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Research Article

Being a Resource or a Burden, Preparing Return to Work During Treatment: Breast Cancer Survivors' Experiences

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Background: The return to work (RTW) is critical for physical, psychosocial, and financial wellbeing and the normalization of breast cancer (BC) survivors. While research indicates that these survivors experience several barriers to the RTW after treatment, limited knowledge exists on preparing the RTW during treatment from women's perspectives.
Objective: To explore the experiences of women with BC preparing their RTW during cancer treatment.
Methods: A qualitative, inductive study was performed and 21 BC survivors with experience from RTW were interviewed individually. Qualitative content analysis was used to analyze the interviews.
Results: Most participants believed that their RTW would be unproblematic. They used all their energy to remain hopeful. Losing value as a human being and as an employee was a painful experience. The need for support to keep hope alive and nurture their feelings of value was described as crucial.
Conclusions: Feelings of hope and value were sustained through positive contact with the workplace, receipt of realistic information on the RTW, continuity of treatment and care, experiencing active listening from healthcare providers, and receipt of information about and coordination of support services.
Implications for practice: HCPs should inform BC survivors that their disease may have long-term side effects and is a burden that may affect their work life and cause cognitive and psychological distress.
HCPs must strive to provide continuity and individualized information during treatment regarding optimal use of the sick leave system, legal rights, support service, contact with work, and individualized RTW planning.

Keywords: breast cancer; qualitative study; return to work

1. Introduction

Breast cancer (BC) is the most common cancer in women, with nearly 4000 new cases annually in Norway [1]. Thanks to screening, a standardized patient pathway for BC and multimodal and often long-lasting treatment, the 5-year survival rate for Norwegian BC patients has increased to 92.3% [1]. As BC primarily affects working-age women (25 through 69 years) [1], the return to work (RTW) is critical for survivors' physical, psychological, economic, and social wellbeing and normalization of life and also has socioeconomic effects. Even though the majority of BC survivors RTW [2], impaired work ability and job disruptions are found during treatment and in the short and long term after treatment [3–7]. Research has shown that the RTW after cancer treatment is challenging from the perspectives of BC survivors, employers, and healthcare professionals (HCPs) [5, 8, 9], underscoring the need to make this issue a priority in survivorship research [10].

The key barriers to RTW for breast cancer (BC) survivors are multifaceted. Demographic factors such as older age, lower educational level and income, lack of family support, previous low activity levels, and nonpermanent employment status at diagnosis are shown to significantly impact RTW

[2, 11–13, 22]. Additionally, medical and clinical factors, including advanced cancer stage, treatments like surgery affecting arm function and hand strength, and receiving chemotherapy and multimodal treatments, are documented barriers. [11, 12]. The consequences of cancer and its treatment, particularly pain, fatigue, and psychological distress, also hinder RTW [16–18, 21–26]. Many BC survivors lack support in navigating the bureaucracy involved in RTW, as well as guidance on how and when to return [20]. The nature of work further impacts RTW, with lower-skilled jobs, physical job tasks, unsupportive supervisors and coworkers, lack of job adjustments, and financial concerns being significant barriers [12, 13, 18]. Conversely, factors promoting early RTW include work value, perceived job ability, workplace self-efficacy, legal advice for workers, professional orientation, gradual reintegration, physical exercise during treatment, and comprehensive information and support from HCPs [21–25].

Previous research has also identified several employer-related barriers and facilitators for RTW for BC survivors. A systematic review by Greidanus et al. [9] showed large variability in perceived employer-related barriers, whereby employers' willingness to provide support seemed dependent on their perceptions of the survivor, employer goals, and national or organizational policies. Facilitating factors are related to knowledge of BC in companies, close follow-up, a primary focus on both physical and psychosocial work factors, and protocols for RTW for BC survivors [26, 27]. In Norway, employers are obligated by law to regularly follow-up with workers on sick leave with dialog meetings; to develop a follow-up plan in cooperation with the worker [28]; and to regularly report to the Norwegian Labor and Welfare Administration (NAV), which pays wages during sick leave.

Although HCPs play a crucial role in the RTW for BC survivors, their involvement is often lacking [29]. Research indicates that BC survivors receive limited support from HCPs, who rarely address RTW issues proactively [30]. The main barriers include HCPs' focus on cancer treatment, lack of time, knowledge, skills, and coordination [31]. However, close follow-up and support from HCPs, along with help in managing side and late effects, are facilitating factors. Therefore, HCPs' competence, expert advice, holistic care, and information from HCPs are essential for BC survivors' RTW decisions during active treatment [32, 33].

Research has shown that BC survivors may experience several different individual employer- and healthcare-related barriers and that the RTW must be seen as a process from diagnosis onwards. In line with this, Greidanus et al. [34] found that BC survivors require personalized, holistic, and tailored support during the four RTW phases: (1) disclosure, (2) treatment, (3) RTW planning, and (4) the actual RTW, where communication, practical support, and assessment of work ability are important requisites in each phase. Based on this model, and the fact that research has shown that less work absence and continuous connections with employers and colleagues are associated with the success of RTW, highlighting the importance of focusing on the RTW in the hospital setting during early medical treatment [35]. However, limited knowledge exists on BC patients' experience preparing to RTW during cancer treatment. The overall aim of this study was therefor to obtain more knowledge on the RTW process for BC survivors during treatment and how it can be improved. Specifically, we aimed to answer the following research question: how can BC survivors be supported during adjuvant chemotherapy to improve their preparedness for the RTW?

2. Materials and Methods

A qualitative, inductive design employing individual interviews was performed, allowing us to explore and analyze experiences from the individual participant to gain a deeper understanding of the phenomenon, moving from the particular into a greater whole [36].

2.1. Recruitment and Eligibility Criteria. The participants were recruited in 2021–2022 using purposive sampling and recruited via the Norwegian Breast Cancer Society website and local newspaper based on the following eligibility criteria: (1) women diagnosed with BC, early stage, adjuvant chemotherapy; (2) between 18 and 70 years of age; (3) working at the time of diagnosis; (4) completed adjuvant chemotherapy and radiation; (5) had minimum 12 months experiences with RTW; and (6) who speak Norwegian. The exclusion criteria were no history of metastasis or major comorbid health conditions.

The study was approved by the Regional Committees for Medical and Health Research Ethics in Norway (203838) and the Norwegian Center for Research Data (100879). The participants were provided with information about the purpose and method of the study and were told that participation was voluntary. Written informed consent was obtained from all participants. Confidentiality, anonymity, and the right to withdraw from the study at any time without any consequences were ensured. Furthermore, the data were kept secure throughout the research process in accordance with the university's laws and regulations.

2.2. Participants. Participants interested in the study provided and sent contact information to the first author who provided them with more information about the study and obtained their consent to participate. All 21 women who provided contact information were included in the study. We found it easy to recruit BCSs, as they believed their participation was meaningful and would help future patients in a similar situation. The participants were recruited from five municipalities and received chemotherapy and, in some cases, radiation therapy (adjuvant) from two main outpatient clinics that were organized in different ways (Table 1).

2.3. Data Collection. Most (14) interviews were conducted face-to-face by first and last authors at the university and seven interviews were performed virtually, due to geographic distance. The researchers had no relationship with

Table 1: Participants' characteristic early-stage adjuvant ($n = 21$).

Age at diagnosis	30–39: 3 40–49: 4 50–59: 14 60–67: 0
Year of diagnosis	2005–2010: 1 2011–2016: 8 2017–2020: 12
Treatment	Surgery, chemotherapy, and radiotherapy ($n = 12$) Surgery and chemotherapy ($n = 8$) Surgery and radiotherapy ($n = 1$)
Workplace	Public sector: 12 Private sector: 9
Full-time work at diagnosis	21

the participants before the interviews. The purpose of the study, position of the researchers/interviewers, and the confidentiality were repeated before the interview started.

The interview guide was semistructured with and had open-ended question (Figure 1). The researchers listened carefully and asked follow-up questions for clarifications, as well as questions related to information about and support with RTW during treatment, and experienced promoting factors and barriers for RTW. The interviews were recorded and lasted between 50 and 70 min and were transcribed by the interviewing authors. The COREQ and SRQR guidelines [37, 50] was used to ensure trustworthiness in the study. After 21 interviews with the BC survivors, we regraded the information power [38] in the data collected as sufficient as the participants provided in-depth, nuanced descriptions that generated sufficiently rich data to fulfill the study's aim.

The research team consisted of females only and included one oncology nurse (ON), one intensive care nurse (ICN) with a PhD, one registered nurse with a PhD, and a co-researcher (ICN) with extensive experience as a service user returning to work after BC treatment. The co-researcher was considered a valuable member of the research group.

2.4. Data Analyses. First and last authors performed and transcribed the interviews. The transcripts were then translated into English by a professional translator with expertise in health-related qualitative data. The research group compared the original Norwegian versions with the translated text. The transcribed interviews were analyzed by means of qualitative content analysis [39]. Using an inductive approach, the text was read and coded by the first and last authors separately. The researchers' individual understandings of similarities and differences and patterns were then discussed to unify the threads of meaning spanning the categories and subthemes into themes as suggested by Graneheim et al. [39]. Suggested subcategories, categories, and themes were discussed with the second author. Valuable insights and feedback on the aim and research questions were obtained through including the third author with own BC, RTW, and research experience in the research group. Through the analyses, we identified two main themes, "keeping hope alive" and "feeling valued," in answer to the research question: how can BC survivors be supported during treatment, to improve their preparedness for the RTW?

Interview guide

How can BC survivors be supported during adjuvant chemotherapy to improve their preparedness for the return to work?

- Will you please share your experiences related to aspects during treatment that influenced your RTW in a positive way.
- Why and how were they helpful?
- Please describe the challenges.
- How can the RTW process be improved?

Figure 1: Interview guide.

3. Results

The analysis concluded in two main themes, each explained by three subthemes (Table 2). We found that the participants were not prepared for their RTW and did not know that there would be any issues. Most participants and their families believed that the RTW would be unproblematic. We were surprised by their unawareness of side effects and energy loss and how this could influence their RTW. During treatment, patients were deeply involved with the treatment itself and the short-term side effects. Consequently, keeping hope alive took all their energy, and everything else was put on hold. In retrospect, however, they saw the need for individualized information regarding the RTW and barriers to optimal use of the sick leave system, legal rights, long-term side effects of treatment, and individualized RTW planning.

They described a feeling of losing value in their work and family life. They also described the feeling of being valued when they met with the same oncologist, ON, or NAV adviser again. The balance between feeling valued or feeling like a burden was described as challenging and very much dependent on how they were welcomed, included, and informed by HCPs, colleagues, and leaders.

3.1. Main Theme 1: Keeping Hope Alive. We found that the participants had little or no energy left to plan their RTW or keep in contact with their colleagues during treatment. From being a resource at work and at home, they were thrown into survival mode in need of treatment and support from HCPs, family, friends, and colleagues. The participants were at different ages and stages of life when diagnosed. Some were young and had children in kindergarten or at school. One young participant described that the cancer diagnosis came unexpectedly and was experienced as a shock:

> "*It was a shock like an atomic bomb hitting me*" *(informant number 5).*

The participants with young children described a fear of dying and leaving their children behind. Psychological reactions during and after BC treatment were described as not

Table 2: Themes and subthemes.

Themes	Keeping hope alive	Feeling valued
Subthemes	Specialized knowledge to meet anxiety and fear of dying	Coordinated support services
	Continuity of treatment and care	Individualized and realistic information on barriers they might meet in RTW even if they do not ask
	To be included in the early RTW planning	Continuously in contact with work manager and colleagues for support and information

sufficiently addressed. Keeping hope alive was perceived as crucial. Some general practitioners (GPs) were highly valued due to their ability to talk about these feelings and how they influenced daily life. Nevertheless, the psychological support received was almost nonexistent. Participants were left to deal with their anxiety alone—something that affected both their personal life and work life.

Participants described being hit by other life crises before their diagnosis and during or after treatment. Such experiences were energy-consuming and influenced the BC treatment process.

One of the participants, a middle-aged widow, highlighted the need for professional support related to emotional trauma.

> "*My husband was only 25 years old when he died of cancer and my sister-in-law died a year later from breast cancer. It was emotionally difficult for me to go to the same cancer department for treatment" (No. 2).*

Experiencing continuity in HCPs was highlighted. It made them feel safe during the treatment period. Knowing and trusting their HCPs made the information more realistic and easier to understand and follow. They felt valued. Continuity in treatment and care supported this feeling. Some participants had their own ON during the treatment trajectory. Information was therefore easily tailored to the patient, which was greatly appreciated by the participants. They felt that they were well taken care of and informed about medical challenges throughout the treatment period (e.g., chemotherapy and radiotherapy), and they also knew who to call.

> *"My oncology nurse was very professional. She was an angel, taking care of me, and tailoring the information to my needs" (No. 7).*

Some participants met with new oncologists and ONs at every consultation/treatment. This made them feel like simply a number with low value. They described a busy healthcare system and unmet information needs.

> *"I met different nurses and doctors every time I had treatment appointment. It is difficult; you do not know who you are going to ask for advice because they are always changing" (No. 21).*

The participants shared that navigating cancer, and its treatment, took all energy. They described challenges in their marital relationships, identity, and sexuality, as well as the economic impact. Painful divorces and financial ruin due to the BC diagnosis and treatment were described of a young participant.

> *"My marriage did not survive this cancer crisis. Some couples grow stronger through a crisis, but we grew apart. I did not get any support from my husband through the cancer trajectory. He had a difficult time as well. We went through a family support programme, but it was too late. I was left with financial problems. We had just bought a house" (No. 13).*

Early RTW planning was regarded as important. Being included in the working group despite being on sick leave gave strength and nourished hope. Lack of interest and follow-up initiatives during BC treatment from leaders were considered very disappointing and demotivating. BC survivors themselves felt responsible for staying in contact to keep them informed about changes in their workplace such as reorganization, new leaders, or changes in job assignments/work tasks. Some leaders were described as having little or no knowledge about how to support BC survivors at work during and after BC treatment. Supportive leaders were also described. They invited BC survivors on sick leave to lunch and to take part in social activities at the workplace. This made them feel missed and needed. One participant (private sector, office) said.

> *"It was therapy for me to stop by the office. We had lunch and talked about everyday life. My colleagues said it was nice to see me; it was very positive because I didn't need anything else. I showed up with my wig and their positive reaction meant there were fewer barriers when I had to go back again. We were done talking about my illness and they saw and accepted how I looked, it was a kind of rehabilitation for me" (No. 9).*

Most participants stated that support from leaders and colleagues was important. Especially close colleagues who showed empathy and care and stayed in contact through emails, phone calls, walks, and coffee dates helped them stay updated on what was happening at work and made them feel missed.

> *"My closest colleagues acknowledged my needs, every time I said I hope to be back soon, they would say you will be back when you are ready. You must not start too early, no one needs that, least of all you" (No. 11).*

3.2. Theme 2: Feeling Valued. In hindsight, the participants described having no energy for future planning when undergoing treatment. They were completely unaware of what kind of information they would have benefited from in the long run. In retrospect, they understood how they misinterpreted laws and regulations regarding sick leave and their legal rights. Cognitive challenges made it difficult to understand the national law regarding paid sick leave. They lacked the resources and energy to investigate their legal rights and opportunities. The system was perceived as being complicated and poorly accessible for the users, which caused some to lose pension payments or work time saved to prolong their sick leave. Getting in touch with advisers at insurance companies and the NAV was a frustrating experience. Information on how part-time positions influence salary and pension was almost impossible to find and understand. Contact with the NAV was digital only, which made information even more difficult to understand. They did not feel like a valued resource in society. One middle-aged participant (private sector) stated:

"I was unaware of my financial rights. I did not know what I was entitled to. Nobody informed me, my leader, my GP, NAV—nobody told me anything about my health insurance coverage. I therefore lost the insurance I was entitled to" (No. 16).

Some participants started working full time after treatment and used vacation days when they were too exhausted to work. They were afraid of the financial consequences that working on a part time basis reduced positions would bring regarding salary and pension. One participant (public sector) said

"I broke down at work after a year, I thought that if I continued, I would die. I think in retrospect that someone should have stepped in and said that your plan is too ambitious. If cancer patients are to return to work, expectations must be adjusted over a much longer timeframe than we have now" (No. 20).

Participants described workplaces with a system of short-term replacements when the BCSs were on sick leave, and workplaces where work tasks left undone due to sick leave were distributed among the colleagues. Staff shortages in the public sector were a major issue due to tight budgets. The participants experienced little or no goodwill from employers to provide cover for long-term sick leave, because of the related financial consequences for the company. This made them feel like a burden to both employers and colleagues. One middle aged (public sector) said

"*My colleagues have been very busy while I have been on sick leave and there will be more work pressure on them since there are no stand ins. There is nobody employed to take on my tasks, and this increases my guilty conscience" (No. 8).*

They described how the workplace economy controlled the employer's ability to individualize the RTW and that many leaders and GPs lacked knowledge about a RTW after BC treatment. The participants also felt responsible for contributing to staff shortages, apologetic to their employers and colleagues when they returned to work, and felt they needed updates about workplace changes. One participant (public sector) said

"*I know I'm a problem when I go back to work: one more person who needs facilitation" (No. 1).*

"I want to be useful, contribute, and relieve the others: they have so much to do" (No. 4).

Participants in workplaces with staff shortage and high turnover, such as public health services, described dissatisfaction with follow-up from their leaders during their treatment. The feeling of being a burden was described as a barrier to keeping in contact with the workplace, as expressed by one participant (public sector).

"My leader did not show any interest in using my qualifications when I was ready to return to working on a part time basis. She said she had no use for me unless I came back in a 100% position (No. 3)."

Others described the experience of being passed over when interesting tasks were distributed. They also described problems with setting boundaries and saying no when work pressure was high and the leader did not respect the RTW agreement. Others were left alone to find their own way back to work. They described the painful feeling of being able to come and go as they pleased, as if they did not exist. Contact and support from leaders and colleagues and the feeling of being missed were highlighted as crucial.

All participants perceived work as an important part of normal life and were looking forward to returning. A middle-aged participant (public sector) said

"*Work has always been important to me. Losing my working life is a big, painful loss and it affects my quality of life, or perhaps even more, it affects my self-respect" (No. 17).*

Cognitive side effects such as memory loss and lack of concentration impacted their work. One woman expressed how well-intentioned comments from colleagues affected her.

"*Colleagues say I look healthy, but nobody understands that I'm on the sofa for the rest of the evening after work*" *(No. 10).*

Financial security and eligibility for a full pension were also a motivation to work. Some participants found it embarrassing and shameful to receive social assistance instead of working. A middle-aged participant (private sector) stated

"*Work is one of the most important things for me. I have been at the same workplace for 10 years; I have good colleagues and am well liked. I am proud to earn my own*

money and pay taxes to society. I don't want to be on 100% sick leave. I want to say I have a job when I meet other people. I don`t want to say I get social security benefits and social assistance" (No. 12).

The need for an individual plan for a RTW was highlighted, with meetings with all players in the sick leave process. However, some GPs and contacts from the NAV understood the importance of preparing the BC survivors for the side effects that could influence their work life and the value of planning a "slow" and individualized return. In retrospect, the participants described the importance of feeling valued in the process of their RTW and how devastating it was to feel like a burden.

Family, friends, leaders, and colleagues who had experienced cancer themselves or through loved ones gave valuable support.

"My manager has considered my work capacity and fought for my cause. She has been ill with cancer herself, so she understood my situation better than the former manager who increased my workload and gave me the most challenging jobs when I returned" (No. 15).

Some participants were included throughout treatment and advised by leaders and HCPs to start working in reduced positions when they returned to work. Reassignment to a more suitable position with lower responsibility was also important for some to actively manage workplace stress. Meeting support and interest from their GP, leader, colleagues, and/or the NAV were described as crucial. These acts of support made them feel valued in the work life and society.

Some BCSs and their family, friends, and colleagues seemed to believe that recovering from BC was a quick-fix process. Most participants were satisfied with their treatment but found that information on long-term side effects and the importance of tailoring a plan for their RTW were lacking. They were not aware of the changes that would occur after BC treatment and how those changes could influence their family and work life.

"I believed that optimism and regular exercise through treatment would help me through a fast recovery and return to normal working life, but that was not the case. . ." (No. 19).

Some participants had a vague memory of nurses advising them to reduce their work hours upon return, but they did not understand the extent. The treatment focus was on survival. In retrospect however the value of being prepared was highlighted, as well as receiving tailored information. Being included during discussions about treatment and RTW plans made patients feel valued.

"While undergoing treatment, there is a lot of information that is not shared, both about side effects and realistic expectations about a return to work. I am a person who wants to know everything so that I can be prepared for what is coming. I wanted tailored information from the healthcare professionals. I wanted to know what was coming, to be prepared. It's unfortunate that they do not talk about it" (No. 5).

Participants expressed that there was a lack of information on the physical and psychosocial consequences of diagnosis and that they faced challenges with work/life balance after chemotherapy and radiotherapy. Some had never been informed about fatigue as a possible side effect. They recognized different information brochures but did not realize this concerned them.

4. Discussion

We found that most participants and their families believed that when treatment was finished, the RTW would be unproblematic. We were surprised by their unawareness of side effects and energy loss and how this could influence their RTW. Two themes were highlighted as being important through chemotherapy and, in some cases, radiation (adjuvant) to optimize the RTW: keeping hope alive and feeling valued. Keeping hope alive took all their energy and, as a result, everything else was put on hold. Losing value through contributing less to family and work life was described as painful. During chemotherapy, the participants were completely dependent on the busy HCP treatment teams and described their need for support. We found that information about RTW was limited in the diagnosis and treatment phases, as highlighted by previous research [40]. Our findings suggest that HCPs should inform BC survivors that their disease is a burden that may affect their work life and cause cognitive and psychological distress. Understanding possible cognitive limitations will help women plan their RTW with their HCP, family, and employer. We agree with Bøhn et al. [43] that cognitive dysfunction and fatigue need to be acknowledged by clinicians and employers and should be included in future interventions to promote work sustainability in long-term BC survivors.

The participants were totally unaware of what kind of information they might have benefited from. In retrospect, they saw the need for individualized information regarding optimal use of the sick leave system, legal rights, long-term side effects of treatment, psychological counseling, and individualized RTW planning. They described depression, losing their pension, and misinterpreting their sick leave rights due to lack of information.

In line with Brusletto et al. [40], the participants found that their anxiety and fear of death to avoid inflicting additional worries on family, friends, and colleagues were not sufficiently addressed by HCPs. This fear of being a burden lessened when participants met with caring HCP treatment teams and/or GPs with the time and interest to support them and inform about existing supporting services they might need in the bureaucracy involved in RTW. Continuity of treatment and care made them feel valued but depended on how the healthcare was organized and how they were welcomed, included, and informed by HCPs, colleagues, and leaders.

The participants in this study had different ages, marital status, and parental status, and different education levels and worked within both white-collar labor and manual labor. Some had support from their workplace from day 1, whereas others were ignored or opposed. Receiving support from the workplace and the feeling of being missed and wanted back at work gave the BCSs a sense of being valued. All participants in our study expressed a desire and motivation to RTW. This finding is in accordance with previous studies demonstrating that work gives structure, a sense of "normality" and a feeling of social belonging, positive self-esteem, and financial security [41, 42].

In line with Vandraas et al. [45], we found that collegial social support during cancer treatment influenced sustained work ability. As stated by Brusletto et al. [40] and Stergiou-Kita et al. [42], regular invitations to workplace lunches to meet and talk about everyday life were therapy. Coffee and lunch visits at work helped participants process the situation, decreased the feeling of being a cancer patient, and increased their sense of normality and enhanced a sense of self-worth [42, 46]. Having a good relationship with the leader and colleagues during treatment was a key contributing factor to be motivated to RTW [33, 34].

In line with Greidanus et al. [9] and de Boer et al. [12], we found that the absence of practical and emotional support from leaders and colleagues hindered work participation or made it more stressful for BC survivors to RTW. In Norway, sick leave for treatment is up to 1 year. In that period, workplaces may change, new leaders may be employed, colleagues may move, and routines may change. Several participants experienced returning to workplaces where stand-ins did their work tasks, and they were left alone to find their way back. They described how resources were sufficient, but without follow up from their leaders and with new colleagues and new work tasks, they were left with a feeling of having no value.

Some BC survivors went back to full-time work after treatment and described the return as too ambitious, resulting in a mental breakdown and sick leave over a long period of time. They were unaware of the reduced work ability that often follows chemotherapy and radiation therapy and misjudged their work capacity [14]. The process of taking sick leave left participants disillusioned, with low energy and self-esteem and worries about the future [15]. Individualized information from HCPs about fatigue and cognitive dysfunction early in the treatment process is important for RTW planning [14, 43]

The participants described leaders without knowledge about BC treatment, side effects, and RTW with and without resources to individualize the BC survivors' RTW. In line with Van Maarschalkerweerd et al. [21] and Strømstad et al. [44], we found that informed leaders with will and resources to show flexibility in work hours and modification in work tasks made an important difference in whether the RTW was successful. Leaders and colleagues with cancer experiences or experiences with other life crises provided another level of understanding and support, which was considered very valuable and should be used in a more systematic manner.

Some described leaders who expected them to deliver services at the same level as before they started treatment. In manual labor like childcare, nursing, or social work, tight budgets gave little or no room for stand-ins and accessibility of appropriate and adequate work tasks. When on sick leave, these participants felt responsible for leaving their leader and colleagues in a difficult situation with tight budgets and no resources for stand-in workers. They described how work left undone due to sick leave were distributed among their colleagues instead of employing stand-ins. This made them feel a burden to both employers and colleagues.

Participants also found their experiences with contacting the often impersonal, digital, and disconnected support services energy-consuming. They were difficult to find and use and learning by doing produced "winners" and "losers." Being offered their own service provider within these support services was highlighted as being important and gave the contact a tailored approach. Negative interactions with the sickness insurance officials (NAV), lack of continuity of service providers and information, and the feeling of being treated as a number made them feel like a burden to the healthcare system. Sterigiou-Kita et al. [42] reported similar findings and found that BC survivors may not fully understand the impact of ongoing deficits in future work performance and how to navigate complex health, insurance, and employment systems.

High-quality BC care pathways are strongly desired but complicated to organize, as the definition of high quality varies by person. The importance of individualized, tailored, or personalized information and support has been highlighted in several studies [14, 40, 48]. We found that research dissemination to policymakers and hospital leaders has failed in the sense that BC survivors still describe busy, impersonalized, and fragmented services and limited resources in workplaces for RTW issues. Prip et al. [47] emphasized that there is a risk of not identifying patients' needs related to work ability in an outpatient setting because of the limited time allocated. HCPs often deprioritize conversations about a RTW due to time constraints and a lack of understanding of barriers related to the RTW process [19, 30]. We understand that individualized, tailored, or personalized information comes at an economic cost, but believe that it might turn into an economic and a human resource saving in the long run.

BCSs report problems remembering all the information given to them. The effect of repetition makes continuity of treatment and care necessary [3, 48]. Social support, care cooperation, care continuity, and effective communication are highlighted as success factor for quality cancer care [49]. The participants in this study underlined how important individualized information and a plan were to succeed in RTW. Some GPs, NAV employees, and leaders were aware of this and prepared for slow returns with close supervision. When the support system showed interest in the BC survivors and their success with RTW, they felt needed and valued. Van Maarschalkerweerd et al. [21] found that employers may lack knowledge on how to handle employees with cancer at the workplace. We agree with these authors that there is a need among BCSs for long-term work-related

support and that employers should be supported by the government when hiring employees with a history of BC, even well after diagnosis, to have a higher chance of regaining employment. The financial risk is high to BC survivors, and their knowledge and experience are needed in a society with a labor shortage.

In line with Vayr et al. [29] and Prip et al. [47], we believe that ONs and oncologists have an important role in the information process. They must ask questions about identity, family and finances, the importance of work, and work environment factors to support BCSs in returning to work as stated by Van Maarschalkerweerd et al. [21] and inform their patients about other relevant supportive services.

The participants in this study had no idea that this kind of information was needed, but looking back, they saw the need for information on the RTW process and on the side effects of treatment that might influence this return. They did not feel prepared for the fatigue, anxiety, depression, and concentration problems affecting them during and after treatment. This underlines the fact that HCPs must answer both questions asked as well as questions not asked. Some participants in this study had their own ON during the treatment trajectory. Information was therefore easily tailored to the patient in treatment. This was very much appreciated by the participants.

5. Study Strengths and Limitations

The research design allowed the BCSs to provide useful insights into how they experienced being prepared for their RTW during treatment. Trustworthiness was sought by applying the COREQ and SRQR [37, 50]. To strengthen the study's credibility, a co-researcher with lived experience related to BCSs and RTW processes was included in the research group. The first and last authors participated in all interviews and analyzed the transcribed material both individually and collaboratively. Credibility was further obtained by providing detailed descriptions of the participants' experiences, including quotations to emphasize the link to the data credibility was enhanced. All four researchers were involved in the analytic process, engaging in critical reflection and dialog. Tables included show the analytic steps from raw data to themes. Detailed descriptions of the research process ensured transparency and thereby dependability. The researchers' preunderstandings were discussed to keep an open mind, and transferability was sought by providing sufficient information about the participants and researcher bias in the interpretation of findings was acknowledged and addressed through continuous reflexivity and collaborative analysis. Furthermore, the inclusion of a co-researcher, with lived experience, contributed to the relevance, accessibility, and contextual grounding of the findings. This multiperspective approach significantly strengthened the analytical credibility of the study.

6. Conclusion

Through listening to BC survivors' experiences with their RTW during treatment, we found that there are different ways in which HCPs and workplace leaders better can support BC survivors in optimizing the RTW process. The focus of the participants was to keep hope alive through treatment and then return to normal work life. They were unaware of their need for information on returning to work. In retrospect, they experienced that realistic and individualized information from HCPs prioritizing continuity, coordinated support services, and informed and involved workplace leaders may prevent them from falling short, leaving them disillusioned, with low energy and self-esteem and with worries about the future. RTW research dissemination must reach HCPs, GPs, policymakers, and leaders to support them in making evidence-based decisions when resources are allocated. To be able to provide high-quality services and receive them may influence both job satisfaction and patient satisfaction in a positive way.

7. Implications for Clinical Practice

- Evidence-based knowledge on RTW processes during chemotherapy and radiation therapy (adjuvant) should be provided in an individualized and realistic manner.
- Healthcare systems must strive for continuity of treatment and care and active listening.
- The treatment team must have ONs with specialized knowledge and time to deal with the anxiety and fear of death of BC survivors and must refer them to support services if necessary.
- Information about and coordination of support services are crucial. ONs play an important role in information dissemination and coordination of support services.
- It is crucial to create a workplace involvement where the BC patient is included and treated as a resource and not as a burden.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Conflicts of Interest

The authors declare no conflicts of interest.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Supporting Information 1. Supporting Information Table 1: participants' characteristics. Flowchart illustrating participants' recruitment and inclusion criteria.

Supporting Information 2. Supporting Information Table 2: themes and subthemes. Diagram showing the thematic analysis process.

Supporting Information 3. Supporting Information Figure 1: interview guide used during data collection.

Supporting Information 4. SPQR Checklist.

Supporting Information 5. COREQ Checklist.

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