Influence of Spousal Support on the Quality of Life of Women Living with Breast and Gynaecological Cancers in Ibadan, Nigeria

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Abstract

Breast and gynaecological cancers are the commonest cause of death among females (Inoue-Choi, Robien, &Lazovich, 2013). This research was conducted to establish the influence of spousal support on Quality of Life (QoL) of Women Living with Breast and Gynaecological Cancers (WLWBGCs) in a Nigerian tertiary hospital. The study used descriptive cross-sectional design to study 160 WLWBGC purposively selected from the Radiation Oncology unit and the Surgical Outpatients Clinic of the hospital. A structured questionnaire was used to collect relevant data from the participants after obtaining ethical clearance and consent form. The data were analysed using descriptive (mean, standard deviation, and frequency/percent), and inferential statistics (Chi-square) with the aid of Statistical Package for Social Sciences (SPSS) software. The level of significance was taken to be 0.05. The women's QoL was due to the fact that more than half of their population experience poor physical, emotional, social, sexual and spiritual life. Although some of the women received emotional, informational and instrumental support from their spouses, the spousal supports provided did not significantly improve their QoL (X^2 = 2.880, p-v = 1.113). Therefore, since spousal supports did not influence the QoL of WLWBGCs, further studies focusing on improving the QoL of this category of women is therefore recommended.

Keywords: Spousal Support, Quality of Life, Breast cancer, Gynaecological, Women

Introduction

Cancer belongs to the class of diseases that impact severely on the physical health as well as the emotion of the victims (Chittem, 2014). The disease actually disturbs human's daily physical activities, career and social life (Ozkan & Ogce, 2008; Ozkan, Ogce, & Cakir, 2011; Banovcinova, & Baskova, 2016). Diagnosis and treatment of cancer leads to long-term worsened QoL in cancer survivors (Stanton, Rowland, & Ganz,2015). Besides, the diagnosis and treatment procedures synergy affects the QoL of the women. Social support has been viewed as promising solution to the potential associated poor QoL of the patients (Bodenmann, 2011; Badger, Segrin, Hepworth, Pasvogel, Weihs, & Lopez, 2013).

Specifically, breast and gynaecological cancers are the most common cancers in women worldwide having 2.4 million new cases per year (Afolayan, Ibrahim & Ayilara, 2012). Cancer of breast remains the most common cancer in women, while gynaecological cancers come second. Gynaecological cancers include cancers of the cervix, ovary, vagina, vulva, uterine body,and fallopian tubes (Ferlay, Shin, Bray, Forman, Mathers, & Parkin, 2010).Other gynaecological cancers include ovarian, endometrial, and choriocarcinomas (Akinde, Phillips, Oguntunde & Afolayan, 2015).

The diagnosis and treatment of breast and gynaecological cancers disrupts women's functioning ability in a number of ways. This is due to the fact that the diagnosis of breast and gynaecological cancers is a distressing event that affects the physical, psychological functioning, lifestyle and relationships with family and friends (Bloom, Stewart, Oakley-Girvan, Banks, & Shema, 2012). Social support was also shown to be very important in the prevention of anxiety, depression, and other psychological problems, which are commonly

observed in cancer patients. Women therefore need support when coping with the stress associated with the diagnosis and treatment of cancer (Friedman, Kalidas, Elledge, Dulay, Romero, Chang, &Liscum, 2006).

Studies have found that social support is associated with better adjustment to disease and better quality of life (Schulz, & Schwarzer, 2004; Cotter & Lachman, 2010). However, the subjective appropriateness of the support offered is important, especially the one that is received from a soulmate like the spouse (Cotter & Lachman, 2010). However, the QoL which is the extent to which one's usual or expected physical, emotional, social, spiritual and mental well-being is affected by the individual's medical condition is a multi-dimensional concept that defines the person's view and satisfaction with life (Arriba, Fader, Frasure, & Von Gruenigen, 2010). Spouses are regarded as the key sources that play major role within the social network for married women who are living with reproductive system cancers (Schwarzer, Knoll &Rieckmann, 2014). The extent to which a woman's functioning ability is disrupted during stressful situation varies with a number of factors, including the support she receives from her intimate partner (Schwarzer, 2014). The extension of the spousal's emotional support (expression of positive effect, empathic understanding and the encouragement of expressions of feelings, for example, sharing of most private worries and fears), instrumental support (offering of material aid or behavioural assistance, for example, helping in house work) and informational support (offering of advice, information, guidance, or feedback that can provide a solution to a problem, for example, offering suggestions about how to deal with a personal problem) that the women living with these cancers receive can improve their coping attempts thereby, improving the quality of life of these patients (Schulz, & Schwarzer, (2004).

Statement of Problem

Breast and gynaecological cancers kill more women than any other diseases worldwide. Apart from the associated mortality, the quality of life (QoL) of cancer patients is possibly going to be adversely affected. It is believed that the QoL of women with gynaecological cancer is likely to determine their coping and life expectancy. Their diagnoses cause cumulate into greater distress in female patient than any other diseases. Breast and gynaecological cancers affect the reproductive organs which are very critical to marital affairs such as sexual needs, enjoyment and satisfaction. Thus, it can cause frictions in families as well as impairing needed social supports from spouses.

Akso,, due to the fact that complications of cancer disease potentially interfere with the quality of daily activities of the women, it makes the issue of studying their QoL a worthwhile task. Therefore, this study was designed to examine the influence of spousal support on the participants' QoL. There was no evidence of breast and gynaecological cancers in Nigeria either from statistics or literature to make the study worthwhile and enhance knowledge.

Objective of the study

1. To describe the socio-demographic characteristics of the participants
2. To assess the quality of life of the women living with breast and gynaecological cancers
3. To examine the spouses' support for their partners (WLWBGCs)
4. To describe the level of perceived spousal support received by WLWBGCs

Research Questions

1. What are the demographic characteristics of the participants?
2. What is the quality of life of the women living with breast and gynaecological cancers?
3. What is the level of spousal support to their partners (women) living with breast and gynaecological cancers?
4. What is the level of perceived spousal support received by women living with breast and gynaecological cancers?

Hypothesis

1. There is no significant relationship between the level of spousal support provided and the quality of life of women living with breast or gynaecological cancer.

Methodology

The study employed a descriptive correlational design to establish the variance in the QoL of those WLWBGCs who received adequate spousal support, and those who received inadequate spousal support. A total of 160 WLWBGCs attending the Radiology Oncology, and the Surgical Outpatient Clinic of the University College Hospital, Ibadan (UCH), Ibadan were recruited for the study.

Target Population

The target population was the women that were diagnosed and were undergoing treatment or treated for breast and gynaecological cancers in the University College Hospital.

Study Population

The study population was the WLWGCs that were attending the Radiology Oncology and the Surgical Outpatients clinics at University College Hospital, Ibadan. The married WLWBGCs, who were still living with their spouses as at the time of collection of the data, were included in the study. WLWBGCs but who were critically ill at the time of data collection were excluded from the study.

A 4-sectioned structured questionnaire was designed for data collection. Section A elicited the participants' socio-demographic variables, while section B was 23-items adapted from European Organization for Research and Treatment of Cancer's QoL; version 30 (Aaronson, Mattioli, Minton, Weis, Johansen, Dalton, & de Boer, 2014). Each item was answered on a three-point scale, ranging from "Not at all" to "Always". The scores range from 0 to 3.Section C contains 20 items which assessed spousal support available to the participants. This section was adapted from the Social Support Scales (SSS), (Schulz, & Schwarzer, 2004). Responses to each item were scored on 3-point scale, ranging from 0 = "Never" to 3 = "All the time".

The questionnaire was translated by a translator expert to Yoruba language using back-to-back translation for participants who could speak Yoruba language only. The instrument was validated by experienced researchers, gynaecological oncology experts, and statistical analyst following their expert review. The reliability of the instrument was ensured via a pilot study method. Thus, the reliability co-efficient of the instrument was 0.9.

Ethical Considerations

Ethical clearance for the study was obtained from the UI/UCH Ethical Review Committee. Written informed consent was obtained from each participant prior to data collection. Participation in the study was made voluntary. Participants were neither coerced nor exposed to any harm. To ensure confidentiality, participants were attended to privately and the questionnaire did not reflect their names and addresses.

Procedure for data Collection

The data was collected from radiation oncology, and the surgical outpatients units, simultaneously. Thus, two research assistants were recruited (one for each unit). Both research assistants were trained to be familiar with the information in the questionnaire and mode of administration. Data were collected from the purposively-selected participants with the aid of questionnaire. The research assistants helped with the administration and retrieval of the questionnaire. They were to check for proper completeness of the retrieved questionnaires on the spot. Data collection took a period of six (6) weeks to ensure representativeness of the of the sample size.

Method of Data Analysis

The data were analysed descriptively using frequencies/percentages, and inferentially by establishing the difference in the QoL of WLWBGCs based on the adequacy of spousal support available to them using chi-square. The hypothesis was tested at $p < 0.05$ significant level.

RESULTS

Research Question 1: What is the demographic characteristic of the participants?

Table 1: Socio-demographic characteristics (N = 160)

Socio-demographic information	Frequency	Percent
Age		
<20years (Teenagers)	3	1.9
21 - 40 years	149	93.1
41 - 65 years	8	5.0
Level of Education		
Primary	40	25.0
Secondary	68	42.5
Tertiary	36	22.5
No formal education	16	10.0
Occupation		
Employed	53	33.1
Self-employed	48	30.0
Unemployed	22	13.8
Trading	37	23.1
Marital status		
Married	122	76.3
Separated	29	18.1
Singles	9	5.6
Family type		
Monogamy	93	58.1
Polygamy	31	19.4
Did not specify family type	36	22.5
Religion		
Christianity	89	55.6
Islam	60	37.5
Did not specify	11	6.9
Husband's level of education		
No formal education	34	21.3
Primary	36	22.5
Secondary	28	17.5
Tertiary	62	38.8
Husband's occupation		
Employed	95	59.4
Self-employed	20	12.5
Unemployed	29	18.1
Trading	16	10.0

The result of the study showed that the total of one hundred and sixty (160) women participated. The ages of the women ranged from 16 - 65 years. The mean age of the women being 42 years ± 11.2 (standard deviation). In addition, 120 (76.3%) of the patients were married; 93 (58.1%) of the patients were in monogamous family, but 36 (22.5%) did not disclose the type of family they belonged to. 40 (25.0%) and 16 (10.0%) of them had primary and informal education, respectively. Table 1, also showed that 22 (13.8%) were unemployed, while the remaining ones were either employed or self-employed. Furthermore, 89 (55.6%) and 60 (37.5%) of the patients were Christians and Muslims, respectively, while the remaining did not disclose their religious affiliations. In addition, 160 of the participants' spouses, 62 (38.8%) have tertiary education , 95 (59.4%) of the spouses are employed.

Objective 2: To assess the Quality of Life of patients living with Breast and Gynaecological Cancers

Table 3: The quality of life of the Women Living with Breast and Gynaecological Cancers

Nature of QoL	*Poor*	*Good*	*Statistics*					
	N (%)	*N (%)*	*Mean*	*Min.*	*Max.*	*Poor*	*Good*	*Std. D*
Physical QoL	47(29.4)	113(70.6)	4.29	0	12	0-4	>4	2.60
Emotional QoL	70 (43.8)	90(56.2)	7.96	0	15	0-8	>8	3.26
Social QoL	54 (33.8)	106(66.2)	10.23	2	15	2-10	>10	4.11
Sexual QoL	47 (29.4)	113(70.6)	7.22	0	15	0-7	>7	3.84
Spiritual QoL	40 (25.0)	120(75.0)	9.83	0	12	0-10	>10	3.76

Min. = Minimum
Max. = Maximum

Out of the 160 patients studied, 70 (43.8%) had poor emotional quality of life (QoL), while 47 (29.4%) had poor physical and sexual QoL. Besides, 54 (33.8%) poor social QoL, while 47 (29.4%), and 40 (25.0%) were experiencing sexual QoL, and spiritual QoL, respectively.

Research Question 3: What level of spousal supports was available to the WLWBGCs?

Table 4: Spousal Support to Patients Living with Gynaecological Cancers

Spousal Support			Statistics					
	Adequate	Inadequate	*Mean*	*Min.*	*Max.*	*Poor*	*Good*	*Std.D*
Emotional Spousal support	118 (73.8%)	42 (26.2%)	*18.24*	*0*	*24*	*0 –18*	*>18*	*8.52*
Informational Spousal support	118 (73.8%)	42 (26.2%)	*11.28*	*0*	*15*	*0 –11*	*>11*	*5.39*
Instrumental Spousal support	114 (71.2%)	46 (28.8%)	*15.68*	*0*	*21*	*0 – 17*	*>17*	*7.44*

Min. = Minimum
Max. = Maximum

Table 4 summarizes the varying aspects of spousal support to patients living with cancers. Out of the 160 women studied, 42 (26.2%) received inadequate emotional spousal support, and inadequate informational spousal support, while 'Instrumental Spousal Support' was inadequate for 46 (28.8%) women as well.

Research Question 4: What influence did the spousal supports have on the physical, emotional, social, sexual and spiritual life of the WLWBGCs?

Hypothesis: WLWBGCs who received adequate spousal support have significant better QoL than WLWBGCs who received inadequate spousal support.

Spousal Support	QoL		X^2	df		Remark
	Poor	Good				
Inadequate Spousal Support	29 (33.7%)	16 (21.6%)	2.88	1	0.113	Not Significant
Adequate Spousal Support	57 (66.3%)	58 (78.4%)				

Table 5 summarizes the variance QoL between the two categories of WLWBGCs (i.e. those who received adequate spousal support and the other who received inadequate spousal support. Women who received adequate spousal support contributed more to the proportion of those who experienced 'Good QoL' than women who received inadequate spousal support. However, the difference in the QoL experienced by the two categories of women was not significant, statistically (p-value > 0.05).

Discussion

The mean age of the women was 42 years 11.2 (standard deviation). This mean age happens to fall within the reproductive age and it contributes largely to the work force. The World Health Organization takes the reproductive age of women to be 15 – 49 years. However, a previous study had shown that the mean age of women suffering from breast or gynaecological cancers was 54years (Evse et al, 2014).The current study is similar to a study that reported women age to be 40 years having breast cancer (Lawrence, Perez, Hernández, Miller, Haas, Irie, &Villén, 2015). This is an indication for effective and timely cancer screening programmes for all women.

In this study, over one-quarter (29.4%) of the women experienced poor sexual QoL due to the fact that the women feel less of a woman (less feminine) and not satisfied with their present sexual life. It has been reported earlier that

female sexuality is usually affected more negatively and such sexual problems continue for a longer time in breast and gynaecological cancers than in other cancer types and chronic diseases (Errihani et al, 2010). Also, similar to the study is a report that female cancer patients engage in fewer sexual behaviours and experience lower levels of sexual arousal than healthy women (Emilee, Ussher, &Perz, 2010). This is indicating that more than a quarter of the women treated with breast or gynaecological cancers have depreciated quality of reproductive life which may affect home and increase rate of divorce in the society. Nevertheless, the spiritual life, which searches and sustains meaning for living of the women is equally poor due to the fact that one quarter of the women's population (25%)'s quality of spiritual life is low. This denotes that the women may be hopeless of their condition, may not find meaning in living and loss faith in God despite the fact that the study revealed that majority of the women are religious. This was in contrast with a study on the quality of spiritual life of women living with gynaecological cancers, that was reported that the spiritual was found to be the highest mean which was due to the fact that the women were praying, visiting mosques, attending religious meetings/institutions, and having positive thoughts which was quite effective in increasing the patients' spiritual wellbeing (Akyuz et al, 2015).

Furthermore, it was discovered in the study that spousal support has negative effect on the QoL of the WLWBGCs. This was contrary to Lepore & Revenson, (2014) who said that spouses are the main source of support for the majority of chronically-ill patients. Surprisingly, it was found in the study that those women who received adequate spousal support experience poor quality of life. This could have been that the women were over-pampered, too dependent and could not get out of their weakness or hysteria. From this, it was suggested that we use expo facto as our design and come up with the role played by spousal support in QoL of women living with cancers.

Summary

Limitation of the study

The study can be generalized to all the WLWBGCs in UCH but replication of the study in other settings may be required.

Conclusion

The research study was on the influence of spousal support on the quality of life of WLWBGCs in the University College Hospital (U.C.H), Ibadan, Nigeria. The findings from the study revealed that the QoL of the WLWBGCs in UCH is poor as evident by the reported poor physical, emotional, social, sexual and spiritual life. The spouses of these women provided emotional, informational and instrumental support to these women, although it was inadequate. However, these supports did not in any way improve their QoL significantly. Meanwhile, those who did not receive spousal support but experienced good QoL could have been that they were able to adapt as a result of other factors. This could be an indication for further studies.

Recommendations

In this study, spousal support for the WLWBGCs did not significantly improve their QoL. Probably, the women may benefit from other forms of social or economic supports. This calls for further studies. Meanwhile, the stakeholders should find a way of improving the QoL of the WLWBGCs through varying intervention programmes as deemed appropriate, particularly, now that this study has reported insufficiency of spousal support in the improvement of QoL of this category of women.

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