaving their families behind. Rather than understanding cancer as a potentially manageable chronic illness, participants initially interpreted the diagnosis as an inevitable death sentence.

One participant expressed this emotional reaction by stating:

"When the doctor said I had cervical cancer, I couldn't hear anything else. My mind immediately thought about death. I cried all night because I believed my life had ended."

Another participant shared:

"I kept asking the doctor whether there had been a mistake. I couldn't believe it because I had never felt seriously ill before."

The diagnosis therefore functioned as what phenomenological scholars describe as a biographical disruption, an event that abruptly interrupted participants' previous life narratives and forced them to reconstruct their understanding of themselves and their future. Daily routines, family responsibilities, employment, and personal aspirations suddenly became uncertain. Participants described experiencing a profound sense of losing control over their own lives. An equally significant finding was that participants experienced an intense need to seek information immediately after receiving the diagnosis. Before they were emotionally prepared to begin treatment, many attempted to understand cervical cancer by searching the internet, consulting relatives, asking healthcare professionals, or contacting cancer survivors. Information seeking represented an effort to reduce uncertainty and regain a sense of control over an unfamiliar situation.

One participant explained:

"When I arrived home, I immediately searched Google about cervical cancer. I wanted to know whether people could survive this disease. I read many stories until I finally found survivor communities."

Another participant recalled:

"I asked everyone I knew if they had ever heard about cervical cancer because I needed reassurance that this disease could be treated."

These narratives reveal that communication became essential from the earliest stage of illness. Participants did not seek information merely to understand medical procedures; they searched for hope, certainty, and emotional reassurance. The process of information seeking therefore represented the beginning of participants' health communication journey. Communication functioned as a mechanism for reducing fear, reconstructing meaning, and preparing psychologically for the treatment process.

Interestingly, participants consistently distinguished between receiving clinical information from healthcare professionals and hearing experiential narratives from fellow cancer survivors. While physicians provided accurate medical explanations regarding diagnosis and treatment options, survivors communicated lived experiences that participants perceived as emotionally authentic and psychologically reassuring. Survivor narratives helped participants imagine the possibility of recovery, thereby gradually replacing fear with hope.

One participant reflected:

"The doctor's explanation made me understand the disease, but listening to another survivor made me believe that I could survive."

This finding illustrates that different forms of communication fulfilled different psychosocial needs. Clinical communication reduced informational uncertainty, whereas peer communication reduced emotional uncertainty. The coexistence of these communication processes became the foundation for participants' subsequent adaptation throughout treatment and remission.

Overall, the experience of diagnosis represented far more than the beginning of medical treatment. It constituted the collapse of participants' previous assumptions about health and the beginning of a profound process of existential reconstruction. The diagnosis disrupted ordinary life, generated uncertainty, and initiated an active search for meaning through communication with healthcare professionals, family members, and fellow survivors. Thus, rather than being understood solely as a medical event, the diagnosis emerged as the first stage of a transformative communication journey that ultimately shaped participants' identities as cervical cancer survivors and, later, as patient navigators.

While the diagnosis initially generated shock, fear, and uncertainty, participants did not remain within this emotional state indefinitely. As they progressed through treatment, they gradually reconstructed the meaning of their illness through religious beliefs, spiritual reflection, and acceptance. This process of spiritual meaning-making became a central mechanism that enabled participants to transform fear into hope and continue their journey toward remission.

Negotiating Meaning Through Spiritual Acceptance

Following the initial emotional turmoil after receiving a cervical cancer diagnosis, participants gradually entered a process of reconstructing the meaning of their illness. Rather than remaining overwhelmed by fear and uncertainty, they began to reinterpret their experience through spiritual beliefs and religious values. This process of spiritual meaning-making enabled participants to shift their perception of cervical cancer from a life-threatening catastrophe to a meaningful life journey

that demanded patience, faith, and personal transformation. Across all interviews, spirituality emerged not merely as a coping mechanism but as an interpretive framework through which participants understood suffering, maintained hope, and regained psychological stability.

Participants consistently described the early phase following diagnosis as a period marked by existential questioning. Many struggled to understand why they had developed cervical cancer despite perceiving themselves as healthy individuals who had fulfilled their family and social responsibilities. Questions such as "Why did this happen to me?" and "What have I done wrong?" reflected participants' attempts to reconcile the diagnosis with their previous understanding of life. However, these questions gradually evolved into a broader spiritual reflection in which illness was interpreted as part of God's plan rather than as an unjust punishment.

One participant explained:

"At first I kept asking why Allah gave me this disease. After praying and reflecting, I realized that perhaps this was not a punishment but a test that would make me stronger."

Another participant expressed a similar perspective:

"I eventually accepted that every illness has a purpose. Maybe God wanted me to become a better person and appreciate life more than before."

These narratives demonstrate that participants actively negotiated the meaning of illness through religious reflection. Acceptance did not occur immediately after diagnosis but developed gradually through continuous engagement with personal faith, prayer, and contemplation. From a phenomenological perspective, spirituality became the medium through which participants reconstructed a disrupted life narrative and restored coherence to experiences that initially appeared incomprehensible.

Importantly, participants distinguished between merely acknowledging the diagnosis and genuinely accepting it. Acceptance was described as an ongoing process rather than a single emotional event. During the early stages of treatment, participants admitted that they often experienced fluctuating emotions, alternating between hope and despair. Nevertheless, spiritual practices such as prayer, reciting the Qur'an, participating in religious gatherings, and seeking guidance from religious leaders gradually strengthened their emotional resilience.

One participant recalled:

"Every time I was scheduled for chemotherapy, I prayed before entering the treatment room. Prayer gave me courage because I believed that whatever happened was under God's control."

Another participant shared:

"Reading the Qur'an made me calmer. It did not remove the pain, but it changed how I faced the pain."

These findings suggest that spirituality functioned less as a means of eliminating suffering and more as a process of transforming participants' relationship with suffering. Physical discomfort, uncertainty regarding treatment outcomes, and fear of recurrence remained present throughout their illness journey. However, participants described becoming increasingly capable of confronting these challenges after integrating spiritual beliefs into their daily lives. An equally significant finding was that spiritual acceptance fundamentally influenced participants' communication with others. As participants became more accepting of their illness, they reported feeling more comfortable discussing their diagnosis with family members, healthcare providers, and fellow survivors. Several participants explained that before reaching spiritual acceptance, they avoided conversations about cancer because discussing the disease intensified their fear. Following acceptance, communication became more open, honest, and emotionally constructive.

One participant reflected:

"At first I didn't want anyone to know because I was ashamed and afraid. After I accepted my illness as God's will, I found it easier to talk to my family and even encourage other patients."

Another participant explained:

"When I accepted the illness, I no longer felt embarrassed to ask questions or seek help. I realized that communicating with others was part of my healing process."

These narratives indicate that spiritual acceptance facilitated not only intrapersonal adaptation but also interpersonal communication. Participants' willingness to disclose their illness, seek information, express emotions, and receive support increased as they gradually reconstructed the meaning of their diagnosis. Spirituality therefore functioned as a catalyst for more open communication rather than merely serving as a private coping strategy.

Participants also emphasized that spiritual beliefs sustained hope throughout prolonged treatment. Rather than hoping exclusively for complete physical recovery, many described a broader understanding of hope that included emotional peace, meaningful relationships, and the opportunity to continue serving their families. This redefinition of hope reduced participants' dependence on uncertain medical outcomes and allowed them to focus on aspects of life that remained meaningful despite illness.

One participant stated:

"I stopped asking whether I would recover completely. Instead, I prayed that God would give me strength to live each day with gratitude."

Another participant commented:

"Healing is important, but inner peace is equally important. Even if the treatment is difficult, I believe God always accompanies me."

From a phenomenological perspective, these statements reveal a transformation in participants' orientation toward illness. The diagnosis initially symbolized loss and mortality; however, through spiritual meaning-making, it gradually became associated with personal growth, gratitude, and renewed purpose. Illness was no longer experienced solely as a biological condition but as a meaningful life event that reshaped participants' priorities, values, and interpersonal relationships.

Perhaps the most remarkable aspect of this theme is that spirituality became the foundation for participants' future commitment to supporting other cervical cancer survivors. Several participants described their survival as evidence that God had entrusted them with a responsibility to help others facing similar circumstances. Consequently, their desire to become patient navigators was interpreted not merely as voluntary service but as a spiritual calling that emerged directly from their illness experience.

One participant explained:

"After surviving cancer, I felt that Allah had given me another chance. I wanted to use that opportunity to accompany other women so they would not feel as lonely as I once did."

Another participant similarly reflected:

"Perhaps this illness was God's way of preparing me to help others. If my experience can give hope to another patient, then my suffering has meaning."

These narratives illustrate that spiritual meaning-making extended beyond individual adaptation and evolved into a motivation for prosocial engagement. Participants no longer perceived themselves exclusively as cancer survivors but as individuals entrusted with the responsibility of communicating hope to others confronting similar challenges. In this sense, spirituality became closely intertwined with communication, empathy, and service.

Overall, this theme demonstrates that spiritual acceptance represented a dynamic process through which participants reconstructed the meaning of illness, restored psychological equilibrium, and developed greater openness in communicating with others. Rather than eliminating uncertainty, spirituality enabled participants to reinterpret uncertainty as part of a meaningful life journey. This transformation laid the psychological and communicative foundation that allowed participants not only to continue treatment but also to envision themselves as future sources of hope and guidance for other cervical cancer survivors.

Although spiritual acceptance provided participants with emotional stability and renewed hope, they continued to face substantial physical, psychological, and social challenges throughout treatment. Chemotherapy, radiotherapy, surgery, and repeated hospital visits demanded continuous adaptation and perseverance. Participants therefore described treatment not merely as a medical procedure but as a prolonged journey requiring resilience, supportive communication, and sustained motivation. These experiences are explored in the next theme, Enduring the Long Journey of Treatment Through Communication-Driven Resilience.

Enduring the Long Journey of Treatment Through Communication-Driven Resilience

Following the gradual acceptance of their illness through spiritual meaning-making, participants entered the most demanding stage of their cancer journey, the prolonged period of medical treatment. Unlike the moment of diagnosis, which was experienced as a sudden emotional disruption, treatment was perceived as an extended process requiring continuous physical endurance, emotional adaptation, and sustained psychological resilience. Participants consistently described chemotherapy, radiotherapy, surgery, and repeated hospital visits not merely as clinical procedures but as lived experiences that challenged their identity, hope, and determination. Throughout this journey, communication emerged as a critical resource that enabled participants to endure the uncertainty and suffering associated with treatment.

Across all interviews, participants emphasized that treatment represented a succession of physical and emotional challenges rather than a linear path toward recovery. Chemotherapy sessions were frequently associated with severe nausea, fatigue, appetite loss, hair loss, weakness, and prolonged exhaustion. Radiotherapy introduced additional discomfort, while repeated medical appointments created ongoing uncertainty regarding treatment outcomes. Nevertheless, participants consistently described these physical hardships as secondary to the emotional burden of not knowing whether treatment would ultimately be successful.

One participant described her experience as follows:

"Chemotherapy was not the hardest part. The hardest part was wondering whether all the pain would really make me better."

Another participant reflected:

"Every treatment session felt like entering another battle. I was exhausted physically, but mentally I kept asking whether I would ever return to a normal life."

These narratives illustrate that participants experienced treatment as a prolonged confrontation with uncertainty. Rather than fearing the medical procedures themselves, they struggled with the unpredictability of recovery, the possibility of recurrence, and the disruption of everyday life. Consequently, resilience during treatment was constructed not solely through individual determination but through continuous communication that helped participants interpret and manage uncertainty.

Participants repeatedly explained that communication with healthcare professionals became essential in reducing anxiety throughout treatment. Detailed explanations regarding treatment

procedures, possible side effects, expected recovery, and medical progress helped participants regain a sense of control over situations that initially appeared overwhelming. Importantly, participants emphasized that communication characterized by empathy and patience was considerably more reassuring than purely technical medical explanations.

One participant stated:

"When the doctor explained every step patiently, I became less afraid. I realized that understanding what was happening made the treatment easier to face."

Another participant commented:

"I always prepared questions before meeting the doctor because every explanation reduced my worries a little."

These findings suggest that communication functioned as a mechanism for reducing informational uncertainty. Participants' confidence in continuing treatment increased when healthcare professionals communicated clearly, consistently, and compassionately. Thus, effective communication did not merely transfer medical information but also strengthened patients' emotional readiness to continue treatment.

However, participants consistently reported that communication with fellow cervical cancer survivors fulfilled needs that differed fundamentally from those addressed by healthcare professionals. While physicians provided clinical expertise, survivors communicated experiential knowledge derived from living through similar circumstances. Participants described these interactions as particularly meaningful because they demonstrated that recovery was not merely a theoretical possibility but an attainable reality.

One participant explained:

"The doctor told me the treatment would work, but meeting another survivor who had completed the same treatment made me truly believe that I could survive."

Another participant recalled:

"Seeing someone who had gone through chemotherapy and was smiling again gave me hope that no medicine alone could provide."

From a phenomenological perspective, these interactions transformed abstract medical optimism into concrete lived possibilities. Survivor communication enabled participants to envision a future beyond illness by providing authentic narratives of perseverance and recovery. Consequently, hope was constructed not solely through clinical prognosis but through interpersonal communication grounded in shared experience.

Participants also described treatment as a period during which their relationships with family members became increasingly significant. Family communication extended beyond practical caregiving responsibilities and evolved into an essential source of emotional regulation. Conversations with spouses, children, siblings, and parents frequently reassured participants that they were not confronting illness alone. Emotional encouragement, expressions of affection, shared prayers, and everyday conversations contributed substantially to participants' determination to continue treatment despite recurring physical difficulties.

One participant reflected:

"Whenever I wanted to give up, my children reminded me that they still needed me. Their words became my strength to continue treatment."

Another participant explained:

"My husband never forced me to be strong. He simply stayed beside me and kept telling me that we would face everything together."

These narratives reveal that resilience emerged through relational communication rather than individual perseverance alone. Participants interpreted family communication as evidence of belonging, acceptance, and shared commitment, thereby reducing feelings of isolation frequently associated with chronic illness.

Interestingly, participants acknowledged that their own communication patterns also changed throughout treatment. During the initial stages, several participants deliberately concealed their diagnosis from relatives, friends, or colleagues due to fear of stigma and pity. As treatment progressed, however, many gradually became more willing to discuss their illness openly. This communicative openness was facilitated by increasing self-acceptance, spiritual reflection, and supportive responses from significant others.

One participant stated:

"At first I kept everything to myself because I was embarrassed. Later I realized that talking about my illness actually made me stronger because people wanted to help."

Another participant added:

"Once I stopped hiding my condition, I discovered that many people genuinely cared. Sharing my experience reduced my emotional burden."

These findings suggest that communication itself became part of the healing process. Rather than merely expressing emotions, participants experienced communication as an active means of reconstructing identity, receiving validation, and developing confidence throughout treatment. Speaking about illness transformed participants from passive recipients of care into active participants in their own recovery.

A particularly significant finding concerns the gradual emergence of resilience as a communicative achievement rather than a purely psychological characteristic. Participants repeatedly emphasized that their ability to persevere resulted from continuous interaction with multiple communication partners, including healthcare professionals, family members, religious communities, fellow survivors, and patient navigators. Each communication relationship fulfilled distinct psychological functions that collectively sustained participants' motivation to continue treatment.

As one participant summarized:

"I survived not because I was naturally strong. I became strong because so many people kept encouraging me every day."

This statement encapsulates the essence of participants' treatment experiences. Resilience was not understood as an inherent personal trait but as a socially constructed process continuously reinforced through supportive communication. Encouragement, empathy, information sharing, spiritual conversations, and shared experiences collectively enabled participants to reinterpret suffering as a temporary stage rather than an irreversible condition.

Overall, participants described treatment as an extended communication journey in which resilience was gradually developed through meaningful interactions with others. Medical treatment addressed the biological dimensions of cervical cancer, whereas communication addressed its emotional, psychological, and existential consequences. Participants' perseverance therefore emerged not solely from medical intervention but from communication processes that sustained hope, reduced uncertainty, and reaffirmed their capacity to continue living despite prolonged adversity.

As participants progressed through treatment, one communication relationship consistently emerged as particularly influential: communication within the family. Beyond providing practical assistance, family members became the primary emotional anchors who helped participants

navigate fear, uncertainty, and physical suffering. The next theme explores how family communication functioned as an emotional resource, shaping participants' resilience and their capacity to continue the journey toward remission.

Family Communication as Emotional Resources

As participants progressed through treatment, communication within the family emerged as one of the most significant sources of emotional strength throughout their illness journey. Although family members undoubtedly provided practical assistance such as accompanying participants to hospitals, managing daily activities, and supporting treatment decisions, participants consistently emphasized that emotional communication was considerably more meaningful than physical caregiving alone. Expressions of encouragement, empathy, reassurance, and unconditional acceptance became essential resources that enabled participants to confront prolonged uncertainty and maintain their commitment to treatment. Family communication therefore functioned not merely as social support but as a dynamic relational process through which hope, resilience, and emotional security were continuously negotiated.

Across all interviews, participants described their diagnosis as affecting not only themselves but also every member of their family. The disclosure of cervical cancer became a collective emotional experience in which fear, sadness, and uncertainty were shared among spouses, children, parents, and siblings. Consequently, communication within the family underwent substantial changes as members attempted to understand the illness together and adapt to its consequences.

One participant recalled:

"When I told my family about the diagnosis, everyone cried. We did not know what would happen next, but we promised that we would face everything together."

Another participant explained:

"The illness was not only mine. My husband, my children, and my siblings all experienced the emotional burden with me."

These narratives illustrate that cervical cancer was experienced as a family illness rather than an individual medical condition. From a phenomenological perspective, participants understood their illness within the context of interpersonal relationships, where emotional experiences were collectively shared rather than privately endured. Communication therefore became the primary mechanism through which families reconstructed stability after the disruptive experience of diagnosis.

Participants consistently emphasized that encouragement from spouses represented one of the strongest motivations to continue treatment despite repeated physical suffering. Rather than offering unrealistic optimism, spouses frequently provided emotional reassurance by remaining physically present, listening attentively, and expressing confidence in participants' ability to overcome treatment challenges.

One participant reflected:

"My husband never said everything would be easy. He simply stayed beside me during every chemotherapy session. His presence spoke louder than words."

Another participant explained:

"Sometimes he just held my hand without saying anything. That silence made me feel safe because I knew I was not fighting alone."

These findings reveal that supportive communication was not limited to verbal interaction. Participants frequently interpreted physical presence, attentive listening, affectionate gestures, and shared silence as powerful communicative expressions of emotional support. Such non-verbal

communication reassured participants that they remained valued members of their families despite experiencing severe illness.

Children also played an important communicative role in sustaining participants' motivation throughout treatment. Participants frequently described conversations with their children as reminding them of their continuing responsibilities and future aspirations. Rather than increasing psychological pressure, these interactions strengthened participants' determination to survive.

One participant shared:

"Whenever I wanted to stop treatment because I was exhausted, I looked at my children. They always told me, 'Mother, please keep fighting because we still need you.'"

Another participant stated:

"My daughter constantly encouraged me by saying that we would celebrate together after I recovered. Those simple conversations gave me strength."

From a phenomenological perspective, these interactions enabled participants to reconstruct hope by reconnecting with meaningful social roles beyond illness. Communication with children reminded participants that they continued to occupy significant positions within their families, thereby preventing cervical cancer from becoming the defining feature of their identities.

Interestingly, participants also described family communication as evolving throughout treatment. During the early stages of illness, many participants deliberately concealed emotional distress to protect family members from additional anxiety. They often attempted to appear emotionally strong despite experiencing fear and uncertainty internally. Over time, however, participants gradually became more willing to express vulnerability, discuss treatment difficulties, and seek emotional reassurance openly.

One participant explained:

"Initially I pretended to be strong because I didn't want my children to worry. Eventually I realized that sharing my feelings actually brought us closer together."

Another participant reflected:

"I learned that being honest about my fears did not make me weak. Instead, my family became even more supportive because they understood what I was experiencing."

These narratives demonstrate that communication during illness became increasingly reciprocal. Participants gradually shifted from protecting family members through emotional concealment toward developing relationships characterized by openness, mutual empathy, and shared emotional responsibility. Such openness strengthened trust within the family and reduced participants' sense of isolation during treatment. An equally important finding concerns the role of family communication in medical decision-making. Participants repeatedly emphasized that treatment decisions were rarely made independently. Instead, discussions involving spouses, children, siblings, and extended family members enabled participants to evaluate treatment options, manage financial concerns, and maintain confidence in their decisions.

One participant stated:

"Every important decision was discussed together. My family wanted me to feel that I was never making those decisions alone."

Another participant explained:

"Whenever I became confused about treatment, my children helped me understand the doctor's explanation and encouraged me to continue."

These findings indicate that family communication extended beyond emotional reassurance and functioned as collaborative decision-making. Through dialogue, family members transformed

complex medical information into shared understanding, thereby reducing uncertainty and strengthening participants' confidence throughout treatment.

Participants also acknowledged that family members occasionally experienced emotional exhaustion. Watching a loved one undergo repeated chemotherapy and prolonged physical suffering created feelings of helplessness among caregivers. Nevertheless, participants described continuous communication as enabling both patients and family members to support one another emotionally.

One participant reflected:

"There were times when I comforted my husband because he looked more frightened than I was. We encouraged each other."

This statement highlights the reciprocal nature of supportive communication. Rather than viewing participants solely as recipients of care, family communication evolved into a mutual process in which emotional support flowed bidirectionally between patients and their loved ones. Such reciprocity reinforced participants' sense of dignity and agency despite the challenges of illness.

Perhaps the most significant aspect of this theme is that participants consistently interpreted family communication as providing emotional security rather than simply emotional encouragement. Knowing that family members remained emotionally available enabled participants to tolerate uncertainty regarding treatment outcomes. Communication therefore reduced not only loneliness but also existential vulnerability associated with living with cervical cancer.

As one participant summarized:

"Medicine treated my body, but my family healed my spirit."

This statement encapsulates the lived meaning of family communication throughout participants' treatment experiences. Participants did not attribute resilience exclusively to personal courage or medical intervention; instead, they perceived resilience as emerging from relationships characterized by empathy, presence, trust, and continuous emotional dialogue. Family communication thus became an indispensable emotional resource that sustained participants throughout the long and uncertain journey toward remission (Gordon & Tannen, 2023; Sahertian et al., 2021).

Overall, this theme demonstrates that communication within the family represented far more than social support. It functioned as an ongoing relational process through which fear was shared, hope was maintained, treatment decisions were negotiated, and emotional resilience was collectively constructed. Through everyday conversations, physical presence, mutual reassurance, and collaborative decision-making, family members helped participants preserve their sense of belonging, purpose, and confidence despite the profound disruptions caused by cervical cancer.

While family communication provided participants with emotional stability within their closest relationships, many continued to experience uncertainty that family members could not fully understand because they had never personally experienced cervical cancer. Participants therefore began seeking connections with individuals who shared similar lived experiences. Communication with fellow survivors introduced a new form of support based not only on empathy but also on shared experiential knowledge. The following theme explores how interactions among cervical cancer survivors became powerful spaces for reconstructing hope, exchanging practical knowledge, and shaping participants' future identities as patient navigators.

Learning Hope Through Survivor Communication

As participants gradually adapted to treatment and developed stronger emotional stability through family support and spiritual acceptance, they continued to experience uncertainties that neither healthcare professionals nor family members could fully resolve. Although physicians provided essential medical information and family members offered unconditional emotional support, participants consistently explained that neither group had personally experienced cervical cancer. Consequently, they sought communication with fellow survivors who shared similar lived experiences. These interactions became transformative spaces where fear was gradually replaced by hope, uncertainty was reduced through experiential knowledge, and participants reconstructed their understanding of life after cancer. Across all interviews, participants described meeting other cervical cancer survivors as one of the most influential moments in their recovery journey. Unlike clinical consultations, which primarily focused on diagnosis and treatment protocols, conversations with survivors centered on everyday realities of living with cancer. Participants learned how others managed chemotherapy, coped with side effects, maintained family relationships, returned to work, and ultimately resumed meaningful lives after remission. These lived narratives provided participants with forms of reassurance that medical information alone could not offer.

One participant recalled:

"When I first met another cervical cancer survivor, I immediately noticed how healthy she looked. At that moment, I realized that recovery was possible because I was looking at someone who had already survived what I was experiencing."

Another participant reflected:

"The doctor explained the treatment very well, but survivors explained how to live through the treatment. That was what I really needed."

These narratives illustrate that survivor communication functioned as a bridge between medical knowledge and lived experience. Participants did not simply receive additional information; they acquired practical wisdom that enabled them to imagine a future beyond illness. From a phenomenological perspective, interactions with survivors transformed cancer from an abstract threat into a shared human experience that could be understood, navigated, and ultimately overcome (Alvarenga et al., 2025).

Participants consistently emphasized that communication with survivors reduced feelings of isolation. Before joining survivor communities, many believed that no one truly understood the emotional consequences of cervical cancer. While family members sympathized with their suffering, participants felt that only another survivor could genuinely comprehend the fear associated with diagnosis, treatment, body image changes, and uncertainty regarding recurrence.

One participant explained:

"I never had to explain my feelings because they already understood. They had experienced the same fear, the same pain, and the same uncertainty."

Another participant stated:

"For the first time, I felt that I belonged somewhere. I was no longer the only person struggling with cervical cancer."

These findings demonstrate that shared illness experience fundamentally transformed communication. Participants described conversations within survivor communities as requiring fewer explanations because mutual understanding had already been established through similar lived experiences. Communication therefore became more authentic, emotionally meaningful, and psychologically validating than many of their previous interactions (Ronald & Lawrence, 2023; Sahertian et al., 2021).

An equally important finding concerns the role of storytelling within survivor communities. Rather than exchanging abstract advice, participants shared personal illness narratives that described their individual journeys from diagnosis to remission. These stories became powerful communicative resources that enabled newly diagnosed patients to reinterpret their own experiences.

One participant recalled:

"Listening to another survivor's story changed my perspective. I stopped thinking about dying and started thinking about how I could survive."

Another participant explained:

"Every survivor had a different story, but every story reminded me that cancer was not the end of life."

From a phenomenological perspective, storytelling functioned as a process of collective meaning-making. Through listening to others' experiences, participants reconstructed the meaning of their own illness. Personal narratives became shared narratives, allowing individuals to reinterpret suffering not as an isolated tragedy but as part of a broader journey experienced by many women. Participants also described survivor communities as safe communicative spaces where they could openly discuss topics that were often difficult to express elsewhere. Conversations included concerns about femininity, marital relationships, sexuality, fertility, fear of recurrence, and emotional exhaustion, subjects that participants sometimes hesitated to discuss with healthcare professionals or family members.

One participant reflected:

"There were questions I felt embarrassed to ask the doctor. I asked fellow survivors because I knew they would understand without judging me."

Another participant commented:

"Sometimes we laughed together about things that only cancer survivors could understand. Those moments helped me forget that I was a patient."

These narratives reveal that communication among survivors extended beyond emotional support and information exchange. Survivor communities provided socially safe environments where participants could express vulnerability, normalize difficult experiences, and reconstruct identities that had previously been dominated by illness. Communication therefore became an essential mechanism for restoring self-confidence and dignity (Paananen & Logren, 2025).

A particularly significant finding concerns participants' gradual transformation from recipients of support into providers of support. As treatment progressed and participants became increasingly confident in their own recovery, many reported feeling a growing responsibility to encourage newly diagnosed patients. Initially, participants simply shared their experiences when asked by others.

One participant explained:

"When I realized that my story gave hope to another patient, I understood that surviving cancer also meant having a responsibility to help others."

Another participant reflected:

"At first I came to the community because I needed encouragement. Later I stayed because I wanted to become encouragement for someone else."

These narratives illustrate an important phenomenological transformation. Participants' identities shifted from passive recipients of communication to active communicators capable of influencing the emotional adaptation of others. Hope was no longer something they received; it became something they intentionally communicated.

Interestingly, participants consistently emphasized that hope was transmitted not through persuasion or motivational speeches but through authenticity. They believed that newly diagnosed patients trusted them because they had personally experienced cervical cancer and successfully navigated treatment. Their credibility therefore originated from lived experience rather than professional expertise.

One participant stated:

"Patients listened because they could see that I had gone through everything they were facing. My experience became my strongest message."

Another participant added:

"I never told anyone that treatment would be easy. I simply told them that they were not alone because I had once stood where they were standing."

These findings suggest that experiential credibility became the foundation of survivor communication. Participants' personal histories functioned as communicative resources that fostered trust, empathy, and emotional connection. Rather than providing unrealistic reassurance, participants communicated realistic hope grounded in shared experience. This authenticity distinguished survivor communication from other forms of supportive interaction.

Overall, this theme demonstrates that communication among cervical cancer survivors represented far more than peer support. It constituted a unique communicative environment in which experiential knowledge, storytelling, empathy, and shared identity collectively transformed fear into hope. Through these interactions, participants reconstructed the meaning of survivorship, developed confidence in their own recovery, and gradually recognized their capacity to become sources of hope for others. Survivor communication therefore served as the critical bridge between personal recovery and future service as patient navigators.

As participants became increasingly involved in survivor communities, communication gradually evolved from receiving hope to giving hope. Their personal experiences of illness were no longer viewed solely as memories of suffering but as valuable resources for supporting others facing similar challenges. This transformation marked a profound shift in identity, where surviving cervical cancer became inseparable from a growing commitment to accompany, encourage, and advocate for newly diagnosed patients. The following theme explores this process of transforming suffering into service.

Transforming Suffering into Service

One of the most profound findings emerging from this study is the transformation of participants' identities following remission. Although participants initially viewed cervical cancer as a deeply personal tragedy characterized by fear, uncertainty, and suffering, their experiences gradually evolved into a commitment to support other women facing similar diagnoses. This transformation was neither immediate nor externally imposed. Instead, it developed progressively through participants' own reflections on survivorship, their interactions with fellow survivors, and their growing awareness that their personal experiences had become meaningful resources for others. Consequently, suffering was no longer perceived solely as a painful memory but as the foundation for compassionate service. Across all interviews, participants consistently described remission not as the end of their cancer journey but as the beginning of a new life purpose. Completing treatment and achieving remission did not eliminate memories of physical pain or emotional distress. Instead, participants explained that surviving cervical cancer encouraged them to reinterpret those difficult experiences as opportunities to accompany newly diagnosed patients who were experiencing similar uncertainty.

One participant reflected:

"After I recovered, I realized that surviving cancer was not only about living longer. It was about using my experience so that other women would not face this journey alone."

Another participant explained:

"I often asked myself why I survived while many others continued to struggle. Gradually I understood that perhaps my experience was meant to help someone else."

These narratives reveal a significant phenomenological transformation. Rather than perceiving survival as an individual achievement, participants reconstructed remission as a social responsibility. Their illness experiences acquired new meanings because they could now contribute to the emotional well-being of other patients. From this perspective, suffering was no longer viewed exclusively as loss but as a source of experiential knowledge capable of benefiting others.

Participants repeatedly emphasized that empathy developed naturally from their lived experiences rather than through formal education or professional training. Having personally experienced fear, uncertainty, physical suffering, and emotional vulnerability enabled participants to understand newly diagnosed patients in ways that extended beyond clinical knowledge. They consistently described feeling emotionally connected to patients because they recognized many of the same concerns they had once experienced themselves.

One participant stated:

"When I meet a newly diagnosed patient, I immediately remember how frightened I was. That memory helps me understand what she needs before she even tells me."

Another participant reflected:

"I do not need to imagine their fear because I have lived through it myself."

These narratives demonstrate that empathy was grounded in shared lived experience. Participants' ability to accompany patients did not primarily depend on communication techniques but on experiential understanding. Their personal illness histories became the basis for authentic emotional connection, enabling them to communicate with sensitivity, patience, and credibility.

Importantly, participants did not describe helping others as an obligation imposed by healthcare institutions. Instead, they consistently portrayed their involvement as a voluntary response emerging from gratitude, compassion, and a desire to give meaning to their own survivorship. Many explained that accompanying patients provided them with emotional fulfillment because it transformed painful memories into positive contributions.

One participant explained:

"If my experience can reduce someone else's fear, then everything I went through has meaning."

Another participant stated:

"Helping another patient also helps me remember how far I have come. Every time someone gains hope, I feel grateful for my own recovery."

These findings indicate that service functioned as a reciprocal process. While participants provided emotional support to patients, they simultaneously reinforced their own identities as survivors who had successfully overcome adversity. Supporting others therefore strengthened participants' own psychological well-being and reaffirmed the meaning they had constructed throughout remission.

An equally important finding concerns participants' perception that emotional companionship was often as valuable as medical treatment itself. Participants frequently recalled moments during their own illness when they had longed for someone who genuinely understood their experiences. This memory motivated them to ensure that newly diagnosed patients would not experience the same loneliness.

One participant reflected:

"When I was first diagnosed, I wished someone would simply sit beside me and say, 'I have been through this too.' Now I try to become that person for other patients."

Another participant shared:

"Sometimes patients do not need answers. They only need someone who understands what they are feeling."

From a phenomenological perspective, these statements reveal that participants no longer defined healing exclusively in biomedical terms. Healing increasingly included emotional presence, shared understanding, compassionate listening, and interpersonal connection. Their own suffering had fundamentally reshaped their understanding of what patients required during illness.

Interestingly, participants consistently rejected the notion that they had become "experts" after surviving cervical cancer. Instead, they described themselves as companions walking alongside patients rather than professionals directing patients' decisions. They emphasized listening before advising and understanding before persuading.

One participant explained:

"I never tell patients what they must do. I simply share what helped me and allow them to decide what feels right for them."

Another participant reflected:

"Every patient's journey is different. My role is not to replace doctors but to accompany patients through experiences that I also once faced."

These findings suggest that participants' communication practices were fundamentally patient-centered. Rather than exercising authority, they prioritized empathy, mutual respect, and shared understanding. Their credibility emerged not from professional status but from their willingness to accompany patients with humility and authenticity.

Participants also described becoming increasingly aware that their own recovery inspired hope simply through their presence. Newly diagnosed patients often expressed relief after meeting survivors who appeared healthy and actively engaged in everyday life. Participants gradually recognized that their existence itself communicated a powerful message: cervical cancer did not necessarily signify the end of meaningful living.

One participant reflected:

"Sometimes patients smile before I even say anything because they can see that I survived."

Another participant stated:

"My presence tells them that recovery is possible. Words become important only after they begin to believe that."

These narratives illustrate that communication extended beyond spoken language. Participants' physical presence, appearance, confidence, and willingness to share their experiences collectively functioned as communicative symbols of hope. Their identities as survivors became living testimonies that challenged assumptions equating cervical cancer with inevitable death.

Overall, this theme demonstrates that remission initiated a profound transformation in participants' identities. The lived experience of suffering evolved into compassionate service grounded in empathy, gratitude, and shared humanity. Rather than distancing themselves from memories of illness, participants integrated those experiences into a renewed sense of purpose centered on accompanying others through similar journeys. Transforming suffering into service therefore represented far more than volunteering; it reflected a fundamental reconstruction of identity in which personal adversity became a source of relational healing and meaningful contribution to the lives of other cervical cancer patients.

The transformation from survivor to companion did not stop at providing emotional support. As participants became increasingly involved in accompanying patients, they gradually assumed broader communicative roles within the healthcare system. They translated medical information into understandable language, facilitated dialogue between patients and healthcare professionals, reduced uncertainty, and strengthened patients' confidence throughout treatment (Paananen & Logren, 2025; Stults-Kolehmainen et al., 2020). These evolving responsibilities demonstrate that participants were no longer simply survivors offering encouragement but had become health communication agents whose lived experiences enabled them to bridge clinical care and psychosocial support.

Becoming Health Communication Agents

Participants' transformation from cervical cancer survivors into patient navigators represented more than a change in social role. It reflected the emergence of a new communicative identity in which personal illness experiences became valuable resources for supporting, informing, and empowering other patients throughout their treatment journey. Participants no longer perceived themselves solely as survivors who had overcome adversity but increasingly recognized their capacity to facilitate communication, reduce uncertainty, and strengthen hope among newly diagnosed women. Consequently, their role evolved beyond emotional companionship into that of health communication agents who bridged the gap between clinical care and patients' lived realities.

Across all interviews, participants consistently explained that newly diagnosed patients often experienced overwhelming confusion immediately after receiving a cervical cancer diagnosis. Medical terminology, treatment options, possible side effects, and prognostic information frequently exceeded patients' emotional readiness to process complex information. Participants observed that many patients remained silent during consultations with physicians because fear and anxiety limited their ability to ask questions or fully understand medical explanations.

One participant explained:

"Many patients simply nodded while the doctor was speaking, but afterward they admitted they did not understand what had been explained. They were too frightened to ask questions."

Another participant reflected:

"After patients leave the consultation room, that is usually when they begin asking questions because they finally feel emotionally ready to talk."

These narratives indicate that communication barriers frequently emerged during the earliest stages of treatment. Participants recognized that patients often required additional opportunities to process medical information after consultations had ended. Consequently, patient navigators became important communicative intermediaries who translated complex clinical explanations into language that patients could more easily understand.

Participants repeatedly described helping patients interpret medical information without replacing the authority of healthcare professionals. Rather than offering medical advice, they clarified treatment procedures, explained hospital processes, and shared practical experiences regarding chemotherapy, radiotherapy, and post-treatment recovery. Their explanations were grounded not only in knowledge acquired through training but also in personal experience as cervical cancer survivors.

One participant stated:

"I never explain medicine like a doctor does. I explain what the treatment felt like because patients often need to know what to expect emotionally as well as physically."

Another participant commented:

"Sometimes patients only need someone to translate medical language into ordinary language."

These findings demonstrate that patient navigators fulfilled an important communicative function by connecting biomedical knowledge with experiential understanding. Participants reduced informational uncertainty not through professional authority but through accessible, empathetic communication rooted in lived experience.

Beyond facilitating understanding, participants consistently described their role as creating emotionally safe environments where patients could express fears that they hesitated to discuss elsewhere. Conversations frequently included concerns regarding death, body image, fertility, sexuality, family responsibilities, and fear of recurrence. Participants explained that patients often disclosed these deeply personal concerns because they believed fellow survivors would understand without judgment.

One participant reflected:

"Patients often cry when they speak with us because they finally feel understood. Sometimes they simply need someone who listens without interrupting."

Another participant explained:

"Many women are afraid to tell their families how frightened they really are. They tell us because they know we have experienced the same emotions."

These narratives reveal that participants created communicative spaces characterized by empathy, trust, and psychological safety. Listening became as important as speaking, while emotional presence often proved more meaningful than providing immediate solutions. Communication therefore functioned as an intervention that alleviated emotional distress by validating patients' lived experiences.

Participants also described serving as bridges between patients, families, and healthcare professionals. They frequently encouraged patients to communicate openly with physicians, prepare questions before consultations, and involve family members in treatment discussions. Likewise, they occasionally helped family members better understand the emotional experiences of cervical cancer patients, thereby facilitating more supportive communication within the family.

One participant explained:

"Sometimes I encourage patients to write down their questions before meeting the doctor because anxiety makes it easy to forget what they wanted to ask."

Another participant recalled:

"I also explain to family members that patients do not always need advice. Often they simply need someone willing to listen."

These findings illustrate that participants' communication extended beyond direct interactions with patients. They actively strengthened communication across multiple relational contexts, enabling more collaborative relationships among patients, families, and healthcare providers. Interestingly, participants consistently emphasized that hope should be communicated realistically rather than optimistically. They deliberately avoided promising complete recovery or minimizing the challenges of treatment. Instead, they sought to communicate hope grounded in honesty, authenticity, and shared experience.

One participant explained:

"I never tell patients that everything will be easy because that would not be true. I tell them that treatment is difficult, but it is possible to get through it."

Another participant reflected:

"Patients trust us because we speak honestly. Hope becomes meaningful when it is based on reality."

From a phenomenological perspective, these statements reveal that participants practiced ethical communication grounded in authenticity rather than false reassurance. Their credibility derived from transparent communication that acknowledged suffering while simultaneously affirming the possibility of meaningful survivorship.

Perhaps the most significant finding within this theme concerns participants' recognition that communication itself became a form of healing. Participants consistently observed that patients who felt heard, understood, and emotionally supported often became more willing to continue treatment, ask questions, involve their families, and maintain hope during prolonged therapy.

As one participant summarized:

"Sometimes our words cannot change the disease, but they can change how patients face the disease."

This statement encapsulates the communicative essence of patient navigation. Participants did not perceive healing solely as the elimination of disease but as supporting patients in developing confidence, emotional stability, and meaningful engagement throughout their illness journey. Consequently, patient navigators emerged not simply as volunteers but as health communication agents whose lived experiences enabled them to facilitate understanding, strengthen relationships, reduce uncertainty, and cultivate realistic hope.

Overall, this theme demonstrates that participants' transformation culminated in the development of a new communicative identity. Their experiential knowledge, empathy, authenticity, and interpersonal skills collectively enabled them to bridge medical care and psychosocial support. Patient navigation therefore represents not merely a supportive service but a distinctive form of health communication practice grounded in lived experience and relational understanding.

The Essence of the Lived Experience: A Transformative Health Communication Journey

Phenomenological analysis across all themes revealed that the lived experiences of cervical cancer patient navigators were fundamentally characterized by a transformative journey of communication. This journey did not begin when participants became patient navigators; rather, it began at the moment of diagnosis, when communication was first experienced as a means of confronting uncertainty. Throughout diagnosis, treatment, remission, and survivorship, communication continuously reshaped how participants interpreted illness, reconstructed hope, and redefined their identities (Smith, 2019).

The participants' experiences illustrate that communication evolved through several interconnected stages. Initially, communication functioned as a means of seeking information to reduce uncertainty following diagnosis. As participants progressed through treatment, communication acquired deeper emotional significance through interactions with healthcare professionals, family members, religious communities, and fellow survivors. These interactions gradually transformed communication from a process of receiving support into one of creating support for others.

A central finding of this study is that remission represented not the conclusion of participants' cancer experiences but a critical turning point in which personal suffering acquired new social meaning. Participants no longer viewed survival as an individual accomplishment. Instead, they interpreted remission as an opportunity, and, for many, a moral responsibility to communicate hope, empathy, and experiential knowledge to women confronting similar diagnoses. Consequently, patient navigation emerged as a natural extension of participants' own communication journeys rather than simply a volunteer role assigned within the healthcare system.

The findings further demonstrate that communication within patient navigation extends beyond information exchange. Participants simultaneously performed multiple communicative functions: reducing uncertainty, translating medical information, facilitating emotional disclosure, strengthening family communication, validating patients' experiences, and fostering realistic hope. These interconnected functions suggest that patient navigators operate as relational communication agents who complement clinical care by addressing psychosocial needs that formal healthcare interactions may not fully meet (Mustofa et al., 2023; Ronald & Lawrence, 2023).

From a phenomenological perspective, the essence of participants' lived experience can therefore be understood as a process of transforming personal suffering into compassionate communication. Their experiences reveal that illness, rather than diminishing their capacity to contribute to others, became the very foundation upon which empathy, credibility, and meaningful interpersonal relationships were constructed. Through this transformation, communication itself became both the pathway through which participants achieved psychological adaptation and the primary means through which they subsequently supported the adaptation of others.

Accordingly, the lived experience of cervical cancer patient navigators can be summarized. A transformative health communication journey in which the disruption caused by cervical cancer is gradually reconstructed through supportive, spiritual, familial, and peer communication, enabling survivors to transform personal suffering into empathetic communication practices that sustain hope, facilitate remission, and empower other women navigating similar experiences. This essence captures the shared meaning underlying all participants' experiences and illustrates that communication is not merely a supportive component of survivorship but the central mechanism through which survivorship itself is experienced, interpreted, and ultimately shared with others.

The findings further extend previous studies on patient navigation by demonstrating that the effectiveness of patient navigators is rooted not only in facilitating access to healthcare services but also in their ability to communicate through experiential credibility. Consistent with the work of Harold P. Freeman, patient navigators help reduce barriers to cancer care; however, this study reveals an additional communicative dimension whereby survivors translate medical information, facilitate emotional disclosure, normalize patients' fears, and construct realistic hope through shared lived experiences. These findings suggest that experiential communication should be recognized as a core component of patient navigation programs, particularly in survivorship care.

The study also supports the proposition that social support is fundamentally communicative rather than merely structural. Participants consistently emphasized that family relationships, survivor communities, and patient navigator interactions became meaningful because they were characterized by empathy, dialogue, active listening, and mutual understanding. This finding aligns with the Social Support Theory developed by Sheldon Cohen and Thomas A. Wills, while extending their perspective by illustrating how supportive communication evolves throughout different phases of cervical cancer survivorship, from diagnosis to remission.

5. Conclusion

This phenomenological study demonstrates that the lived experiences of cervical cancer patient navigators constitute a transformative health communication journey, in which communication functions as the central mechanism enabling survivors to reconstruct meaning, negotiate uncertainty, develop resilience, and ultimately transform into communicative agents supporting other women throughout remission. Rather than serving merely as recipients of healthcare information, participants gradually evolved into providers of communication who facilitated understanding, emotional adaptation, and hope for newly diagnosed patients.

This finding reinforces the view that communication is not simply the transmission of health information but a relational process through which individuals construct meaning, cope with illness, and reshape their identities, as proposed by Richard L. Street Jr. and colleagues in the patient-centered communication framework, as well as by Dale Brashers through the perspective of uncertainty management. The most important theoretical contribution of this study is the proposition of the Transformative Health Communication Journey as a conceptual explanation of cervical cancer survivorship. Existing literature generally conceptualizes patient navigation as a healthcare intervention that facilitates access, continuity of care, and treatment adherence. By contrast, this study demonstrates that patient navigation may also be understood as the culmination of a communication-centered identity transformation, in which survivors reconstruct their own experiences of illness through communication before becoming communicative resources for others. This conceptual perspective broadens existing discussions in health communication by positioning communication not only as an intervention but also as the primary mechanism through which survivorship identities are constructed and transmitted.

From a practical perspective, these findings suggest that healthcare institutions should integrate patient navigators into multidisciplinary oncology teams not solely because of their experiential knowledge but because of their unique communicative competence in reducing uncertainty, strengthening patient engagement, fostering family communication, and cultivating realistic hope throughout the remission process. Developing structured communication training for patient navigators may further enhance their contribution to patient-centered cancer care while complementing the biomedical expertise of healthcare professionals.

This study is limited by its focus on patient navigators from a single healthcare institution, and future research should examine whether similar communication processes emerge in different healthcare settings, cultural contexts, and cancer populations. Comparative and longitudinal studies may further refine the proposed conceptual model and examine its applicability across broader survivorship programs. Ultimately, this study concludes that remission represents not the end of the cancer journey but the beginning of a new communicative identity. Through continuous interaction with healthcare professionals, family members, survivor communities, and newly diagnosed patients, survivors transformed personal suffering into empathy, hope, and service. In doing so, they demonstrate that healing is not solely a biomedical achievement but also a communicative accomplishment, reinforcing the growing recognition within health communication scholarship that communication itself is a fundamental determinant of patient adaptation, resilience, and survivorship.

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