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Experiences of Breast Cancer Women About Partner's Unsupportive Behaviors: A Phenomenological Study

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Abstract

Background: Failure to fulfill the physical and psychological needs of breast cancer patients and their partners can result in anxiety, depression, and marital problems.

Aim: The present study was performed with aim to elucidate the experiences of breast cancer women regarding partner's unsupportive behaviors.

Method: This qualitative study was conducted with a Dickelman descriptive phenomenological approach in the chemotherapy and oncology department of Shahid Ghazi Tabatabai and Shahid Madani hospitals of Tabriz city in 2021. A total of 9 female breast cancer patients were included. Individual in-depth interviews and note-taking were used to collect data using MAXQDA Software. The semi-structured interviews were used to collect data. Interviews were analyzed using the Dickelman, Allen, and Turner method.

Results: A total of 1500 primary codes were obtained, and finally 3 main categories were extracted including financial inadequacy, emotional impoverishment and breakdown of shared life, and existential devaluation as a woman.

Implications for Practice: The results showed need for the husband to pay more attention to the impact of his behavior on his wife; also talking about the problem on the part of the couple is the biggest factor in understanding the support that can be expressed. Also, men and women do not think the same in understanding the needs of their sick partner. Male caregivers are usually less understanding of their spouses. Therefore, health professionals should pay more attention and help men cope with this problem and bear the suffering of their wives.

Keywords: Breast cancer, Experience, Phenomenological study, Unsupportive behaviors

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Introduction

Breast cancer is a prevalent and significant health problem affecting women in developed countries and improvement of attitudes toward breast cancer positively affects the screening behaviors of women (1-3). The mortality rate associated with breast cancer constitutes 30% of all female cancers (4,5). It ranks as the second leading cause of cancer death, with approximately 41,000 women succumbing to the disease annually (6). In Iran, breast cancer is the most prevalent cancer among women, accounting for 21% of all cancer cases (7). Self-care education is important in patient receiving chemotherapy (8). The treatment modalities for breast cancer, including surgical intervention, chemotherapy, radiation therapy, and hormone therapy have been linked to negative impacts on the patient's overall well-being and lifestyle (9,10). Research has demonstrated that female cancer patients have difficulties with their partners as a result of the extended duration of treatment and the possibility of limb loss and mortality (11). The majority of women diagnosed with breast cancer undergo a mastectomy, which involves the removal of one or both breasts may experience a disrupted sense of body image. The impact of cancer and its treatment on women's daily routines, familial responsibilities, and occupational pursuits is a source of concern for them (12,13).

During recent decades, there has been a shift in our comprehension of the ramifications of cancer. It has been acknowledged that the effects of cancer extend beyond the physical realm and encompass psychological and social dimensions. Several strategies have been developed to provide support and alleviate the challenges faced by cancer patients throughout their illness (14,15). Research has demonstrated that the male partners of women diagnosed with breast cancer are susceptible to experience significant depression symptoms as a result of heightened stress levels and inadequate social support (16). Women undergoing treatment may encounter a reduction in sexual response, a diminished desire for intimacy, and apprehensions regarding bodily alterations (16).

There is a strong correlation between the unsupportive behaviors exhibited by men and the disease-induced behaviors displayed by their spouses. Specifically, the presence of these behaviors prompts reciprocal responses from partners. This phenomenon pertains to the discomfort encountered by females and their tendency to evade conformity, which can have deleterious implications for patients (17). According to the research findings (18), the adverse impact of a spouse's unfavorable behaviors on the patient's mental equilibrium outweighs the favorable impact of the spouse's positive behaviors. Hence, problem-avoidance behaviors have significant and widespread impacts on the psychological coping of patients. Interventions that prioritize the couple may benefit from a targeted approach that addresses the reduction of avoidance behaviors related to the issues faced by the couple (19).

Most of the research conducted on couples impacted by cancer has focused on patients with breast and prostate cancer (20,21). The manner in which the woman handles cancer diagnosis is a crucial factor that influences the couple's ability to adjust to the illness (22). Positive supportive coping strategies include appropriate peer counseling, having faith in the partner's capabilities, and exhibiting solidarity. These strategies may also entail self-sacrifice, such as assuming additional responsibilities or doing household chores (23). The significance of spousal reactions, coping styles, and trusting communication cannot be overstated in the context of a patient receiving a cancer diagnosis. Clinicians and researchers should take these factors into consideration when delivering news, as they have a significant influence on patient's health outcomes (24). Improving and promoting health behaviors should be prioritized as a fundamental objective in cancer treatment. Conversely, it is indisputable that women constitute a fundamental cornerstone of both the household and the broader community. Enhancing the well-being of women diagnosed with breast cancer not only enhances their chances of survival but also elevates their standard of living and fosters greater familial unity (25). One significant fundamental observation regarding the impact of marriage is that married individuals diagnosed with late-stage cancer tend to have a longer lifespan compared to those who are single, divorced, or widowed that have received the same diagnosis. Previous research has investigated the satisfaction levels of individuals with breast cancer in their marital relationships (26), alterations in sexual and intimate relationships following cancer treatment (27,28), the influence of cancer on familial relationships (29), and the support provided by partners to these patients (30).

The review of the conducted research shows that there is little knowledge about the experiences of couples with breast cancer from the unsupportive behavior of the spouse and the description of the behavior or the way the spouse supports the patient, and there are also problems regarding the

registration of the type of relationship between the patient and the spouse. Therefore, the present study was performed with aim to elucidate the experiences of breast cancer women regarding unsupportive partner behaviors.

Methods

This qualitative study was conducted with a Dickelman descriptive phenomenological approach in the chemotherapy and oncology department of Shahid Ghazi Tabatabai and Shahid Madani hospitals of Tabriz city in 2021. The inclusion criteria comprised women diagnosed with breast cancer and undergoing cohabitation during their illness. The patients who were unwilling to continue participation in any phase of the research (withdrawal after being included), as well as those who had a mental illness or were taking psychoactive drugs excluded from the study. A purposive sampling technique was used in this study. It is important to acknowledge that in qualitative research, the sources of information hold greater significance than the samples and should be given priority (31). All participants provided either oral or written consent for participation in the study. The study incorporated individuals who demonstrated a good capability in conveying their experiences. Successive participants were chosen through a process of analyzing earlier interviews, with the aim of providing greater clarity on questions and ambiguities that arose during preceding interviews. The study adhered to the principles of purposive sampling with maximized variation in terms of age, sex, education level, religion, and location. Data collection continued until data saturation. Theoretical saturation achieved by conducting interviews with a total of 15 participants. The study's saturation criterion was met when no new concepts were introduced or when new and significant dimensions were not added to the previously established concepts during the two last interviews. The research employed in-depth and semi-structured interviews as the primary data collection method. The mean length of primary interviews was 55 minutes with a range of 40 to 75 minutes, while the mean length of subsequent interviews was 25 minutes with a range of 10 to 41 minutes. Individual in-depth interviews and the analysis was done using Van Manen's phenomenology and collected data was analyzed by using MAXQDA Software.

Following the completion of interviews and subsequent transcription of audio recordings, the process of data analysis and interpretation initiated. Phenomenology entails the utilization of particular systematic approaches for analysis. For analysis and data analysis obtained from semi-structured interviews, the method Dickelman was applied which is used in Allen and Tanner's study (30) in interpretive phenomenology. In the current research, seven steps were employed to achieve the goal. In the first stage, after the end of each interview and the recording of field observations and notes, in order to get a general idea, the participants' interviews were repeatedly listened to and their statements were recorded word for word on paper and reviewed several times. In the second stage, in the search to discover potential subjects, the researchers used what they saw and heard in the form of an "interpretive summary" and the meanings hidden in it were understood and extracted. These meanings are just the simple expression. There were no participants, but it included the atmosphere of the interview and how the couple answered the questions. In the third stage, the written texts and the content of the interviews were discussed and analyzed as a team (researchers) in order to reach a common understanding and the main themes were extracted. In the fourth stage, after extracting the contents of the themes, the research team carefully studied the extracted concepts again and while clarifying and classifying the data, made a general and composite analysis of each text or interview. At this stage, any disagreements and contradictions in the interpretations were resolved by referring to the texts of the interviews or the participants. In the fifth stage, the texts of the interviews were compared in order to identify, determine and describe common meanings and actions. The sixth stage followed by identifying and extracting the fundamental patterns that established the relationship between the topics. In the final stage, in order to explain, clarify and classify and resolve any disagreements and contradictions in the interpretations, a draft version of the contents for accreditation and writing the final version of the project report to the members of the research team and experts in the field. Phenomenological researches were presented. In each stage, while the work is progressing, by integrating the interpretative summaries, a more general and combined analysis was formed so that the resulting themes are related in the best possible way (30).

The data was organized by considering the common categories and subcategories. The distinct categories for patients were identified through a process of iterative reading, immersion, and

reflection on the primary themes of the phenomenon. Initially, the transcript of each interview was meticulously reviewed several times to obtain a general comprehension. Subsequently, the linguistic components comprising words, sentences, or paragraphs extracted from the interview transcripts were analyzed and categorized as initial codes representing the participants' experiences of unsupportive partner behaviors. Then, the initial codes were subjected to a groupification process whereby they were grouped according to shared characteristics and distinctions into core categories. The final categories and subcategories emerged as a result of the abstraction process that involved constant comparison, reflection, and interpretation (32).

The study followed the rigor principle introduced by Lincoln and Guba (1985), which encompasses credibility, dependability, confirmability, and transferability (33). Credibility was achieved by the continuous presence of the main researcher in the research environment and ongoing discussion of the findings in the research group. Transferability was accomplished by sampling with maximum diversity. Dependability was ensured by more than one researcher undertaking the analysis. All members of the research group worked together in data analysis. Confirmability was accomplished by an audit trial of all research activities. The establishment of credibility was achieved by maintaining a consistent presence of the primary investigator within the research setting and engaging in ongoing discussions with the research team regarding the findings. The maintenance of transferability was achieved by maximum variation sampling.

Results

The mean age of the participants was 45.65±9.80 (ranging 27-83 years). Also, 71% lived in city, 95.4% were married, 3.3% single and 1.3% divorced.

The present investigation utilized a Dickelman descriptive phenomenological approach consisting of three stages, namely direct understanding, analysis, and description. During the stage of direct understanding, the researcher becomes fully engaged and immersed in the phenomenon. The investigator refrains from offering any form of criticism, evaluation, or personal viewpoint and instead gains an understanding of the phenomenon as recounted by the participants.

A total of 1500 primary codes were obtained, and finally 3 main categories were extracted from them using the analysis of 7 subcategories. The findings of this study showed what breast cancer patients thought about unsupportive behavior and how they explained it based on their shared experience. Through qualitative data analysis, three core categories related to women emerged, including financial inadequacy, emotional impoverishment and breakdown of shared life, and existential devaluation as a woman (Table 1).

Table 1. The categories and subcategories extracted from experiences of breast cancer women regarding spouse's unsupportive behaviors

Core categories	Subcategories
Financial inadequacy	Financial hardship
	Living in poverty
	High treatment costs
Emotional impoverishment and the breakdown of shared life	Inclination to separate after the disease diagnosis
	Feeling entrapped in a shared life continuum
Existential devaluation as a woman	Sexual dissatisfaction after the disease
	The sense of diminished status in the partner's eyes

Financial inadequacy

Life and treatment quality can be compromised by financial inadequacy. This main category includes the subcategories of financial hardship, living in poverty, and high treatment costs.

- ***Financial hardship***

Experiencing financial difficulties and lacking employment and insufficient income to cover

medical treatments can be a source of significant concern for the family. In this regard, one of the participants stated:
"…I don't have any financing, I don't have any money, and he is aware that he will need to give me money for my treatment. Even though the machine at the treatment center was broken down, I had to wait a long time before I could be treated because neither my husband nor I had any money at the time. In fact, neither of us had any money at all. She stated that he had exhausted all of his financial resources on me." (Participant No. 4)

- ***Living in poverty***

Women lacked access to a safety financial resources and a means of earning an income on their own. It is extremely irritating for the husband to pay for his wife's medical expenses. In this regard, one of the participants said:
"…I spend money for my wife because I have no choice. People would make fun of me and say that I don't put much effort into caring for my wife, that I do not take my wife to a doctor. That is the sole reason I spend.'" (Participant No. 4)

- ***High treatment costs***

Considering to the low income of households and the economic problems in the community, medical costs are a major concern. One of the participants stated in this regard:
"…At this point, my expenses are covered by my father. I also work as a hairdresser and sell flowers. My income is not very high, but there is no other way for me to make ends meet because the cost of living is so high." (Participant No. 2)
The other participant said:
"…The cost of treatment is very high, and we can't afford it. This makes my husband nervous." (Participant No. 6).

Emotional impoverishment and the breakdown of shared life

The disruption of favorable familial connections after acquiring an illness is profoundly distressing for the couple. This category encompasses the subcategories of man's inclination to separate after the disease diagnosis, feeling entrapped in a shared life continuum.

- ***Inclination to separate after the disease diagnosis***

Following the onset of the illness, male individuals express a tendency to seek separation from their partners. Some couples who receive a cancer diagnosis may end up splitting up. In this regard, one of the participants stated:
"…At the end, he said 'I spent money for the doctor.' He did not consider it to be his responsibility to spend money on me." (Participant No. 2)
After illness, the patient expects more affection and intimacy.
"…I think he was afraid of removing my breast. After the illness, he distanced from me and turned his face away so that he would not see me. This caused me to become very upset and anxious, and I began to cry." (Participant No. 4)
Another participant said in this regard:
"…At first, we were against performing the operation. I was nervous about doing it. Instead, we began treatment with herbal medicine. Following the completion of the subsequent tests, the physician insisted that I go ahead with the operation. 'The disease will advance if you don't do it,' the doctor warned. He [her spouse] didn't bat an eyelid. Even after the operation, he exhibited absolutely no signs of emotion." (Participant No. 3)

- ***Feeling entrapped in a shared life continuum***

Patients with breast cancer felt that they were not emotionally supported as before, and their spouses did not pay attention to them. They expected that their spouses pay more attention to them after their illness. One of the participants stated:
"…From the day that my spouse found out that I had cancer, he no longer supported me like before" (Participant No. 9)

Existential devaluation as a woman

The woman may experience a sense of responsibility for the upcoming difficulty due to the man's excessive expectations and tendency to attribute blame solely to her. Additionally, the manifestation of the female's physical imperfection and loss of an organ, coupled with the male's empathetic sentiment, results in a diminished sense of self-esteem for the female. One of the participants stated in this regard:

"…I had a lot of support from my brothers. Only they provided the money I needed. They supported me greatly and even gave me their bank cards to use. My husband didn't spend a single dime. In preparation for the second operation, he visited the medical facility. But he didn't come because of me; he came because my son was injured after falling off the elevator. He was wearing slippers instead of shoes and asked me to visit the shoe store owned by my brother and purchase him some new footwear there. I never escaped the impression that I was his slave." (Participant No. 1)

- ***Sexual dissatisfaction after the disease***

Following a cancer diagnosis, sexual issues emerge as a primary area of apprehension for families, inducing anxiety and numerous concerns for both males and females. The diagnosis of cancer and its associated treatments, including surgical interventions, have been found to impact the sexual desire of both men and women. Furthermore, such effects may result in a sense of emotional detachment on the part of the male partner. In this regard, one of the participants reported:

"…You notice that your husband is texting on his phone at two in the morning. I try to act as if I haven't seen anything at all, but I can't sleep because of anxiety." (Participant No. 4)

- ***The sense of diminished status in the partner's eyes***

Each person establishes a position and value in their own mind and has perceptions of this position in their partner's mind. A woman expects to be treated with value and importance by her partner in their shared life. One of the participants reported:

"…I wanted my wife to at least see me and respect me like before my disease, but now that I'm sick, he doesn't see me" (Participant No. 3)

Another participant said in this regard:

"…He doesn't show any emotion; he doesn't talk, and he doesn't say anything at all; he just looks and doesn't care at all to sympathize. There are times when I say that no man is as insensitive as he is." (Participant No. 7)

Discussion

The current study is the first in Iran which investigated the experiences of unsupportive partner behavior in women with breast cancer using a combined approach. The most significant finding of the present study was the category of financial inadequacy. According to the reports of the participants, an individual's poor financial status may have a negative impact on their quality of life and the quality of medical care they receive. This category includes the subcategories of financial hardship, living in poverty, and high medical expenses. Empirical data indicates that the incidence of clinical depression is comparatively greater among women with lower incomes than those with higher incomes. Similarly, the prevalence of depression is elevated among widowed, divorced, or single women who lack a source of income. Financial concerns are formidable impediments to cancer treatment (34). Previous research has indicated that a decrease in the quality of life of couples and an increase in anxiety may be attributed to low income in the family of women diagnosed with breast cancer (35,36).

According to the findings of the current research, women's experiences of their partner's unsupportive behavior emerged in the form of three main categories and 8 subcategories. These core categories and subcategories were: financial inadequacy (financial hardship, living in poverty, high treatment costs), emotional impoverishment and the breakdown of the shared life (inclination to separate after the disease diagnosis, feeling entrapped in a shared life continuum,), and existential devaluation as a woman (sexual dissatisfaction after the disease, sense of diminished status in the partner's eyes). According to a recent study, inadequate resources and insufficient familial financial support can leave numerous women with cancer vulnerable to financial hardships. Women who serve as the primary

breadwinners or who are part of dual-income households may experience substantial financial losses due to their inability to work (37).

The findings of another study suggest that residing in regions characterized by elevated poverty rates exhibits a significant correlation with delayed detection of breast cancer. The results revealed that geographical location of an individual's domicile is a significant factor in assessing the likelihood of developing end-stage breast cancer. Further investigation is required to evaluate and measure impediments to healthcare, encompassing the availability and utilization of primary healthcare services in regions exhibiting a disproportionate incidence of advanced-stage cancer cases, and to effectively utilize the resources and capacities present in all societal groups with the aim of mitigating the impact of advanced breast cancer, particularly in regions with elevated levels of poverty (38). The financial vulnerability of women with cancer is often attributed to their limited financial resources and inadequate familial support. According to the findings, female cancer patients tend to experience inadequate familial support and face greater challenges in affording transportation, nursing care, and household cleaning services compared to their male counterparts (39).

Breast cancer incurs substantial costs and has a detrimental impact on the financial status of affected families. Such costs affect a significant portion of families because breast cancer is now managed using multiple treatment modalities (40).

In another investigation, it was found that husbands of women diagnosed with breast cancer encountered financial difficulties in covering medical expenses, as well as the costs associated with supporting their families and children. This resulted in an inequity between income and expenditures. This understanding holds crucial implications for both the patient and their partner (41). A research indicates that various factors impact both marital and overall life satisfaction (42). These factors include the personality traits of spouse, the level of intellectual maturity, the extent of mutual understanding between partners (43), mental stability (44), financial concerns, the level of support within the marriage, the value placed on spouse, the degree of accountability within the relationship, as well as the presence of love, intimacy, passion, and sexual satisfaction. Another research has indicated that breast cancer has an impact on various aspects of a couple's life, including psychological, physical, sexual, social, interpersonal, family, professional and financial dimensions (45). Mushtaq et al. conducted a qualitative study in Pakistan, exploring the challenges breast cancer patients and their spouses face in their intimate and romantic relationships. Intimacy at its worst involves proximity to another individual without consideration for their presence. Breast cancer has been observed to have a negative impact on romantic interaction and intimacy between couples. This is attributed to the emotional instability experienced by patients, which results in reduced sexual activity. (46). Consequently, emotional distress and decreased marital satisfaction among breast cancer patients and their partners were attributed to reduced romantic interaction and intimacy. Moreover, the term "attention" may hold different connotations for males and females. Women experience higher levels of happiness and satisfaction in their intimate relationships compared to men. Conversely, men tend to express the impact of intimate relationships in relation to other functional domains (46).

One of the subcategories examined in the present study was the inclination to separate from one's partner. According to the results of a research, they believed they had reached the end of their shared life. The presence of love, intimacy, and emotional connection is crucial for achieving marital satisfaction among couples. However, it has been observed that some couples experience a deficiency in these fundamental components within their marital relationship (46).

Another subcategory pertains to the sensation of being entrapped in the shared life continuum. A study conducted in Malaysia revealed that women who undergo a mastectomy due to breast cancer experience feelings of incompleteness and unattractiveness. Additionally, they express concern that their physical defects may lead to their husband leaving them (47). According to Esmaili et al. (2013), the provision of support from the patient's family, particularly the spouse, is the foremost requirement expressed by patients following a cancer diagnosis (48). The adaptation strategies employed by female breast cancer patients have an impact on the adaptation of their respective spouses. The utilization of optimism by wives as a mechanism to deal with illness exhibits a negative correlation with the anxiety levels of their spouses. In another qualitative investigation, four communication procedures were employed by couples to manage breast cancer, with both partners engaging in patient improvement participation, patient assistance, family normalization, and modulation or minimization

of cancer perception (49). In Iran, the onset of breast cancer occurred at least a decade later than in developed nations (50). The breast is widely regarded as a symbol of beauty, motherhood, and sexual attractiveness. Consequently, the removal or deformity of the breast, known as mastectomy, can have negative implications for the sexual relationship between couples (51). Patients experience a negative perception of their physical appearance. Furthermore, the patients experience not only psychological ailments but also marital dissatisfaction and a lack of fortitude in their interpersonal connections with their partners (52).

As the limitations of the present study, due to a lack of access to the previous files of cancer-affected women, we were unaware of their prior treatment. Moreover, given the COVID-19 pandemic, certain samples exhibited an insufficient inclination to partake in interviews.

Implications for practice

The results showed need for the husband to pay more attention to the impact of his behavior on his wife; also talking about the problem on the part of the couple is the biggest factor in understanding the support that can be expressed. Also, men and women do not think the same in understanding the needs of their sick partner. Male caregivers are usually less understanding of their spouses. Therefore, health professionals should pay more attention and help men cope with this problem and bear the suffering of their wives.

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Conflicts of interest

The authors declared no conflict of interest.

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