

Perception on Breast Cancer and Relationship Dynamics among Couples in Ibadan Metropolis, Nigeria

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One of the common diseases in women is breast cancer when compared to all cancers. Empirical studies on BC have focused on prevention and management of BC. However, this study explored a dyadic approach to BC and how it impacts upon relationship functioning among couples. Hence, this study described spouses' and community members' perception of breast cancer; examined the dynamics in spousal relationships at different phases of the disease and highlights coping mechanisms for women living with breast cancer and their spouses. Hinged on Triangular Theory of Love, the study was conducted through mixed method approach, 660 respondents were recruited using multi-stage sampling techniques. Majority of women living with cancer and their spouses were knowledgeable about breast cancer, but trivialized its signs and symptoms. Also, BC is perceived as life-threatening and requires lots of money for proper diagnosis and treatment. While dynamics in relationship changed as a result of treatment which affected the quality of time couple spent on leisure; decrease in sexual activities; changes in child rearing and pattern of communication. More so, coping strategies adopted included; avoidance of BC thought, genuine love, faith in God and adherence to medical advice. This study highlights barriers that may impact upon treatment due to trivialization of the signs and symptoms of BC. Thus, the need for regular examination and early diagnosis for couples to avert late stage of the disease and a breakdown in spousal relationship.

Keywords: Perception, breast cancer, relationship dynamics, couples

Introduction

Cervical cancer (CC) ranks fourth among women globally in terms of cancer incidence, whereas breast cancer is the most often diagnosed malignancy (Sung *et al.*, 2021). In 2020, there were about 10 million cancer deaths and 19 million new cancer cases globally, according to figures released by GLOBOCAN (Sung *et al.*, 2021). In 2018, 18.1 million women received a breast cancer diagnosis; nevertheless, 9.6 million of them lost their lives to the illness (WHO, 2020; Barrios, 2022). Breast cancer is now the most frequent cancer among women worldwide, with an increasing prevalence particularly in Sub-Saharan Africa. These statistics are still accurate in Nigeria (Ezeome *et al.*, 2022; Joko Fru *et al.*, 2020). By 2040, there will be over 28 million new cases worldwide, up 47% from the current estimate. Low- and middle-income countries (LMICs) are likely to see the most

increases in new cases (Sung *et al.*, 2021). Forty percent (40%) of cancer survivorships occur in low- and middle-income countries (LMICs), such as Nigeria (McCormack, McKenzie, Foerster, Zietsman, Galukande, Adisa *et al.*, 2020). This suggests that there are difficulties with cancer health disparities (worldwide). Breast cancer (BC) is a type of malignant tumor that develops in the live cells of the glandular tissue of the breast's ducts or lobules. It is a dangerous, non-communicable illness that primarily affects women. It is the second most frequent cancer globally and the primary cause of cancer-related deaths in developing nations (WHO, 2022). In both developed and developing nations, breast cancer is the most prevalent kind that affects women (WHO, 2022). The number of new cases of BC is rising worldwide in 2012, there were almost 1.68 million cases diagnosed; in 2018, there were nearly 2.1 million

new cases diagnosed; and in 2020, there were 2.26 million cases diagnosed worldwide (Ferlay *et al.*, 2020).

A comprehensive analysis of women's experiences with breast cancer in sub-Saharan Africa was conducted by Magwesela *et al.* in 2023. Their analysis sheds light on the experiences and overall well-being of African women who have been diagnosed with breast cancer. Culture, values, and the support of family and community all have an impact on these experiences. Their findings imply that women with breast cancer may greatly improve their quality of life if they were encouraged and given complete care, including social, economic, and spiritual support. In a similar vein, research conducted in by Ammar *et al.* (2023), found that almost 40% of married or formerly married women felt unfavourable changes in their marital relationship, and nearly half of the women perceived negative societal changes following their sickness.

Age, marital status, motherhood, prescription treatment (mastectomy in particular), lack of informal support in social life, and lack of partner support among married or formerly married women were among the factors that influenced survivors' lived experiences. Stress became a shared component between the two spouses as a result of the disease's effect. Husbands are essential in the life of breast cancer patients because they handle finances, make decisions, offer emotional support, and stay active throughout the treatment. Therefore, organized psycho-social therapy incorporating the husband provide superior outcomes compared to patient-focused methods alone. Male partners may play an important role in their spouses' rehabilitation and should be encouraged to participate in their therapy as it will help them heal Akpor *et al.* (2023). Accordingly, Abboah *et al.* (2024) examined men's experiences and perspectives after being diagnosed with breast cancer. After diagnosis with breast cancer, males have several challenges, particularly in terms of their masculinity. It is critically necessary to raise public and professional awareness of MBC in order to alter the view of males in favor of early diagnosis, treatment adherence, post-treatment monitoring, oncological outcomes, and improved quality of life. In a different study conducted by Okafor *et al.* (2023) found that, majority of men 75

percent and 87.4%, respectively had not gone with their wife or other female partner to a breast or cervical cancer screening, while nearly half (49.2%) and one-third (33.5%), respectively, had urged their partners to do so. In all, only 138 (54.3%) of the males were thought to be "involved" in helping their female spouses check for malignancies of the breast and cervical region. There was a strong correlation between male engagement and screening for female malignancies ($\chi^2 = 77.62$, $p < 0.001$).

In Africa, 168,690 instances of breast cancer were detected in 2018, accounting for 74,072 deaths (Sharma, 2021). What is most concerning, though, is that Nigeria leads the world in the absolute number of BC cases diagnosed and fatalities documented in 2018, with 26,310 cases and 11,564 deaths (Sharma, 2021). Even though partners are the main source of social support for BCSs, BC may have an adverse effect on how happy BCSs are in their relationships, which could lead to a decrease in their sense of social support and worsening physical and psychosocial outcomes as well as their general well-being (Krasne *et al.*, 2022). Encouraging partners' interpersonal awareness within the framework of their relationship can lead to the improvement of relationships. Nigeria has low breast cancer survival rates for a variety of reasons, such as the spread of the Western lifestyle (i.e., physical inactivity, consumption of processed or unhealthy foods, alcohol, and tobacco) (Ngwa *et al.*, 2022), poor access to cancer screening (Sharma *et al.*, 2021), inadequate oncology patient navigation (Chidebe and Pratt-Chapman, 2022), and restricted availability of comprehensive cancer treatment in this nation (Olasehinde *et al.*, 2021).

It's clear that breast cancer is turning into a potentially fatal illness in Africa, and as a result, there are women who are extremely afraid and anxious about their diagnosis and prognosis. The patient's entire life, as well as the physical, spiritual, financial, and psychological situations of his or her family, is impacted by any information regarding the diagnosis and prognosis of breast cancer (Iddrisu, Aziato, and Dedey, 2020). According to Krok, Telka, and Moro'n (2023), BC may also have an effect on BCSs' social aspects, namely with regard to their partners and the general quality and pleasure of their relationships. It may be quite

painful to tell your spouse you have cancer, as they are supposed to love you and support you emotionally. Your spouse should be able to help you during this difficult time. For breast cancer survivors and their spouses, receiving a cancer diagnosis and undergoing treatment may be extremely stressful and have an effect on their relationship. A healthy relationship, a high quality of life, and the ongoing management of cancer and its treatment all depend on effective communication (Shrout, *et al.*, 2021; Parmelee and LoBiondo-Wood, 2020; Lai *et al.*, 2020).

When the WLBC is unable to do their duties due to the adverse effects of their treatment regimen, the spouse can assist them emotionally by expressing love and helping out with tasks. It is important to remember that a woman who receives a breast cancer diagnosis is viewed as unwell and is forced to adopt a "sick role," which prevents her from carrying out her prior social and marital obligations. Undoubtedly, the task of assuming a fitting new position within the household adds to the stress experienced by both the woman and the man who must deal with the reality of a partner who is considered to be incapacitated owing to limitations imposed by her altered health state.

This might influence the pattern and stability of the marriage between a spouse and a breast cancer patient in the future. Previous studies have focused mainly on biomedical aspect, etiology, prevention and management of BC. However, little attention has been given to the social aspect of BC, as it affects spousal relationship in Ibadan. Despite the social costs associated with the WLBC, there is little or no satisfactory empirical research analysis of the social burdens that could arise from the infected person to the spouse and the significant others. While previous studies have focused mainly on biomedical aspect, etiology, prevention and management of BC. However, little attention has been given to the social aspect of BC, as it affects spousal relationship in Ibadan. Indeed, sociological explanations of the consequences of the health condition on spousal relationship is lacking among couples whose spouses are affected. In fact, among couples whose spouses are impacted by the physical condition, sociological explanations of the effects on the marital connection are weak. As a result, this study looked at how couples whose spouses have breast cancer perceive the disease and the dynamics of their relationships. It also took into

account the societal toll that the partner's health issue had on their marriage as a whole in the Ibadan Metropolis.

Theoretical thrust

The triangle theory of love was used as the analytical framework for the investigation. According to this theory, the degree of closeness or bonding in a marriage is determined by three factors: intimacy, passion, and decision/commitment. Furthermore, it is possible to conceptualize love as the three vertices of a triangle: closeness, passion, and decision/commitment. Love, physical attraction, and sexual consummations are the results of passion in a marriage, but intimacy, as defined by the triangle theory, is affective (or emotional), involving emotions of warmth, closeness, connection, and bondedness. It is, in fact, essentially a motivating investment (Sternberg, 1986). On the other hand, the third component, decision/commitment, views a relationship as a short-term declaration of love and a long-term commitment to upholding that love (Sternberg, 1986). Decision and commitment may not always go hand in hand in a relationship, as Sternberg (1986) pointed out, since it is possible to love someone (the spouse) without committing to the relationship over the long run or to be committed without admitting that one loves the other person in a marital relationship.

Methodology

Descriptive cross-sectional survey design was adopted for this study. The study was conducted in the Ibadan Metropolis, in Oyo State, Nigeria. The Ibadan metropolis was purposively selected as the study area because it houses the first cancer registry in Nigeria which was established in 1962, and is located within the Department of Pathology, University College Hospital (UCH) Ibadan. Thirty in-depth interviews and four case-studies were conducted on life experiences of (WLBC). These are individuals who are formally in a relationship, or living with a partner, and have the health challenge of breast cancer. Qualitative data was obtained through In-Depth Interviews (IDIs) and Case-Studies. For the interviews, fifteen (15) IDIs were conducted with women living with breast cancer, and fifteen (15) IDIs with their spouses. The participants were purposively selected from the

women who were attending clinics at the Breast Cancer Unit, University College Hospital, Ibadan. The decision to purposively select women from this unit was based on the fact that the WLBC usually attended the clinic for diagnosis, treatment and follow-up checks. For the quantitative survey, involved the use of Semi-structured questionnaire through multi-stage sampling technique in selecting respondents at the community level. Purposive sampling was used to select five urban Local Government Areas (LGAs) in Ibadan. Twenty-four wards were randomly selected out of 59 wards in the selected LGAs. Kish's (1965) formula was used to determine the sample size, and systematic sampling was used to proportionately administer semi-structured questionnaire on 660 community members comprising Ibadan North (167), Ibadan North-East (148), Ibadan North-West (75), Ibadan South-East (134) and Ibadan South-West (136). University College Hospital (UCH) Ibadan, which has a high referral population-based cancer registry. The data was analysed with Nvivo Software, Version 8, and content analysis guided the interpretation of the data. The retrieved administered questionnaires were analysed using the Statistical Package for Social Sciences (SPSS) Version 23. Quantitative data were analyzed using descriptive and inferential statistics at $p \leq 0.05$. Ethical approval was sought and obtained from the UI/UCH Ethical Review Board College of Medicine, University of Ibadan, with approval number UI/EC/17/0120. Furthermore, permission was obtained from the Chairman, Medical Advisory Board (CMAC) to have access to patients in the hospital. Consent of all the people involved in the study was sought at different levels. Individual consent was sought at the household level and during interviews.

Results

Background characteristics of the respondents

Table 1 shows the breakdown of the background characteristics of the respondents from the quantitative study. The table reveals that there were a little more female (50.6%) than male (49.4%) in the sampled population. The mean age of the respondents was 36 years. A very few proportions of the sampled population were younger than 19 years (3.5%) and older than 50 years (11.2%). Christianity (66.5%) was the dominant religion in

the study location, as about two out of three of the respondents indicated that they were Christians, while others were practicing Islam (32.6%) and Traditional religion (0.9%).

The major ethnic group in the study location was Yoruba (85.0%), which was a true reflection of the Ibadan metropolis being the emphasis of this study, and which reflected that they were mainly from the South-Western states of Nigeria. The other ethnic groups were in the minority in this particularly study location. In the same vein, most of the respondents were employed, either in the public or private sector (42.2%), followed by a significant number of them (36.4%) who were self-employed, which showed that the Ibadan metropolis is economically active and buoyant. There were records of individuals who were unemployed (13.8%), who were dependent on others for their needs. Some of these dependents estimated the cash received from their benefactors to be about N10, 000 per month. Nevertheless, majority of the respondents (69.7%) earned less than N20,000 per month followed by those who indicated that they received between N20,000 and N49,999 (21.8%) per month. A few numbers of respondents (3.9%) earned above N80, 000 per month.

The table also revealed that the study location appeared to be a literate community, wherein majority (65.6%) had acquired education up to the tertiary level. About one out of six respondents (5.5%) had secondary education, while 6.1% of the respondents had no formal education. By implication, there was the possibility that majority of the respondents might have heard about breast cancer, perhaps about its etiology, prevention and treatment regimen.

On the marital status of the respondents, more than half of the sampled populations (54.7%) were married, while (42.4%) were single at the time of the survey. This suggests that a higher proportion of the respondents would have been able to assess how breast cancer affects spousal relationship.

Table 1: Background characteristics of respondents (N=660)

Demographic characteristics	Frequency (N=660)	Percentage
Gender		
Male	326	49.4
Female	334	50.6
Age (35.53±11.244 years)		
≤19	23	3.5
20-29	193	29.2
30-39	214	32.4
40-49	156	23.6
≥50	74	11.2
Religion		
Christianity	439	66.5
Islam	215	32.6
Traditional	6	0.9
Ethnic group		
Hausa	5	0.8
Igbo	55	8.3
Yoruba	561	85.0
Others(Ijaw, Fulani, Igala,Esan)	30	5.9
Occupation		
Unemployed	91	13.8
Public/Private sector Employed	280	42.4
Self-employed	243	36.8
Others	46	7.0
Income (month)		
Less than ₦20000	460	69.7
₦ 20000 - ₦ 49999	144	21.8
₦ 50000 - ₦ 79999	30	4.5
₦ 80000 and above	26	3.9
Highest Educational level		
No formal education	40	6.1
Primary education	36	5.5
Secondary education	151	22.9
Tertiary	433	65.6
Marital status		
Single	280	42.4
Married	361	54.7
Separated/Divorced/Widowed	19	2.9
Spousal Education*		
No formal education	267	40.0
Primary	24	4.0
Secondary	84	13.0
Tertiary	285	43.0

Community members' perception of breast cancer and spousal relationship

This section reported the community members' perception of how breast cancer diagnosis and treatment would affect several aspects of spousal relationship, ranging from the relationship of the affected person with others to affected areas of spousal relationship and affected areas of family finance. As Table 2 revealed, the highest

percentage of the respondents (44.1%) indicated that BC would affect the spouse, followed by 40.1% who stated that it would affect the children and relatives (32.0%). This shows that there is possibility that the occurrence of BC would affect the significant others especially those who are relatives of the affected person.

The specific area of spousal relationship it would affect was ascertained from the respondents.

Nearly half of the respondents indicated that BC would affect the area of spending together (47.7%), sexual intimacy (47.3%), and child bearing (41.1%). Other specific areas of spousal relationship it would affect include sharing responsibilities (36.8%), understanding each other (34.5%), communication (30.8%) and the entire family members (32.9%) among others. This is indicative that BC can affect almost every sphere of spousal relationship.

Another affected area of spousal relationship which could be negatively affected was the family finance. It was revealed that the specific areas of family finance it would affect included general increase in family expenses (25.6%), general increase in marital expenses (30.0%), as well as

cost of social outings. This suggests that the financial aspects of the family of the affected person would be negatively affected due to the additional costs BC that would incur on the management and treatment of the conditions.

Table 3 reveals that there is statistically significant relationship between affected person and how BC affects relationship. For example, the relationship between relatives ($\chi^2 = 106.32$; $p < 0.05$), colleagues ($\chi^2 = 55.12$; $p < 0.05$), religious associates ($\chi^2 = 42.12$; $p < 0.05$), friends ($\chi^2 = 97.94$; $p < 0.05$), neighbours ($\chi^2 = 43.25$; $p < 0.05$), spouse ($\chi^2 = 163.10$; $p < 0.05$) and children ($\chi^2 = 110.42$; $p < 0.05$) of the affected person are affected by the disease with spouse of the affected person being the highest proportion.

Table 2: Distribution of respondents by the assumed affected relationship and affected areas of spousal relationship

Variables	Frequency (N=660)	Percentage (%)
<i>Affected relationship (Multiple response)</i>		
Relatives	211	32.0
Colleagues	128	19.4
Religious associates	91	13.8
Friends	166	25.2
Neighbours	113	17.1
Spouse	291	44.1
Children	269	40.8
<i>Affected area of spousal relationship (Multiple response)</i>		
Understanding each other	228	34.5
Sharing responsibilities	243	36.8
Communication	203	30.8
Resolving misunderstanding	177	26.8
Spending money together	315	47.7
Doing things together	264	40.0
Sexual intimacy	312	47.3
Child bearing	263	39.8
Child rearing	271	41.1
The entire family members	217	32.9
Friends	196	29.7
Religious commitment	172	26.1
<i>Affected areas of family finance</i>		
General increase in family expenses	169	25.6
General increase in marital expenses	198	30.0
Cost of social outings	171	25.9

Table 3: Breast Cancer and the assumed relationship of the affected women

Variables	BC and the woman's relationship		Chi square; p-value
	BC affect woman's relationship (%)	BC cannot affect woman's relationship (%)	
<i>Affected relationship</i>			
Relatives*	176 (49.2)	35 (11.6)	106.328; 0.000
Colleagues*	107 (29.9)	21 (7.0)	55.118; 0.000
Religious associates*	78 (21.8)	13 (4.3)	42.123; 0.000
Friends*	145 (40.5)	21 (7.0)	97.940; 0.000
Neighbours*	93 (26.0)	20 (6.6)	43.247; 0.000
Spouse*	239 (66.8)	52 (17.2)	163.098; 0.000
Children*	212 (59.2)	57 (18.9)	110.422; 0.000
<i>Affected area of spousal relationship</i>			
Understanding each other*	153 (42.7)	75 (24.8)	23.220; 0.000
Sharing responsibilities*	182 (50.8)	61 (20.2)	66.107; 0.000
Communication*	143 (39.9)	60 (19.9)	31.003; 0.000
Resolving misunderstanding*	129 (36.0)	48 (15.9)	33.854; 0.000
Spending money together*	227 (63.4)	88 (29.1)	77.108; 0.000
Doing things together*	195 (54.5)	69 (22.8)	68.250; 0.000
Sexual intimacy*	235 (65.6)	77 (25.5)	105.920; 0.000
Child bearing*	192 (53.6)	71 (23.5)	62.006; 0.000
Child rearing*	202 (56.4)	69 (22.8)	76.313; 0.000
The entire family members*	160 (44.7)	57 (18.9)	49.481; 0.000
Friends*	146 (40.8)	50 (16.6)	46.049; 0.000
Religious commitment*	122 (34.1)	50 (16.6)	26.101; 0.000
<i>Affected areas of family finance</i>			
General increase in family expenses*	132 (36.9)	37 (12.3)	52.124; 0.000
General increase in marital expenses*	156 (43.6)	42 (13.9)	68.661; 0.000
Cost of social outings*	135 (37.7)	36 (11.9)	56.754; 0.000

*Significant at $p < 0.05$, degree of freedom for all variables cross-tabulated is equal to 1

Spouses' and Community members' perception about relationship survival as a result of breast cancer

Table 4 shows that, about one-fifth of the male population (24.5%) reported that they would continue their relationship with their fiancé if she develops breast cancer. 37.1% also reported that they could marry a woman treated with breast cancer, and 28.5% reported that they could marry a lady with a known pedigree of BC. Majority of them (57.4%) posited that they would continue the relationship if their wife suddenly develops BC.

Similarly, from Table 5, shows that, one-fifth of the female population (23.7%) reported that they could allow their son to marry a lady with a known pedigree of BC, though the lady does not presently have it. Furthermore, 23.1% of the women responded that they would advise their sons to

continue relationship with a fiancé who suddenly develops breast cancer.

From Tables 4 and 5, shows that, there were instances wherein the responses from the male and female respondents were indifferent. In Table 4, one-third of the male respondents (32.2%) reported that were undecided if situation arose for them to marry a woman affected with BC. Majority of them (44.2%) reported that they do not know if they would stop or continue a relationship with a fiancé that develops BC, while 42.9% also were of the opinion that they would not marry a lady with a known pedigree of BC. In the same vein, on table 5, the female respondents had various responses. 36.8% were undecided if they would allow their son to marry a lady with a known pedigree of BC, while majority (42.8%) reported that they do not know if they would advise their

sons to continue relationship with his fiancé if she develops BC.

From the quantitative study as presented in Table 4, the male respondents were requested to respond to some straight forward questions, and over half (57.7%) of the respondents declined that they cannot marry a lady diagnosed with breast cancer. About one- third of the men population (31.3%) reported that they would stop the

relationship if their fiancé developed breast cancer. Also about one-third of the men (29.4%) reported that they would not marry a woman who had been treated of BC 28.5% reported that they would not marry a woman with a known pedigree of breast cancer, though she does not presently have it. In the same vein, half of the male respondents (56.1%) reported that they cannot have sex with a woman without breast.

Table 4: Perceived effects of breast cancer on spousal relationship from the viewpoint of male respondents (N=326)

Variables	Frequency	Percentage
Marriage with affected women		
Yes, I can	33	10.1
No, I can't	188	57.7
Can't say	105	32.2
What happens if fiancé develops breast cancer		
Stop relationship	102	31.3
Continue relationship	80	24.5
Don't know	144	44.2
Marriage with women treated of breast cancer		
Yes, I can	121	37.1
No, I can't	96	29.4
Don't know	109	33.4
Marriage with women of known pedigree of BC		
Yes, I can	93	28.5
No, I can't	93	28.5
Don't know	140	42.9
Having sex with a woman without breast		
Yes, I can	45	13.8
No, I can't	183	56.1
Don't know	98	30.1
Ever-had sex with a woman without breast		
Yes, I have	14	4.3
No I have not	239	73.3
I can't say	73	22.4
If yes, was the sex pleasurable		
Yes, it was	7	50.0
No it was not	5	35.7
I can't say	2	14.3
If wife suddenly develops BC, what happens to sex		
Stop having sex with her	85	26.1
Not stop having sex with her	108	33.1
Don't know	133	40.8
If wife suddenly develops BC what happens to relationship		
Continue with relationship	187	57.4
Discontinue relationship	19	5.8
I don't know	120	36.8
Role to play if wife develops BC		
Take her to hospital	245	75.2
Herbal treatment	3	0.9
Leave her to take decision	7	2.1
Others	71	21.8
Roles, if daughter suddenly develops BC		
Take her for medical treatment	162	49.7
Herbal treatment	5	1.5
God forbid	91	27.9
I don't know	5	1.5
Other	63	19.3

Table 5, reflected the perception of the female population of this study, and majority (65.3%) were not in support of their son getting married to a woman with breast cancer, while 39.5% would not allow their son to marry from a family with a known history of breast cancer, and one-third of the female respondents (34.1%) reported they would advise their son to discontinue the relationship with a fiancé who suddenly develops breast cancer.

As a sign of commitment and love to spousal relationship, as shown in Table 4, one-third of the men population (33.1%) posited that they would still continue to have sex with their wives if she

suddenly develops breast cancer. Majority (57.4%) stated that they would continue their relationship with their wives no matter the challenge or health condition, while 75.2% responded that they would be ready to assist to get their wives diagnosed at the hospital. Also, almost half of the male respondents (49.7%) were ready to take care of their daughter medically if suddenly develops BC. Again, the women population on table 5 were ready to seek medical help for their assumed daughter in-law or diagnosed grown up daughter if they were diagnosed of breast cancer.

Table 5: Perceived effects of breast cancer on spousal relationship from the viewpoint of the female respondents (N=334)

Variables	Frequency	Percentage
<i>Sons' marriage with affected woman with BC</i>		
Yes, I can allow	19	5.7
No, I cannot allow	218	65.3
Don't know	97	29.0
<i>Sons' marriage from family with history of BC</i>		
Yes, I can allow	79	23.7
No, I cannot allow	132	39.5
Don't know	123	36.8
<i>Advice to son whose fiancé develops BC</i>		
Continue the relationship	77	23.1
Discontinue the relationship	114	34.1
I don't know	143	42.8
<i>Reaction if daughter develops BC</i>		
Take her to hospital for treatment	155	46.4
Herbal treatment	6	1.8
God forbid	105	31.4
I don't know	68	20.4
<i>Reaction if son's wife develops BC</i>		
Seek medical attention	238	71.3
Divorce her	3	0.9
Not sure of what to do	23	6.9
Others	70	21.0

Dynamics in spousal relationships and the different phases of breast cancer: pre-diagnosis, post-diagnosis and post-treatment

This objective of the study highlighted above provided the information obtained from the partners about the changes they could recall that occurred in their spousal relationship at the various stages and phases of the health challenge. That is, the spousal relationship that existed pre-diagnosis, post-diagnosis and pre-treatment. This was elaborated around how they viewed and experienced the

following concepts of stability, instability, satisfaction, dis-satisfaction in their relationship.

The phases of the disease and the dynamics of the resulting spousal relationship

Relationship before Diagnosis

Responses elicited from the partners reflected true state of a typical spousal relationship wherein there was love, trust, cordiality, and there was normal interaction between the partners (husband and wife). In the existing spousal relationship, there was optimum hope of longevity, and continuity of the

bond and love shared between them. It also appeared that every aspect of the relationship was functioning well. Also, in situations where there were misunderstanding, they were usually settled/sorted out amicably, without involving any third party. Below is a corresponding narration:

I thank God for answering my prayers when I was praying for a life partner. I prayed for a husband like my father, because my own father was a caring husband, and God answered my prayer. To be honest with you, my husband is caring and our relationship is cordial, and I pray that the money he would use to take care of me more than the usual way, the Lord will give unto him. We do have misunderstandings, but it does not last to the extent that someone has to come and settle our disputes or fight. At times when I want to behave like a typical woman and want to keep malice, my husband would be the first to come for reconciliation. Based on my rating of cordiality, I can say we score a very high percentage. I have never regretted marrying him for once. I never thought of him as my life partner, but after prayers, it was revealed to me that any man that I come across within that time in question would be my husband. To God be the glory here we are, happily married. (IDI, WLBC, Age 43, Post-Diagnosis)

In the same vein, there were some relationships during the pre-diagnosis stage, wherein both partners were indifferent to each other and they had accepted the disposition of their spouse for life. The disposition of the partner, then affected the extent and nature of care given to each other, and this affected the level of satisfaction they expected and received from each other. For instance, a WLBC gave the narration below:

I know perfectly that my husband is a non-challant person that does not care about people or things. So much, that he did not care to follow me to the clinic throughout the diagnosis and treatment period. I have since accepted it as my destiny and

resolved to fate. (IDI, WLBC, Age 49, Post-Treatment)

Relationship after diagnosis (Pre-treatment)

This period in the life of the partners was a phase of life wherein reality dawned on them that the woman had been diagnosed with breast cancer, and she was yet to start any treatment regimen. The disclosure of the new health status to the woman caused an initial imbalance in the psychological make-up of the spouses, which was reflected in the described reactions in the early part of this work. The way the spouses absorbed and handled the diagnosis report depended largely on the intimacy between them, and on their religious belief (faith in God). The level and extent intimacy of the relationship before the diagnosis was being challenged by the new health status. However, the determination and the will to live and abide by the vows of the relationship of 'for better for worse' strengthened the relationship.

From the study, the spouses (husband) were the ones that were found to be and being strong for their wives, and were taking the lead in encouraging them to seek medical attention.

The spouses responded that their relationships were still intact and cordial after the diagnosis of the ailment. The women reported that they received more attention and pampering from their husbands after the diagnosis and pre-diagnosis. Below are some narrations from the post-diagnosis participants, as they were able to recall their experience:

After the diagnosis and confirmation that I have breast cancer, our relationship had been very close and cordial. I can even say, more than usual at least you can see that yourself. With all my experiences, I can pray to have him as my husband second time in life, if have the opportunity. (IDI, WLBC, Age 48, Post-Diagnosis)

After the diagnosis and confirmation that she has breast cancer, our relationship has been the same thing. At least she did not pray for it, neither did she write application for it. So I have accepted her

for better for worse. (IDI, Spouse of WLBC, Age 48, Post-Treatment)

The relationship deepened, I can see and say these through his behaviours to me. (IDI, WLBC, Age 40, Post-Diagnosis)

He has not disappointed me in anyway, instead the cordiality has increased than normal. He has been there for me; no one but him and God. (IDI, WLBC, Age 43, Post-Diagnosis)

Relationship after treatment

In the study, the women living with breast cancer reported that their spouses stood by them during the trying period. The spouses followed them to the clinic, paid the medical bills, stayed with them when hospitalized, and for those working outside-town where the family resides, they sought for a transfer. The relationship deepened after the treatment and its attending aftermath medical consequences. The spouses also saw it as their personal problem taking it that anything that happened to their wives happened to them, and vice-versa. Consequently, they tend to believe the woman would survive the ailment and would recover fully after the treatment. So, they continued to plan their lives together. Below are supporting narrations:

He was closer to me more than before even after the treatment, because he was the one that stayed with me in the hospital, our children did not come at all. He works outside the Ibadan and we have no choice than for him to go back to his station. In order for him to take care of me properly, he requested for his transfer back to Ibadan zone and here we are, we are okay. (IDI, WLBC, Age 43, Post-Treatment)

I bless the name of the Lord, my husband has been there for me, and even his mum has been good to me. They are always telling me to have faith in God that there is nothing God cannot do, at least He answered Sarah in her old age. Though, we got married very late and I believe that it is part of war we are both waging together. I have had several miscarriages

after the wedding and now breast cancer, so who knows where they all came from. (IDI, WLBC, Age 49, Post Treatment)

From the study, it was apparent that the relationship that existed before the diagnosis tend to continue even after treatment. So, there was no indications that the emergence of the ailment constituted any change in the relationship.

Coping Mechanisms adopted by women living with breast cancer and their spouses

While considering all the challenges and crisis that the diagnosis and treatment of breast cancer might have had on the existing spousal, it was pertinent to elicit information from the people affected with breast cancer and also propose to them adoptable coping mechanisms. This is pertinent as this is addressed in the last objective of this study.

As revealed in the study, the advent or incidence of breast cancer on the woman heralded a lot of changes in her physiology, emotions, relationships, and her ability to discharge some roles and responsibilities. As such, the partners who were closest to them bore the resultant burden. It now behooves on the man (husband) to adjust to this challenge in the relationship, and ultimately cope, as it was narrated by some participants below:

He knows am always up and doing, so, for me not able to do all those things, it means am seriously sick, thus with that he has no choice than to cope and adjust. (IDI, WLBC, Age 50, Post-Diagnosis)

You know we are not children of nowadays. A man of over 50 years is not a youth or a kid, therefore my husband had been trained on how to do house chores from his childhood. So, he is used to it and very happy doing it. At least he was not the one doing the house chores before, and now that I am sick, that was when he started doing them. (IDI, WLBC, Age 45, Post-Treatment)

The WLBC and their spouses gave their life-experience coping mechanisms, which could be adopted by others. These coping mechanisms were recommended for spouses of women living with

breast cancer. The salient points are highlighted with the adjoining narrations, as presented below:

1. **Genuine love** Spouses can cope with life before or after breast cancer treatment when there is genuine love between them. No matter the circumstance they should bear it together. The man could also have a critical ailment, and he should also remember that the woman did not pray for sickness, so he should please bear it with her. (*IDI, WLBC, Age 37, Post-Diagnosis*)

Couples should always remember what tied the two of them together, which is genuine love should be focused, never listen to side-comments from friends or any relative. Secondly, they should adhere to whatever they were asked to do by their doctor. Thirdly, prayer does everything, they should both pray the more. (*IDI, Spouse of WLBC, Age 33, Post-Diagnosis*)
2. **Faith in God** Despite the fact that my spouse does not go to church as such, he has better faith in God than I. Therefore, I implore other spouses to increase their faith in God in order to cope with life after breast cancer treatment, and in every aspect of things that surrounds breast cancer. (*IDI, WLBC, Age 43, Post-Diagnosis*)
3. **Feign the presence of the disease** Men can cope if they can erase it from their mind that their wives are having health issues, by this, their love would be like when they first met each other. (*IDI, WLBC, Age 40, Post-Diagnosis*)

Discussion

Personal perceptions on relationship continuity following breast cancer were brought up and explored in the study. The results of the quantitative survey showed that most males stated they would not marry a woman who had been diagnosed or proven to have breast cancer. This is a reflection of their fear of the illness and the possibility that it will kill them, as confirmed by a Fenech *et al.* (2022) established that, women may face difficulty in maintaining sexual relationships with men and that a key factor influencing intimacy is perceived partner responsiveness, which is linked to a partner's support, reliability, and love. According to Ștefănuț, Vintilă *et al.* and Sârbescu (2023), the positive forms of dyadic coping are significantly impacted negatively by the perception of the disease as a threat, whereas the positive forms are impacted positively by the perception of the disease as a challenge. Research suggests that couple-based mindfulness therapies might improve the coping strategies of cancer-affected couples by promoting interpersonal awareness (McDonnell *et al.*, 2022; Price-Blackshear *et al.*, 2020).

Even though their fiancé does not currently have breast cancer, over one-third of the males said they would end their relationship with her if she did.

Their arguments included the fact that breast cancer runs in families, that it might be fatal and cause future separation (sorrow), that dating would be unsafe, and that prevention is preferable than treatment. Additional research revealed that 39.5% of the female respondents were also against their son marrying a woman who had a documented history of breast cancer, and 65.3% of the respondents expressed unfavorable feelings about their son being married to a breast cancer sufferer. Another research, such as that conducted by Srivastava *et al.* (2021); Suo *et al.* (2021) and Maleki *et al.* (2022), makes this clear. These studies found that poor communication between a couple dealing with cancer can result in a number of relationship issues, such as resentment, poor coping, holding back of feelings, etc. The explanations offered were that their unborn kid and their son would eventually bear the weight, that it was incurable, and that it would even result in death. Responses from the WLBC's real experiences further supported these beliefs. The answers resulted from thinking back on the issues and difficulties they had faced during the diagnosis and treatment phases.

Despite this, the majority of them believed that their sons would never marry a woman who had

been diagnosed, treated, or whose family history included breast cancer. However, they continued to believe that nothing should stand in the way of a relationship if the intended pair was in love. According to findings (Clarjis *et al.*, 2022), caregivers feel obligated to care for their loved ones, and the burden they bear has only increased. Likewise, Okyere *et al.* (2023), findings revealed that, patients suffered with physical, social, and nutritional limitations in addition to psychological costs such worry, sadness, pain, stigma, fear of dying, and loss of spouses. Patients with higher family sizes, retired or jobless status, poor educational attainment, and/or low income status had more psychological problems.

The couples were questioned about the dynamics of the marriage in connection to the various stages of the illness (pre-diagnosis, post-diagnosis, and post-treatment). It was important to remember that the couples' pre-diagnosis relationship existed because of their respective characteristics. They accepted their lot in life based on the traits each other's personalities demonstrated in the partnership, which they either appreciated or resolved to fate. As a result, the psychological equilibrium of the relationship was upset by the disease's diagnosis and occurrence. Results indicated that the state of the pre-diagnosis marital relationship influenced how the partners processed and dealt with the revelation.

When taking care of a loved one, intimate relationship experiences encompass everything that was heard, spoken, felt, thought, chosen, assessed, and done (Polit and Beck, 2021). Numerous studies have shown that the intimate relationship is still a crucial component of the healing process. The social-emotional support of caregivers is beneficial during decision-making and processing in addition to providing physical care (Clarjis *et al.*, 2022). Also, Teshome *et al.* (2024), research indicates that women who have had mastectomy require comprehensive care, which includes support from family, community, and medical experts on a physical, psychological, and emotional level.

In cases where there was a friendly or stable connection between the couples, they were able to strengthen their emotional links and seek medical assistance jointly. If nothing else, the sickness diagnosis brought together partners who had previously had underlying problems because they agreed to provide the woman the medical attention

she needed. A basic connection that is based on partner responsiveness is reflected in the intimate relationships. One partner shares intimate thoughts and details with the other throughout this process, while the other partner replies in both verbal and nonverbal ways to show their responsiveness (Fenech *et al.*, 2022). The degree to which a partner reacts to feeling heard, appreciated, and cared for is a critical factor in intimacy (Fenech *et al.*, 2022). Key factors of intimacy include verbal and nonverbal communication, partner responsiveness, and these factors can add up over time to form more comprehensive assessments of a partner's supporting, reliable, and loving nature (Fenech *et al.*, 2022). Partners decided to look for the best treatment and cure since they saw this illness as a shared issue. This therefore transferred into the treatment-related marital connection, wherein the partners were perceived as being accessible throughout the various treatment plans. The research by Kamila *et al.*, and Li (2023) clearly shows that husbands helped their spouses with appointments and showed a concern in their well-being. Studies by Ludet *et al.* (2023), found out that, women frequently encounter major challenges throughout their care and life trajectories in France, according to research on the experiences, social costs, and attitudes related to treatment mobility for breast cancer in France. The primary problems were loneliness, unstable administrative structures, insecure housing, and difficulty receiving treatment. This illustrates how migration and cancer both induce a double biographical disruption that affects the whole course of the disease, from the time a patient enters care until after they have had breast cancer.

Husbands usually approved risk-based screening for breast cancer, but their effect was limited due to their lack of knowledge about breast health and screening. According to Huynh *et al.* (2022), patients' mental well-being and relationships with their significant others were influenced by their sexual health. Breast cancer diagnosis and treatment may have given birth to intimacy issues, which, if left untreated, frequently result in sexual dysfunction. According to Shaffer *et al.* (2022), couples have shown difficulties talking about sexual issues, articulating how they feel about bodily changes, and sharing their fear of harming their spouse. Furthermore, there was a strong correlation found between poor physical and

psychological results and low relationship satisfaction and concordance. For survivors, spouses, and caregivers, maintaining relationships should be a priority throughout the challenges of cancer and into survivorship (Vachon *et al.* and Champion (2024).

Respondents offered several coping strategies for WLBC and their spouses. These included, among many other things, showing and living out real love, avoiding unfavorable social peers, mustering bravery, and marrying a different bride who was not an option. The WLBC might also have a happy life by distracting themselves, seeking spiritual support and comfort, having a supportive spouse role, following medical advice, and utilizing a variety of other coping strategies. The government also contributed to the WLBC's coping mechanisms by offering subsidized medications and standard treatment equipment. In addition to providing breast cancer vaccinations, medical practitioners should also update their medical expertise and treat and communicate with WLBC with empathy.

The study by Chidebe *et al.* and Darlingtina (2024) was supported by the aforementioned findings. In this study, participants adopted spiritual beliefs as a coping mechanism, adhered to their treatment plans, and acknowledged the negative effects of BC on their wellbeing. However, they kept their BC diagnosis a secret from their loved one. Similarly, Sarmah *et al.* (2023), study highlighted sociocultural factors to include; behavioral patterns, habits, beliefs, and views of healthcare that influence women's practices of breast cancer screening in rural South Africa. Women in rural areas in South Africa have deeply ingrained customs and beliefs around breast cancer. As a result, this affects the proactive health behaviors of women with relation to screening for breast cancer.

Since family is the closest system and plays a critical role in coping strategy, this conclusion is consistent with other research showing the importance of family support for cancer survivors (Aprilianto *et al.*, 2021; Brivio *et al.* (2021). According to Chen *et al.*, and Qin's (2024) reported that healthy personal relationships also contribute to patients' and their spouses' improved quality of life.

Conclusion

The study revealed that the WLBC had no choice on the nature and extent of treatment prescribed, as this could be attributed to the late stage of clinical presentations. The doctors therefore prescribed what was most appropriate for the case at hand. The various themes as adopted from the ENRICH marital satisfaction scale was used to explicate how breast cancer diagnosis and treatment affects spousal relationship. Findings revealed that the partners could not understand the personality of each other absolutely, but had to live with whoever they had chosen to share their lives with. In addition, it was indicated that the partners had diverse issues to communicate, but the diagnosis of the disease became the most discussed theme in the relationship. This was borne out of the fact they needed to communicate with each other with a view of proffering solution to the ill-health problem. It also implies that, in addition to the media, religious organizations should likewise spread awareness of even the smallest indication or symptom of BC. Also, ought to be clearly stated in scientific curriculum across all educational levels.

In spite of the conduct of the study under the canon of science, a number of challenges were encountered. First, the study only sampled respondents from the Ibadan metropolis without considering other patients in some other health facilities in Nigeria. This may largely affect the generalisation of the findings from the study. Hence, a larger size of sample size with the inclusion of patients from other health facilities outside the Ibadan metropolis could be significant to the generalisation of the results on breast cancer and spousal relationship for proper health policy formulations.

More so, this study was a self-reported data gathering from the participants and respondents. Relying heavily on self-reported data could undermine the objectivity of the findings because most of their responses could rarely be verified independently. In other words, only face values of their responses were taken into cognizance instead of having an in-depth understanding of the subject matter. This may result to biases that could undermine the results and the generalisation of the findings from the study.

Finally, some of the participants that were recruited from the University College Hospital

(UCH), Ibadan came with late presentation of the breast cancer to the clinic, which led to referrals to the Palliative Unit of the hospital. However, majority of the participants were recruited for the study at the Surgical Out-Patient (SOP) Unit of the hospital, where different cases of breast cancer were attended to. In view of this, most of the participants included in the sample from the unit seemed not to be in perfect frame of mind when discussing issues related to breast cancer. Although this may be as a result of being overwhelmed by the diagnosis or treatment procedures they had undergone, it may undermine the generalisation and validity of the findings from the research.

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