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Spousal Desertion and Coping Strategies among Ever-married Women with Breast Cancer in Kwara and Ogun States Nigeria

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Abstract

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AIM: The study examined the coping strategies among ever-married women with breast cancer in disrupted marriages (divorced, separated, or living-alone ever-married women) who also have limited access to social support.

METHODS: Data for the study were extracted from 2015 behavioral risk factors for breast and cervical cancers in two states of Nigeria. Respondents for the study were identified through three approaches: (1) Self-reported disclosure of breast cancer, (2) informant-leading approach, and (3) outpatients located in oncological specialized health facilities and herbal homes. Formal approval was sought from the management of selected health facilities and community leaders. The respondents also voluntarily shared their experiences after obtaining their informed consent. Textual data obtained from a total of nine breast cancer survivors and patients identified and interviewed were analyzed for this study, using framework and content analytic procedures. The results were presented as excerpts and in themes.

RESULTS: Results revealed two categories of respondents: (1) Breast cancer survivors/patients with husband and (2) those without husbands. Common perspectives were regrets, loss of intimacy, and determination to survive. Basic coping strategies identified are seeking medical support, resignation to fate, and involvement in religion activities. The study concludes that a partner's support was a great yearning for survivors/patients.

CONCLUSION: The authors recommended counseling on partner's assistance among spouses, especially during sicknesses and diseases. It is also important to raise awareness of the risk factors of breast cancer and the need for constant check-ups among women in the study locations, and by extension, other sub-Saharan African countries.

Introduction

There is information on breast cancer as the principal cause of cancer deaths among women worldwide [1], [2], [3], [4], [5] and as the biggest cancer killer in Nigeria [6], [7]. The burden of the disease has also been reported to be more pronounced in developing countries than developed countries where there are availability and access to screening programs and treatments [8]. Studies have indicated that screening offers opportunity for early detection and therapies [9], [10], [11], [12], [13], [14]. Social and family supports have also been proven to be significant in illnesses recovery time, especially concerning breast cancer [15], [16], [17], [18]. Where such supports and access to screening are lacking or inadequate, increasing burden (from the disease) and mortality rates are inevitable [18], [19], [20], [21], [22].

There are studies that confirmed that parents, especially from disrupted marriages (e.g., divorced, separated, and living-alone parents), could be more

vulnerable to deplorable conditions including sicknesses and diseases [15], [23], [24], [25]. Others, in this school of thought, indicated that living-alone spouses are, during the time of illness, more exposed to strain, difficulties in responding to treatment or longer recovery time, including challenges with their post-sickness social and physical relationships [26], [27], [28]. Notwithstanding, there are also studies that have suggested that the supports from husband or intimate partner have the potential for corrective experience and healing benefits to the patient, including enhanced quality of life, security, and love [15], [26], [27], [28]. Cohen and McKay (1984) and Yeji *et al.* (2014) specifically indicated that the support from partner safeguards against distress and boosts self-esteem, which enhances the patient's cognitive reappraise of the stressors as less threatening [15], [26], [27], [28], [29]. If the partner is supportive, the patient's adaptation would improve rapidly and distress could be alleviated [21], [22]. Thus, the partner is expected to provide some supports (or give some kinds of supportive roles) to enhance quick recovery by the patient and reduce or prevent psychological breakdown. Specifically, where the

partner is supportive (e.g., showing empathy, interest) healing advantages could be expected. Where the support is missing or negative such as withdrawal, desertion, dismissal, or stigmatization, it could impact negatively on the health, well-being, and survival of the patient.

In Nigeria, divorce rate and marital separation are increasing [30], [31], giving rise to diminishing intact families while the spread of breast cancer is not abating. Evidences abound that breast cancer has spread across Nigerian communities [6], [9], [10], [32], [33], [34], [35], [36]. The number of cancer patients registered between 2005 and 2009 in Ibadan and Lagos was 5094 cases, in the ratio of 60:40, respectively [33]. Of 1216 cases of cancer registered in University of Maiduguri Teaching Hospital (North East of Nigeria) in 2001/2005, 13.9% were breast cancer cases [6], [36]. Other studies confirmed that a higher proportion of breast cancer patients are young premenopausal women [6], [7]. While the survival rate among Africa women was reported as low, it is relatively above 95% among women in developed countries [37], [38].

In this study, we used the theory of positive social support to examine the coping mechanisms among ever-married women without husbands but with breast cancer experience. The theory describes the assistance (cognitive and emotional) provided to someone coping with a problem in the form of behaviors such as giving active listening, expressing concern that can aid solving that problem at hand [15], [39], [40], [41]. It describes positive social supports as those assistances or interceptions that buffer against distress, reduces shock, and protects against further harm/distress. The opposite is described as social denial (negative support) which includes behavior or activities related to desertion, withdrawal, blaming the spouse/partner for the problem, and other behavior that may aggravate the pain or trauma [15], [41], [42], [43]. While these supports could come from different sources such as state, national, or international agency, spousal supports, including partner's availability and communication, enhance coping with such trauma-related distresses [15], [41], [42], [43].

This theory has also been used in the study on social-cognitive correlates of adjustment to prostate cancer [44] and social-cognitive processing modeling of emotional adjustment in cancer disease [40]. In these studies, it was indicated that the support that confronts, re-evaluate the stressful event such as cancer, facilitates accommodation of that stressful event [40], [44]. However, whenever these cognitive processes fail, the stressor remains active or bounces back [45]. In this context, we hypothesized that the support received (in terms of care, discussion, finances) would have strong post-treatment palliative measures to enable the survivor to cope adequately with and adapt easily back to her usual lifestyles.

Notwithstanding, the numerous studies on coping with sicknesses or diseases [15], [31], [39], [41],

[46], the questions on how to manage with the disease in the face of marital challenges, especially where the husbands (the supposedly closer partners) are not available, have not been explored in the literature, especially, as it relates to qualitative study in Nigeria. What would the women without spouses or with absent-partners do if they are sick? The study, therefore, seeks to understand the coping options among ever-married women without spouses but with breast cancer experience. The data collated and the analyses could serve the need of both national and local policy-makers/decision-takers in the areas of care and supports for breast cancer patients and survivors.

Materials and Methods

Research design

The data for this study were extracted from the 2015 study on Behavioural Risk Factors for Breast and Cervical Cancers in two states of Nigeria and funded by Covenant University Centre for Research, Innovation and Development (CUCRID) Nigeria (Grant No: CUCRID-RG 005-10-14-FS). The main study was conducted in the two states (randomly selected from South West and North Central) of the six geopolitical zones in Nigeria [15]. The entire study covered 1023 women randomly selected in the quantitative segment of the study and 17 in-depth interviews among identified breast and cervical cancer survivors. The report for this study is exclusively based on extracted data related to nine breast cancer survivors/patients with spouses and without spouses. The study was therefore patterned as a case-control study involving only four breast cancer survivors who are living with husbands and five that were separated or living-alone without husbands.

Recruitment of participants

Nine participants were selected through three distinct processes within the purview of the random techniques adopted in the main study: (1) Women who answered "YES" to the questions "ever experienced breast cancer" in the main study were requested to participate in a separate in-depth interview; (2) women who indicated they know someone with such experiences and ready to link us with such individual after formal discussion were recruited as leading informants to locate the survivors; (3) Furthermore, few volunteer outpatients of oncological specialized health facilities and traditional herbal homes that agreed to share their experiences were interviewed. These oncological health facilities and traditional herbal homes were purposely selected as a means of reaching out to the target respondents. Due permission was obtained from the management and proprietor-base of the health

facilities. In addition, formal approvals were sought from the community leaders, especially within the communities where the participants and the facilities are located. Overall, we were able to recruit only three breast cancer survivors through the main survey, two from leading interviewees, and four from both health facilities and traditional herbal homes. Consent forms were duly approved by all prospective respondents. However, for the women without husband/spouse, immediate family member (as suggested by the participant) was consulted for necessary approval. Where the husband/partner, any member of relative or the respondent declined on the consent form, such woman was excused from participating in the interview. In addition, all respondents recruited were assured of confidentiality of their responses and anonymous reporting of the research findings. Respondents were encouraged to participate but were informed of their freedom to withdraw at any stage of the discussion.

Data collection

The basic subjects covered in the interviews range from the lifestyle history, especially in terms of sexual relationship, to participant's knowledge about cancer infection transmission, when and how was the disease detected, health-seeking behavior, and coping mechanisms. We later sought participants' advice to their fellow women who may or may not have such infection. Questions on age and employment status were also asked. We also translated some questions in local dialect where necessary for proper understanding. With the use of in-depth interview technique, we had opportunity to ask and probe for clarifications and more details. Responses were recorded (with participant's permission) and as a compliment, and also, to avoid missing out any vital information, the note taker writes down most responses from each participant. We also encouraged all members of our research team to submit a write up on his/her experience with or reactions of the respondent and impressions of the interview. These reports were always reviewed before the next interview and formed additional input in the analysis [15], [47], [48], [49], [50].

The number of in-depth interviews was small due to the case-control approach of the study. Specifically, few cases were identified, of which limited numbers of patients consented to participate in the interview. In addition, the participants were volunteers and no incentive was provided due to limited funding. Notwithstanding, the fewer number we interviewed was manageable, the shared information is comprehensive enough considering the time frame and limited funding of the project, and our meeting with them might have injected longevity hope in them. In addition, each of the in-depth interviews continued until little or no new information was forthcoming and the sampling continued until theoretical saturation was reached.

Data analysis

The study was patterned as a case-control study involving (1) breast cancer survivors (who live with husbands) and (2) those that were without husbands. The case-control pattern of analysis is suitable as a measure of the increased risk for a population exposed to some factors when compared with an otherwise similar population not so exposed to those factors [51], [52]. Following the analysis procedure of Amoo *et al* (2018), we explored identifying the responsiveness of the survivors/patients that were conditioned by the exposure to the presence of spouse/sexual partner, compared to the responses from other women whose spouse/sexual partner were absent. Responses obtained were transcribed and the textual data analyzed using systematic content analytic procedure [15], [46], [48], [53]. The data were firstly sieved, charted, and sorted in accordance with the key focus of the study [47], [48]. Specifically, after the transcription, the responses from all the interviewees were all assembled together and a number of pages on Microsoft Word were opened with each page detailing responses to each specific question. The transcripts were read and reviewed several times for content understanding [49], [50]. The review exercises provided opportunity to familiarize ourselves with the data, understand and note down useful comments from the responses, and allowed for ease identification of emerging and recurrent [47], [48], [53], [54], [55], [56].

We adopted the patterns of Amoo, *et al* (2018) where, long sentences were broken into simple short sentences grouped by related comments or questions and emerging issues were categorized and coded [15]. The coding system permitted thorough examination of clusters of comments made by respondents and those in the notes we took. In consonance with the research questions, the codes were rechecked and appropriately linked to the research questions [15]. Where necessary, few codes were merged and those that we considered not relevant were removed [15]. We performed cross-tabulation of responses by the presence or non-presence of spouse/partner and by age group for possible comparison [15]. The results from the analysis were compared with existing literature for support, contradiction or as an indication of new observations [15]. The whole exercise complied with RATS qualitative research guidelines and consolidated criteria for reporting qualitative study [15], [47], [48], [54], [56]. The results of the analysis are therefore presented as excerpts having corrected for grammatical errors.

Validity and integrity of the data

We maintained the assurance of the accuracy and consistency of data throughout all the research stages. To further ensure reliability of the data, a wide range of samples, with respect to the presence or absence of spouse/partner and different age groups

was considered [15]. Furthermore, participants' review procedure was adopted where written down responses were read out to ensure correctness and agreement or re-confirmation on the responses [15]. In this study, we guarded against cases of confounding and biases we focused not on the causes of desertion, but exclusively on how the patients are coping with the disease [51], [52]. Specifically, there was also a problem of definition since no respondent could confirm any legal, customary separation, or divorced with her husband, hence, the use of desertion and separation intermittently [15].

Results

The results of the analysis highlighted two distinct categories of respondents: (1) Responses among the breast cancer survivors that have husbands and (2) Responses among the breast cancer survivors without husbands (divorced, separated, living alone, or absence husbands). The results of the analysis indicated that there are differences in the responses of the respondents between the two groups. The results are therefore presented in themes and the excerpts cited on the basis of the presence or absence of the husband.

Participants' demographic characteristics

The results revealed that all the women interviewed had ever ed but many of them were separated. Overall, only one survivor had no formal education but could communicate in pidgin, more than half have had secondary education and above. Furthermore, more than half of them were self-employed, though few have had other working experience from factory shifting jobs. The lifetime cumulative sexual partners (measured as the total number of sexual partners a woman ever had) was above two for more than two-thirds of the respondents. All the participants have given birth to at least a child. The women interviewed were in the age range of 21–48 years. Women with husband were only 4 while 5 were living without spouses.

Pre-cancer infection awareness

The general knowledge of breast cancer's symptoms before the incidence was relatively low. Two of the respondents indicated they had had read and attended seminars on breast cancer. One of these women responded: "Yes, I have read about it in a newspaper magazine but it was the least I ever expected to happen to me" (a woman, aged 34). Seven of the nine survivors had no knowledge of breast cancer before the infection. A woman (aged 47) narrated her

experience: "I never heard about it (breast cancer) until the problem started. It has never happened in my family. Although one of my old aunties has a problem with her breast in those days (around 1998, when I was in the high school) and it was treated traditionally, it never happened to my mother."

The responses also revealed that the majority of the women never had consultation or counseling with health officials on breast check/examination before the sickness began. Responses showed majority of the women rarely visit health facility except for pregnancy confirmation (test) and intermittent antenatal visitations. Specific reasons why the respondents have never visited hospital for breast examination as indicated included inadequate time and cultural connotations. Majority of the women in this category were career women and traders before the incidence.

"I only go to hospital to confirm if I'm pregnant or not" (Woman, aged 31).

"I only go for checkup the moment I missed my period (menstruation); then, I follow the antenatal details every Tuesday" (Woman, aged 37).

"I only check my body to make sure I look fine, not to be checking for sickness" (Woman age 43).

Social support from institutions or community

Respondents were asked whether they ever received or are currently receiving any support in kind or cash from any institution or group of people. Response to this question was mixed and cut across women with or without spouses. More than half of the women (with or without husbands) indicated they have not received any support or knew any agency that supports breast cancer victims. A woman (aged 38) believed that "except you beg for arms on the roadside, nobody will be interested in supporting you." Two women specifically indicated the following:

"As for me, I have not received any dime from any institution, including church and mosque" (woman aged 43).

"I am not aware of any institution that cares for breast cancer victims in this town" (Woman, aged 34).

However, three women indicated they have received support (in cash and kind) from members of their religious organizations and health facility attended. Only one of the three women was without husband. She indicated that members of her family and other relations frequently give her money and foodstuff. "In my own hospital, they gave us (the patients) things such as tissue papers, sanitary towels, kettle for boiling water) free after the operation" (woman aged 41). Another woman who had received support from her working place narrated that "my head teacher never left me alone. He comes around every time and brings

good messages from my colleagues to me. The school gave me money and I think they protected my job while I was going to hospital for treatment almost every day" (woman aged 39).

Husband's support and coping strategies among women with breast cancer

In the adoption of the theory of positive social support, husband support is considered crucial in enhancing timely recuperation and effective coping. In this segment, spousal supports were evaluated among the survivors to underscore husband's availability during the sickness, the level of communication (e.g., showing of empathy), and financial support during this period. The general perception among the women that were having spouses showed the indispensability of a man spouse/partner in the event of sickness. Common coping strategy among women with husband was exclusive reliance on husband for virtually everything. More than half of the women in this category indicated that their husbands pay the bills and take care of the home-front. It is also understood from the interview that most of the women with husband presence belong to ages lower than 40 years. A woman (aged 39) indicated, "husband support is indispensable when it comes to wife's health and survival." Another woman (aged 37) expressed that "her husband assists sometimes in the household chores and augments her money for the bill." Other excerpt includes the following:

"My husband was closer to me during this period of sickness and often asked me about my feelings" (woman, aged 31).

"I relied heavily on my husband for everything during the incidence. There was nobody I could have turned to apart from him" (woman, aged 34).

"Although, other relatives are doing much (even than my husband) but, I cannot substitute this for him" (Woman, aged 37).

Support and coping strategies among women without spouses

The majority of the women without husbands narrated that they used to enjoy closeness with their husbands before the onset of the disease and during the time when the sickness was just emerging. However, the relationship was gradually declining as the pains and burden of the disease were increasing. The general opinion among the five women in this category was that "it started with elements of relaxation on most things they (the couple) used to do together before onset of the sickness started." They indicated that at the beginning of the illness (breast cancer), their husbands were "financially committed to their health and welfare." However, they all expressed disappointment over the

decline of support and commitment over time and are finally faced with no support from their partners.

A woman (aged 47) narrated her experience:

"Our relationship before the incidence was very romantic. We used to go out together: to parties, attended community functions and, at times, bought the same attire for events. I informed my husband about the lump and the sharp pain I was experiencing, and of course, we didn't know anything about it until it was confirmed by the doctor. The problem however started after we were informed of the cost of the operation (surgery), the likely challenges I might pass through and that survival could be 50:50 likelihoods. My husband was totally dejected initially and later "picked up" certain funny behaviour such as leaving home early, coming back late, until he finally disappeared (left home)."

The two women who were as at the time of the interviewed not living with husband expressed loneliness and loss of cordiality. Few of their responses are indicated as follows:

"As far as I'm concerned, I don't think I have husband anymore, and it is glaring with his long-time absence and lack of support" (Woman, aged 38).

"Cordiality is already missing. He seldom comes home, giving different excuses for absenting from home. I bear this (the disease) on my own alone" (Woman, aged 34).

Coping mechanism among the survivors without husbands

The coping strategies as used in this study are described in terms of methods, changes in behavior (or general lifestyles), that are directed toward adaptation to a new event or continue existence after the incidence of the event (i.e., the sickness) has occurred. Precisely, in this study, the coping strategies are those approaches that the patient has adopted or currently using to tolerate or sustain herself despite the incidence of cancer and desertion of her husband/sexual partner.

In the analysis, a thematic framework procedure was used in which responses were coded and emerging concepts/terminologies were mapped into themes. The results of the analysis revealed different perspectives among respondents without husbands as compared with the other categories of the respondents where the husbands were present. The immediate reactions among the respondents tilted toward "regret, financial burden and concern about how to make the husband liable for the sickness and determination to survive or live with the disease." Others have resorted to fate while few women felt indifference with the believed that husband presence or absence has no impact on their survival. However, the basic themes identified as coping strategies are: Seeking medical intervention,

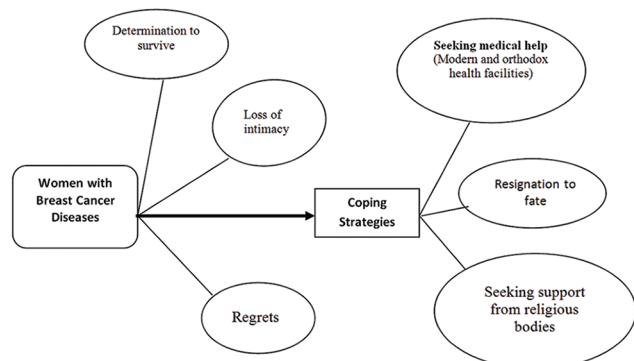


Figure 1: Diagrammatic illustration of perspectives and coping strategies among ever-married breast cancer survivors without husbands. Authors' Mapping, 2019

resignation to fate, and seeking support from religious bodies as depicted in Figure 1.

Seeking medical help (modern and orthodox health facilities)

Majority of the women without spouse/partner indicated they foremost sought for a medical solution to their problem before any other option. They believed that breast cancer is a medical issue that must be treated medically and in health centers. A woman (aged 43) indicated that *"I rely on the assistance from my medical doctor."* A patient (aged 39) expressed that *"this hospital was my first place of call and the official has been taking good care of me. I am getting healed gradually."* Others in this category believed that the impact of visiting orthodox medicine is indispensable in sensitive cases related to the woman breast. A woman (aged 48) from the herbal homes indicated that *"most killer diseases like breast cancers are the handiworks of the enemies and could only be treated using herbal homes."*

Resort to fate

Certain numbers of women without husbands have resigned to fate. Their general perception was that sickness is an *"act of providence"* and *"as long as you're still breathing, then there is hope."* They considered other previous steps they have taken (such as medical consultation) as sufficient enough and are now resolute not to "run" anywhere again for seeking support. Furthermore, few of the women resigned to fate as a result of their low financial status *"I eat, sleep (if it comes) and resort to fate. There is no other option left for me than to believe in God and be praying, because I don't want to die"* (woman, aged 47).

Seeking support from religious bodies

Related to the above coping mechanism is the hope of respondents in religious practices. Virtually all

the five women in this category believed strongly that *"if you seek help from your church or mosque leadership and members, there is assurance you will be helped."* Two of these women were those that have received supports from their religious members. A woman (aged 48) indicated that *"the prayers from your religious leader could also help in healing of the diseases. This is what I go for every time."*

Determination to survive

Other segments of the responses indicated that the women were determined to get healed and survive the disease. Only two women were found in this category with common intention to survive the "ordeal" of breast cancer. A woman (aged 37) indicated that *"there was no one to discuss or share my pain with, but all my concerns now are how to survive this disease."* Another indicated *"since one of my breasts has been removed, I will try hard that the infection did not affect the other as being warned by the doctor"* (woman, aged 41).

Discussion

The study evaluated the coping mechanisms among two-distinct groups of women with breast cancer: (1) Breast cancer survivors that have husbands and (2) breast cancer survivors without husbands. It specifically highlighted the coping strategies among ever-married women with breast cancer where access to family and social supports are not available. The simultaneous examination of experiences of a disease with victims with two distinct backgrounds has added to the body of knowledge on survival strategies on breast cancer. It has also positioned this study as fundamental, especially in a country with a high incidence of breast cancer and high maternal deaths [9], [10]. The study has provided insight into the implications of men's behaviors toward spouses, especially in difficult times such as a sick period. While social and family support has been regarded as potent strategies for quick recovery among the patients [15], [26], [27], [28], [29], the absence of such fundamental supports of husband could have great implications for sick-free society agenda and the general well-being of women. The study thus provided vital information for stakeholders in community health programs and services and could be a useful counseling tool for social workers and other health practitioners.

Evidences from the result obtained in this study indicated that the diseases could strain marital relationship easily. The illustration with thematic framework could be regarded as an important addition to knowledge by providing a simple overview of the various coping perspectives of breast cancer among

women. Furthermore, the study identified common perspectives among women without husband such as regrets, loss of intimacy, and determination to survive. The basic coping strategies identified among the women are seeking medical help, resignation to fate, and religious supports.

Although community perceptions were not evaluated, the understanding from the responses of the respondents concerning the non-supportive attitude from the community could suggest stigmatization. This may also explain why majority alluded that they have not received support from the family members. Besides, the highlight from this study pointed the fact marriages and intact family could enhance good health, or at least, stimulate effective coping during health challenges [15], [24], [25]. The study also revealed that the government's support could either be completely absent or out of reach to most patients covered in this study. It may, however, be necessary to call for government and other stakeholders' attention considering the plight of women suffering for breast cancer in the face of absent husbands.

In terms of policy, the study attempted to position that husband's desertion is a risk factor to women well-being and survival. Wife neglect by the husband is by itself psychologically disturbing, and coping with adverse health challenge under neglect or non-availability of the husband could be traumatic, increase the severity of the sickness or disease, and might increase the risk of death. Having women in this condition in Nigeria should spur policy intervention to encourage spousal care and support especially during hard times of sicknesses and diseases.

Limitations of the study

The in-depth interview approach adopted and the data analysis procedures were time consuming. Sensitivity surrounding the topic and the kind of stigma over the issue posed a serious challenge in the identification of the survivors. The method seems to lack interactions among the participants since only one respondent was interviewed at a time which is unlike focus group discussion. Although the number of in-depth interviews is small, the fewer number was manageable; the shared information seemed to be comprehensive enough considering the time frame and limited funding of the project.

Conclusion and Recommendations

There is virtually a lack of institutional support for the survivors and victims of breast cancer in the studied locations. The most prominent coping mechanism is resignation to fate, dependence on members of their

religious affiliations, and medical treatment. The study concludes that while the missing husband's care and support could aggravate the burden of breast cancer, the lack of support from institution, inadequate knowledge about the disease, and lack of awareness of places for treatment could signal danger toward the realization of sick-free society, which could be of important focus for social health workers, health personnel, governments, and other stakeholders in women well-being. The authors, therefore, recommended counseling among couple on the need for spousal care and support, especially during hard times of sicknesses and diseases. Furthermore, massive community "synthetization" is indispensable to raise awareness of the risk factors of breast cancer, the need for constant check-ups in the study locations, and by extension, sub-Saharan African countries as a whole.

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