



PSYCHOSOCIAL CHALLENGES AFFECTING WOMEN SURVIVORS OF BREAST CANCER. A CASE OF GWERU, ZIMBABWE

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Abstract

This qualitative study explored the psychosocial challenges affecting women survivors of breast cancer in Gweru Urban through identifying the psychological and social challenges affecting their survivorship, examining the factors influencing their survivorship outcomes and exploring the possible impacts of psychosocial morbidity. Non-probability sampling methods were utilised; namely purposive and snowball sampling, in selecting professional respondents and study participants respectively. Data were gathered through conducting semi-structured interviews with 10 female participants within a three week duration. 3 key informants from Claybank Private Hospital, Gweru Provincial Hospital and Gweru District Hospital also partook in the interviews. The study established that women diagnosed with breast cancer experience psychological and social challenges throughout their survivorship. Anxiety, fear and depression were among the foremost psychological challenges discussed in the research, whilst social challenges included poor adjustment to gender and professional roles and social anxiety; amongst others. Another imperative outcome of the research was that survivorship outcomes were influenced by socio-economic aspects such as marriage, employment, availability of local support systems/resources, societal beliefs and individual beliefs regarding the disease. The study concluded that the psychosocial concerns that distress breast cancer survivors emanate from the unavoidable challenges that cancer poses to livelihoods and also the individual's discernment of what it means to be a cancer survivor. An imperative recommendation was the need for non-governmental health organisations across Zimbabwe to fill in the gaps left by governmental health institutions in order to cooperatively address the unique survivorship demands of the breast cancer community in Gweru.

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Introduction

Breast cancer is the most diagnosed cancer among women worldwide. According to the World Health Organisation (2015), breast cancer frequently affects over 1.5 million women each year. Widespread improvement in early detection, diagnosis and medical treatment for breast cancer has been beneficial to women in expanding their odds of survivorship (American Institute for Cancer Research, 2014). In the United States of America, it is estimated that there are currently 3.1 million breast cancer survivors (WHO, 2015). However, breast cancer survivors are at an increased risk to a plethora of psychosocial issues that frequently affect their emotional, cognitive and physical functioning even for years after successful treatment of the disease.

Over the decade, extraordinary advances have been made in breast cancer treatment which has presented women with greater prospects of cure and an increment in life expectancy. According to Rahman (2014) cancer deaths are due to fall dramatically by 2030, with many more people expected to survive. However, this doesn't mean women diagnosed with breast cancer are completely exonerated from the late psychosocial and physiological impacts that are associated with it. There is a general scholarly agreement in the discourse of breast cancer that a number of substantial concerns arise in women even after completion of treatment; regarding physical limitations, emotional worries regarding the future, challenges to lifestyle and career, and relationship/intimacy problems.

The experience of being diagnosed and treated of breast cancer often results in impairment in multiple areas of a person's psychosocial well-being, which includes physical, social and emotional functioning (Beatty, Oxlad, Koczwara, & Wade, 2008). According to Ganz et al. (2011), the earliest studies on the psychological impact of breast cancer on female survivors were focused on its attack on femininity as a result of surgical removal of the affected breast in women who undergo mastectomy. Surgery has been known to affect survivors of breast cancer as it poses a subsequent threat to sexual attractiveness and appeal. The stress of breast cancer is also described as stimulating psychological concerns such as depression, anxiety, and anger.

Furthermore, psychological distress due to the life-threatening nature of cancer is a prominent outcome.

Although the lowest incidence rates of breast cancer are generally found in most African countries, the rate of survival in these countries is much lower compared to other developed countries. This has been arguably accounted to insufficient support systems and structures and negative indigenous beliefs and perceptions regarding the disease and its implications. Breast cancer survival rates range from 80% or over in North America, Sweden and Japan to around 60% in middle-income countries and below 40% in low-income countries (Coleman et al., 2008). The figures are much lower in sub-Saharan Africa. Lower survival rates in less developed countries are a result of a variety of factors which include the lack of early detection programmes, resulting in a high proportion of women presenting with late-stage disease, as well as the lack of adequate diagnosis, treatment and survivorship facilities and care.

According to Muliira, Salas, and O'Brien (2017), a multiplicity of factors can affect health-related Quality of Life (QOL) in most African women with gynaecological cancers (breast, cervix, ovary, and uterus). These may include the woman's socio-demographic status such as age, marital status, education, occupation, and income. Furthermore, Quality of Life may be affected by the physical characteristics of the cancer and the stage of its progression. Side effects of breast cancer treatment (surgery, chemotherapy, and radiotherapy) are known to leave patients with physical difficulties, psychological and sexual dysfunctions, body image disturbances, hormonal changes, and in some cases fear over childbearing potential, which could have a central impact on their health-related Quality of Life.

Muliira et al. (2017), points out that Quality of Life has been broadly deliberated among cancer populations in developed countries, where there is availability of cancer care resources. However, little is known regarding the health-related Quality of Life of cancer groups in developing Africa where resources can be infrequent. There is limited research available that primarily focuses on the influential factors impacting the survivorship outcomes of women and their overall Quality of Life. Nevertheless, the few studies available seem to underline that participants have very little psychosocial support and score very low on the Quality of Life tools in the psychological domain (Muliira et al., 2017). Single persons are more predicted to develop cancer as they postpone medical consults and the beginning of treatment, having lower

survival rate after finding the diagnosis (Marian & Filimon, 2011). Understanding Quality of Life among female patients with breast cancer in the African context can provide information concerning key areas of care that are in need of improvement in-order to subsequently ease suffering among cancer patients and survivors.

In Zimbabwe, breast cancer is the second most common cancer among women after cancer of the cervix. According to the National Cancer Registry (2014), 7,000 women are diagnosed with breast cancer annually. Like most developing countries in Africa, Zimbabwe has a majority of cancer patients who are likely to transition to a survivorship phase after treatment, with little information or follow-up support specifically related to cancer survivorship. Therefore, the bulk of breast cancer survivors in developing countries like Zimbabwe remain unaware of the preexisting post-treatment risks and the options available for managing them. This increases their vulnerability to both psychological and social dysfunctions during their attempt to readjust their lives.

In Gweru, socio-cultural and economic factors may also play a role in the survivorship outcomes of breast cancer survivors. Women are more likely to suffer poor post-treatment health-related Quality of Life. They are less likely to adequately receive the necessary surveillance, follow-up care, including survivorship information compared to their counterparts in developed cities. Many of their concerns related to treatment and survivorship affect other family members and associates. The most consistent recommendation of qualitative research exploring this context, has been the increased awareness of the growing need to provide access to patient navigators, counsellors, and support groups for breast cancer patients and survivors in Zimbabwe.

Aim

The study sought to investigate the psychological and social challenges that affect women survivors of breast cancer.

Objectives of the study

The study sought to:

- i. Identify psychological challenges affecting women survivors of breast cancer.

- ii. Ascertain the social challenges affecting women survivors of breast cancer.
- iii. Examine the factors influencing survivorship outcomes in women survivors of breast cancer.
- iv. Explore possible impacts of psychosocial morbidity on women survivors of breast cancer.

Method

Population

The target population for the study comprised of breast cancer survivors who were women aged between 30 and 80 years and had successfully gone through a minimum period of one year without experiencing cancer recurrence from the time of their initial treatment. The target population also incorporated professional health care employees from local health care institutions working with or who had encountered breast cancer survivors. A total of 10 women participated in the study.

Sample and sampling technique

The study exploited two non-probability sampling techniques namely snowball and purposive sampling methods. Snowball sampling which can also be termed referral sampling was utilized in the selection of respondents from the breast cancer community in Gweru. This method yields a study sample through referrals made among people who share the same experience or who know of others possessing the target characteristics that are of interest to the researcher. According to Curtis et al. (2000) it begins with an index individual who is identified as having the key characteristics required by the research design. The individual is asked to nominate others with similar characteristics. The nominated individuals will therefore constitute a second wave of data collection and so on. It was most applicable for this study since the characteristics of the desired sample population were implicit. Through this method, a satisfactory sample size of 12 participants was reached.

Purposive sampling was also utilized in the selection of professional respondents from local health care institutions in Gweru. Through judgmental sampling, the researcher managed to select 3 professional respondents, one each from Gweru District Hospital, Claybank Private Hospital and Gweru

Provincial Hospital. These respondents consisted of qualified personnel who had knowledge of breast cancer diagnosis, treatment and survivorship, who could provide sophisticated information about cancer to shed more light on the dynamic factors influencing survivorship outcomes and the current status of follow-up support and surveillance for breast cancer survivors in Gweru. Overall, the researcher used purposive sampling because it required a considerably small sample and targeted only those individuals relevant to the subject under study. Thus it was cost and time efficient.

Data gathering instrument

The researchers conducted semi-structured interviews through the support of an interview guide in order to obtain information from breast cancer survivors and health care personnel. According to Polak and Green (2016), semi-structured interviews involve the researcher wanting to find out more about a specific topic or area of interest without there being a strict preconceived plan. The interviewer in a semi-structured interview generally has a framework of themes to be explored and this method is open, allowing new ideas to be brought up during the interview as a result of what the interviewee says (Edwards & Holland, 2013). The use of semi-structured interviews allowed the discussion to cover a considerable number of areas which were originally outside the scope of the study however beneficial to the overall research. Such areas of concern included knowledge of dietary and lifestyle implications. The use of in-depth interviews was particularly rewarding since secondary research on the topic was limited, thus the researcher relied heavily on the primary data generated in interviews.

Design

The qualitative paradigm was employed as the best approach for the purpose of this research. This was achieved specifically through the phenomenological research design. According to Collins English Dictionary (1991) phenomenological research design is a qualitative research design focusing on the detailed description of conscious experiences by examining an individual's unique experiences. Phenomenological research provided the basic foundation that allowed the researcher to get an unbiased and well informed view of participants' personal challenges and experiences with breast cancer

survivorship and the resultant impacts these challenges posed on their psychosocial wellbeing and overall health-related Quality of Life.

Data analysis

The research utilized narrative analysis in order to interpret data obtained from interviews. Narrative analysis is a qualitative inquiry that focuses on the stories and encounters shared by participants on their life experiences. According to Patton (2014) narrative analyses involve the interpretation of the story told, placing it in context and comparing it with other stories shared by participants. Consequently, it was important for the researcher to pay particular attention to how the narratives were conveyed in line with the research questions in order to grasp emerging similarities, differences, and key themes that were of relative importance in addressing the study objectives and making substantial conclusions about the participants.

Results and discussion

The results of this study showed that women who survived breast cancer experienced a considerable number of psychosocial strains in the process of readjusting their lives and the experience significantly differed depending on a number of variables which include age, marital and economic status (*see* Table 1).

Table 1. Summary of socio-demographic information of interviewees

Name*	Age	Occupation	Marital Status	Fam/ Size	Diagnosis Year	Treatment Option
1. Chipo	35	Teacher	Married	4	2017	<ul style="list-style-type: none"> • Mastectomy • Chemotherapy • Radio-therapy
2. Mary	50	Teacher	Married	8	2011	<ul style="list-style-type: none"> • Chemotherapy
3. Jane	56	Lecturer	Married	8	2003	<ul style="list-style-type: none"> • Chemotherapy
4. Judith	47	Teacher	Married	4	2012	<ul style="list-style-type: none"> • Chemotherapy • Radio-therapy
5. Agnes	46	Unemployed	Widowed	5	2016	<ul style="list-style-type: none"> • Chemotherapy • Radio-therapy • Herbal
6. Rumbi	80	Unemployed	Married	5	2004	<ul style="list-style-type: none"> • Mastectomy • Chemotherapy

Table 1. Summary of socio-demographic information of interviewees - *continued*

Name*	Age	Occupation	Marital Status	Fam/ Size	Diagnosis Year	Treatment Option
7. Edith	48	Unemployed	Married	6	2015	<ul style="list-style-type: none"> • Mastectomy • Chemotherapy
8. Sarah	75	Retired	Widowed	4	2006	<ul style="list-style-type: none"> • Mastectomy • Chemotherapy
9. Pretty	40	Teacher	Married	5	2016	<ul style="list-style-type: none"> • Mastectomy • Chemotherapy
10. Fadzi	38	Self Employed	Widowed	5	2015	<ul style="list-style-type: none"> • Mastectomy • Chemotherapy

Note: * Pseudonym

Psychological challenges in survivorship

Psychological anxiety

The most consistent of the psychological challenges reported by interviewees was anxiety. All the 10 respondents (100%), agreed to having experienced anxiety at some point during their survivorship. Eight (80%) of the ten respondents interviewed agreed to experiencing general post-traumatic stress during their transition from patients to survivors. And only 20% exhibited probable signs of major depressive disorder. Chipu expressed that:

“The experience of surviving breast cancer is painful and stressful, especially considering that cancer has no cure and the available treatment options are painful and costly. The uncertainty of not knowing whether I am going to heal or recover is very stressful”.

In addition, Mary expressed that:

“At first I was in denial. I contemplated death. I could not take it. I was afraid since most of the people I knew who had suffered cancer had passed away due to the disease. Furthermore, cancer is associated with many misconceptions so I continue to experience fear and anxiety sometimes”.

A collective assessment of the narratives indicated that cancer survivorship commonly exhibited in respondents; anxiety as a dominant psychological concern. Post-traumatic stress disorder (PTSD) was propagated by the uncertainty of survival outcomes, pre-existing misconceptions about the nature of the disease and the pain endured in the experience. These findings strongly correlated with the conclusions made by the American Cancer Society

(2017) that women diagnosed with breast cancer may experience psychological challenges years further into their survivorship.

Paranoia/Fear

Fear or paranoia was consistently noted in 9 (90%) of the respondents. When asked about possible causes of fear or paranoia during cancer survivorship, 4 (40%) of the participants expressed that their fear was centred on the process of going through painful treatment procedures and its resultant psychological effects. 2 (20%) expressed that it was centred on the financial costs of treatment and disruptions to one's life and the lives of family and friends. 3 (30%) expressed that it was due to uncertainty of not knowing what the future held, and the possibility of death. The fear of recurrence was evident in 9 (90%) of the respondents. It also affected even the majority of respondents who had undergone successful surgery and were at most; satisfied with their treatment results. The paranoia was centred on whether they were completely free of the disease or otherwise still in the line of danger. Fadzi shared that:

“Currently I have a growing fear that my cancer, though successfully treated, will come back again. I have often heard people saying chances of survival are slim if it recurs. I also fear for the future of my children since I am widowed and informally employed and therefore I rely on inconsistent income”.

Agnes noted that:

“I worry that I do not have enough collective support from relatives since my husband died. I have four children who need to be taken care of and at the same time I am currently unemployed. Sometimes I also fear that cancer will affect my other breast or some part of my body and I will have to go through the stressful and grievous process of treatment again”.

The researcher also noted a significant relationship between a participant's level of paranoia and her prevalent income status. Fear, as a psychological challenge was more intensified in 3 (30%) of the ten respondents interviewed who were unemployed during the time of research which would imply that a lack of adequate income and financial support fuelled paranoia amongst this group of participants. There was also evidence that fear emanated from the possibility of separation from a partner or divorce. Although 7 (70%) of the married participants seemed to be content with the agreement that their partners or spouses were at most supportive of their survivorship experience,

they were at the same time seemingly paranoid regarding the security of their marriages as a result of the psychological turmoil it had on their partners.

Major depressive disorder

The study results indicated that serious psychosocial distress was evident in 2 (20%) of the participants; which would imply that major depressive disorder was less common in the late stages of survival. Two respondents, namely Edith and Agnes, exhibited signs of major depressive disorder in their narratives, overall expressions and behaviour. Edith expressed that:

“Breast cancer robbed me of my womanhood. I am missing an essential part of my body. I am not proud about myself even if I am getting treatment. I feel hopeless”.

Agnes expressed that:

“I started being ill after cancer treatment. Everything has changed and I often feel very weak and incapacitated. I feel as if I am not myself because I have experienced a lot of problems during my treatment. I feel like I am not worthy of living”.

Other respondents did not exhibit similar levels of psychological distress as Agnes and Edith leading to the researcher implying that depression was generally uncommon and unpopular in the late stages of survivorship. Similar research carried out by Smith in 2009 showed corresponding results. His study indicated that about 10% of cancer patients who had survived 5 or more years after treatment developed depression. A significant outcome of the research was that depressive symptoms were more prominent in women who were struggling economically or who had experienced unsatisfactory treatment outcomes indicating that the development of depression in breast cancer survivors was often influenced by other medical and socio-economic aspects. Agnes and Edith had previously suffered complicated treatments which further worsened their physiological and psychological functioning.

Insecurity

A negative body image and low self-esteem was a common occurrence in the majority of participants. 6 (60%) of the respondents were open with their feelings and shared that the treatment procedures had left them more insecure

about their physical appearance than the average woman. Insecurity and low self-esteem were significantly influenced by how other close relatives and people beheld the respondents; especially after treatment. Respondents brought up significant challenges such as issues of femininity which include physical attractiveness and appeal to the opposite sex. Chipso indicated that:

“As a woman who is still young I sometimes feel insecure about my body since I was subjected to three treatment procedures namely chemotherapy, radiotherapy and mastectomy which really took a toll on my physical appearance. As you can see my skin has darkened in some areas as a result of a combination of these. I always wonder how my husband sees me and whether he still finds me attractive now that my bust is disfigured”.

Fadzi shared that:

“I sometimes have hopes of pursuing a relationship since I am still young though widowed. But I don’t think guys are ready to deal with a woman who is surviving cancer. I feel self-conscious about how people see me and whether they will accept me, disfigured as I am. So I have accepted my position and fate”.

The results implied that various treatments used for breast cancer potentially resulted in post-treatment physical and emotional effects that impacted women’s view of their bodies and sexuality. However, the study results also indicated that treatment and surgery were not always directly responsible for the development of these feelings. Partners and close friends also played a pivotal role in directly influencing feelings of insecurity and low self-esteem amongst patients. Meaning there was a significant relationship between people’s attitudes towards respondents and the degree or level of insecurity that the patient projected.

Social challenges in survivorship

Intimacy

7 (70%) of the participants expressed that sexual intimacy was a common interpersonal challenge that negatively impacted on survivorship and quality of life. This was largely due to the adverse side effects of common treatments such as chemotherapy and mastectomy (which is partial or complete removal of the cancerous breast during surgery). Results indicated that in most cases, intimacy issues affected both partners in different manners. The

darkening of skin as a result of chemotherapy was a common concern for the majority of participants and this negatively influenced their willingness to sexually engage with their partners. According to Chipso:

“...it affects your sexual life up to the point that your desires and feelings towards your partner are reduced. The husband sometimes tries to adjust to the situation, but it’s a struggle. After my treatment I was left with permanent dark marks around my chest and at times I do not feel comfortable with my husband seeing me like that”.

Mary expressed that:

“My husband was affected and it also affected me because he could not touch my breast during intimacy. I could feel that my husband kept a physical distance from me. Sometimes I would just ignore. I thought he regarded me as handicapped. He no longer got closer to me as he used to before surgery”.

On average, although partners were generally supportive, most spouses were sexually detached from their wives and required long-term adjustment to the situation. This finding influenced the assumption that mastectomy as a treatment option was largely significant in inducing the negative attitudes of women and their partners towards sexual intimacy. This strongly coincided with the assertion made by the American Cancer Society in 2017 that concerns about sexuality arise after treatment of breast cancer and they are relatively more acute in women who have undergone mastectomy, since the loss of a breast may compromise physical and sexual appeal. However, interview results also indicated that in most cases, intimacy issues also affected partners and spouses and this further influenced the attitudes of women regarding sex. The more deleterious a partner’s response, the more difficult it was for the woman to feel confident about her sexuality.

Social anxiety

There was a unanimous agreement among study participants that breast cancer survivorship negatively impacted on social interaction and adjustment especially in traditional Zimbabwe where breast cancer was still tightly knitted into traditional beliefs systems and was subject to prejudice and various acuties. Hence, social anxiety in survivors was influenced by a growing fear of being negatively judged by others in social situations or fear of public

embarrassment. Most of the participants expressed their fear of being seen in public places such as at the workplace and church. Judith indicated that:

“The people around me took me as a sick and dying person. They over sympathised with me to the point that I felt useless and more withdrawn. Some even say HIV is better than cancer and view cancer as a death sentence. To them, I was already dead. This makes me want to avoid socialising with work friends because they were bound to inquire a lot about my predicament and impose their judgement and view on me”.

Chipo also added that:

“You feel as if all people are looking at you and maybe they can see that you have one breast. I am uncomfortable in public places sometimes like church gatherings and recreational functions. You feel that your body has changed and everyone can see that something is missing on you. It’s really uncomfortable sometimes”.

The narratives revealed that social anxiety was propagated by fear of alienation and society’s prejudice. This was in agreement to Muliira et al. (2017) study that indicated that social anxiety disorder can be experienced in cases where there is a growing fear of being negatively judged by others in social situations or a fear of public embarrassment such as in traditional Africa. Cancer survivors had a constant fear of being negatively stereotyped as HIV positive or *walking tombstones*. Furthermore, Muthoni and Miller (2010) view that women from African cultures believed that breast cancer was caused by witchcraft, substantially contradicted with the findings of this study. This group of women did not rule out the existence of witchcraft but nonetheless stated that the two were not related. This might have been principally due to the fact that they had a relatively higher level of formal education and had better access to mainstream information on breast cancer which largely gave them a less superstitious and traditional view of the disease.

Occupation/Professional roles

The commonly identified problems at the workplace were fatigue and psychosocial stress. 50% of the respondents who were employed agreed that there was a significant degree of incapacitation and disconnection during their engagement in routine work activities that was influenced by a combination of physical and emotional dysfunctions. Some participants completely disregarded

tasks that they used to engage in on a daily basis such as entrepreneurial ventures. However, most of the formally employed majority retained their occupations but significantly adjusted their work routine. Judith added that:

“I stopped being a cross-border trader since I was not supposed to carry heavy loads especially with my left arm which was affected by the treatment. Sometimes I need three days of rest from the workplace because I quickly get stressed and tired”.

Chipo also expressed that:

“Yes, treatment has affected my performance at work. There is a lot of absenteeism from work. This is because the treatment is not a one-time thing. After treatment you need to rest because you will be very weak. Radiotherapy is done for 4 weeks on a daily basis meaning to say that work is affected. Being away from work and home is disturbing and it stresses you a lot. Sometimes I really miss my family and workmates”.

The results indicated an agreement with Bardwell et al. (2003) who encountered similar findings and agreed that the impact of cancer-related fatigue on health-related Quality of Life was substantial, reducing the patient's engagement in work, personal and social activity. The researcher also noted that poor work performance was potentially influenced by the attitudes of other employees towards the respondents. Some of the respondents indicated a negative change in the way they socialised with fellow workmates; especially those who were pessimistic in their view of the disease. Jane, who was a lecturer, indicated that a supportive work environment was necessary for survivors who were employed since it sped up the adjustment and healing process.

Domestic/Gender roles

The research results indicated that 6 (60%) of the 7 women who were housewives agreed that treatment induced fatigue had a significant impact on their ability to undertake day to day household tasks and other domestic chores in order to attend to their families. Roles such as cooking and tidying were the most affected since participants were cautioned by their medical personnel not to expose themselves to heat and dusty environments for prolonged periods of time. Judith shared the view that:

“Yes, breast cancer affected my domestic roles as a woman, such as cooking, carrying heavy things. The doctor said I am supposed to stay away from heat sources. I stopped working as a cross boarder trader since I was not supposed to engage in heavy duties or carrying heavy loads especially using my left arm”.

The research gathered that experiencing fatigue was particularly challenging since most of the married participants had generally large family sizes ranging from 4 to 8 members and this consequently resulted in their inability to perform their tasks effectively because of physical weakness. This was further supported by a professional respondent from Claybank who pointed out that breast cancer severely affected the domestic functions of most women since radical treatment options like mastectomy resulted in the extensive damage of arm muscles and nerves; incapacitating most women.

“Women’s gender roles and responsibilities are significantly affected by surgery. Radical treatment methods such as mastectomy can really affect a woman’s physical competitiveness; inhibiting her from doing even the simplest of tasks like carrying a handbag or a shopping bag. Some women also complain of feeling too tired for sexual intimacy” - Claybank Private Hospital.

The results were consistent with Hafiz and Banning (2009) studies carried out in Pakistan Muslim women which discovered that experiencing fatigue can be particularly challenging for women with extended families resulting in their inability to perform efficiently because of physical weakness.

Factors influencing survivorship outcomes

Availability of institutional support systems

Generally, all 10 (100%) participants seemed sure about the current status of cancer care institutions in Gweru, as the majority of the responses were punctuated with, *“There are no support institutions dedicated to breast cancer survivors in Gweru.”* There was relative agreement that limited psychosocial support structures for female breast cancer survivors in Gweru influenced the women’s overall survival outcomes. It was discovered most of the women’s professional support was received from general health care facilities such as the three local hospitals included in the scope of the study. Support was largely given during the treatment period and hardly extended into survivorship. Chipo pointed out that:

“There are no cancer care institutions in Gweru. Most of the institutions are in Bulawayo and Harare. I have never received any follow-up support in Gweru after my treatment at Dr Kadumbo’s surgery. My support comes only from relatives and fellow breast cancer survivors”.

Jane also indicated that:

“There is no dedicated organization that offers psychosocial support to cancer survivors in Gweru. In actual fact we support each other since we are coming up as conquerors and we also help those who have been diagnosed and are in need of help”.

The results concurred with Woodward (2015) findings which linked psychosocial morbidity in breast cancer survivors to factors such as availability of support systems, beliefs and culture and socioeconomic status, and Muliira et al. (2017) Afrocentric research which pointed the issue of limited cancer support structures being available for female survivors in Africa resulting in the presentation of late psychosocial problems. However, regardless of the current state of institutional cancer care support in Gweru, 8 (80%) of respondents were fairly satisfied with the domestic support they were getting from relatives and friends. Hence, inadequate professional support and intervention may have resulted in lack of survivorship information dissemination amongst cancer survivors who were unemployed since the majority of respondents exhibited baseline knowledge of dietary changes, medical and lifestyle requirements since they were formally employed and had access to information from their respective workplaces and associates.

Socio-economic status: Employment/income status

Results revealed significant distinctions in the manner in which employed and unemployed participants responded to breast cancer survivorship, indicating that the income status of women influenced their ultimate survivorship outcomes to a marginable extent. 3 (30%) of the cancer survivors who were unemployed housewives expressed lower scores in cognitive and emotional functioning compared to those who were formally employed. Agnes indicated that:

“...I am stressed because I can’t do my business. I don’t have anywhere to start from because I no longer work as I used to. After diagnosis my relatives and friends stopped communicating with me and assisting me financially. I have

children who are going to school but I don't have enough money to support them and it worries me a lot. The little money I get is spent on drugs and regular hospital visits. I have not been formally employed".

Contrastingly, Judith expressed that:

"My workmates have supported me. They share ideas with me. They give me financial support and some buy drugs and medication for me. Some of my workmates have invited me to their churches to pray and share information. This has positively influenced my survivorship experience".

The reality was that the respondents who were economically stable were more positive in their perception of life and survivorship compared to their unemployed counterparts. Generally, being employed created financial stability which in turn made the disease more bearable. Rahman (2014) study also revealed that a majority (80%) of cancer survivors, who are unemployed housewives, expressed poor scores in cognitive and emotional functioning compared to those who were formally employed. The acceptable certainty was that due to a favourable income status, women who were employed were more positive and optimistic in their general perception of life as cancer survivors when compared to their unemployed counterparts. This implied that a lack of financial income significantly worsened the survivorship experience since women were unable to cope with the pressure to fend for their families at the same time continuing with the costly prescription.

Marital/Relationship status

All 7 (70%) married participants described feeling positive about the survivorship experience suggesting that married women had higher optimism scores than their unmarried counterparts, which translates to significant reduction in the possibility of unsatisfactory survivorship outcomes amongst married women. Most women expressed that their husband supported them financially, emotionally and physically. The three respondents who were widowed, Agnes, Sarah, and Fadzi exhibited more worries about their survivorship outcomes compared to the other seven who were married. Agnes expressed that:

"Being widowed has worked against me because if my husband was alive he would have stood by me because he loved me and he was a caring father. Being

married is beneficial because you can share the burden and get advice and support from your husband”.

Contrastingly, Mary indicated that:

“I am very optimistic about my future as a breast cancer survivor. Being loved by my husband the way I am has really motivated me to appreciate life more. My husband buys me the medication that I require so he has lessened the financial burden”.

The common view amongst respondents was that a spouse’s positive emotional and financial support was more personal, effective and comforting compared to any other external support rendered. Two of the professional respondents interviewed from Claybank and Gweru Provincial hospitals also indicated that it was advisable for patients to bring their partners along when reporting for treatment or counselling since it lessened the emotional burden. They also pointed out that spouses needed information on how to take care of their wives who were experiencing breast cancer.

“I have observed that most of the women who report for check-ups with their husbands seem to be more positive and optimistic about their overall recovery. I think marriage plays a vital role in how patients relate to the disease. Marriage creates an immediate and personal support structure that has more benefits to women and their ultimate survivorship” - Gweru Provincial Hospital

Comparatively, Croft et al. (2014) Eurocentric study suggested married women had higher optimism scores than their unmarried counterparts, which translated to significant reduction in the possibility of prolonged psychosocial morbidity amongst married women. Hence, Croft et al. (2014) deductions significantly correlated with this study’s outcomes. The presentation of major psychosocial challenges such as depression, social anxiety and isolation were much lower in married women than would be evident otherwise. Psycho-social factors have a modular effect on the course of the disease. Supportive social relations have a buffer effect, counter balancing the effects of the stress on immunity, owed to cancer, the result being the reconstruction of immune mechanisms which are important in the resistance to cancer (Levy, Herberman, Sanzo, Lee, & Kirkood, 1990).

Associated beliefs

When asked about their presumptions regarding breast cancer survivorship, 6 (60%) of participants believed that breast cancer diagnosis was a kind of death sentence while 4(40%) believed it consequentially resulted in divorce or separation from a spouse. These two beliefs were generally consistent amongst most of the respondents, implying that women surviving breast cancer were entitled to unique beliefs and perceptions that presumably affected their survivorship outcomes. One woman expressed that cancer was more difficult to bear for married men and they were bound to divorce or leave you eventually.

“When I was diagnosed of breast cancer I was very afraid of dying and living my children and husband. Initially I believed my husband would leave me for another woman” - Chipo

“It is better to be diagnosed with breast cancer before marriage because when married you may feel your partner is going to leave or neglect you and no longer regard you as valuable. Men are afraid of cancer and what surrounds it. Most of them bail” - Judith

“My parents had no hope and they commented that there was no life after surgery. This exacerbated my fear and belief that I was destined to die and sometimes I was scared to visit the hospital for my regular check-ups” - Mary

A professional respondent from Gweru District Hospital further pointed out that people’s beliefs influenced their behaviours in coping with breast cancer. He indicated that although a majority of patients were reporting to the hospital for treatment and access to information regarding survivorship, there was still a significant shortfall in the number of people who sought professional help because some believed that cancer was only treatable by traditional methods. These findings were largely congruent with Scheel et al. (2017) conclusion that cross-cultural studies on beliefs showed common themes including fear related to treatment and isolation or separation (divorce). However, results did not show any conclusive evidence to some of the individual themes propounded by Scheel, such as the belief that cancer is a punishment from God or a supernatural act.

Individual perception

There were two distinct opinions expressed by the group of women in this study, those who found breast cancer life threatening and serious and those

who thought breast cancer was an obstacle that could be dealt with as long as one carried a positive outlook towards life. 7 (70%) of the women who had experienced a steady recovery facilitated by an availability of funds and timely treatment found the severity of breast cancer less daunting, whereas 3 (30%) of the women who had struggled with the disease either financially or physically had a less positive outlook of breast cancer survivorship. One woman expressed how she felt optimistic about life and felt that she had actually achieved the recovery status she had hoped for.

“I am very optimistic about life. I have recovered well. I can do my domestic duties and I can go to work even during church gatherings I mix well with others. I am looking forward to growing old and seeing my grandchildren when my son gets married” - Judith

This implied that survivors who exhibited a pessimistic view of the disease were more prone to cognitive and emotional dysfunction for years following treatment, compared to optimistic counterparts. Although most of the participants were optimistic about their recovery and survivorship, Tsitsi and Agnes were less optimistic and less hopeful about their recovery. Tsitsi shared that:

“I am not proud of or satisfied with the treatment. I am not anticipating recovery. I was not given enough information about breast cancer treatment prior to my surgery. I am experiencing so much pain and people keep telling me that cancer cannot be cured. I am anxious it might recur”.

Agnes argued that the lack of adequate information about the available treatment options severely disadvantaged her during the period of her diagnosis. She stated that she had no idea she had the right to choose the best treatment option of her choice. She only realised that when it was too late. She expressed the view that:

“I am not hopeful about myself being a survivor and I have a lot of questions about my condition. I don't see myself surviving for a long time as a cancer survivor. I was not provided with enough information about the available treatment options by my doctor who first diagnosed me. I am not satisfied that the treatment I am taking currently will yield any positive results”.

Agnes and Tsitsi's narratives strongly validated the view that a patient's experience with breast cancer treatment affected their survivorship outcomes

even for years after the treatment. Participants also felt that breast cancer and its outcomes all depended on one's positivity and general outlook in life. This finding correlated with Mazanek et al. (2010) research which generated results indicating that survivors who exhibited a pessimistic view of their condition were more prone to poorer survivorship outcomes compared to non-pessimistic individuals.

One woman sighted how being positive reduced the burden of surviving breast cancer, because she had been positive and believed that she would recover and she did recover. She further explained how she had watched a television show where one woman had been given a prognosis of 6 months to live but because she chose to be "positive" she lived longer than 6 months. Positivity according to this participant was refusing to believe that the disease would kill her and cooperating with doctors, taking medication and changing her diet and lifestyle accordingly. This indicated that media also played a role in influencing beliefs and attitudes of women during their survivorship phase. This demonstrated the reliability of Albert Bandura's Self Efficacy Theory (2001) which proposes that a high self-efficacy can be obtained through the experience of seeing another person successfully surviving and going through breast cancer, since other participants accredited their positive demeanour to the motivation brought about by relating to successful experiences of other people in similar situations.

Furthermore, the outcomes of the research also proved the applicability of Lazarus and Folkman's Stress and Coping Process (1984) which points out that a *challenge appraisal* is when a woman views or perceives breast cancer as a turning point in her life and an opportunity for personal improvement. Hence, in this study, women who adopted *challenge appraisals* were more inspired to implement healthy coping strategies such as problem solving, positive thinking and persistently seeking psychosocial support. More so, women who had inadequate resources to deal with the demands of cancer survivorship exhibited higher levels of stress and worry (*harm and threat appraisals*), further indicating the aptness of Lazarus and Folkman's theoretical assumption that the level of stress experienced in the form of thoughts, feelings, emotions and behaviours as a result of a traumatic life event such as a terminal illness, depends on the assessment of the availability of resources to cope with the negative stressor.

Conclusions

A considerable population of women survivors of breast cancer experience psychological challenges in their day to day lives. The most consistent psychological concerns affecting the breast cancer community are anxiety, fear and insecurity. These challenges present themselves in unique and variable manners depending on individual characteristics and other socio-economic factors. Other cognitive challenges such as depression affect a minority of survivors and are normally indicative of the presence of a dynamic range of external and individual factors at play.

From the discussion, women survivors of breast cancer also experience social distresses that affect their overall behaviour, manner and attitude towards their surroundings. The major social challenges affecting women are social anxiety, intimacy problems when relating to partners or spouses, and failure to adjust to the demands of their occupations and overall gender roles. These social challenges have been guaranteed to hinder their overall performance at the workplace and at home, as they strive to exercise and deliver their professional duties and domestic chores, respectively.

Conclusively, a number of factors influence the survivorship outcomes of women diagnosed with breast cancer. These factors may stem from an individual's perception and understanding of what it means to be a cancer survivor or from the external environment. Outlook seems to play an imperative role in determining the outcomes of breast cancer survivorship in women. Individuals who possess a more positive and optimistic attitude tend to be satisfied with their survival experience; whilst those who perceive otherwise are seldom satisfied with their experience. Also, the lack of support systems dedicated for breast cancer survivors in Gweru plays a pivotal role in necessitating poor health-related Quality of Life outcomes amongst the socially marginalised and economically disadvantaged group of survivors.

Last but not least, the potential impacts of psychosocial morbidity amongst breast cancer survivors are yet to be comprehensively explored. However, this research managed to arrive to the conclusion that psychosocial concerns such as prolonged social isolation are commonly intertwined with other socio-economic and individual aspects and are not entirely an independent facet. From the research, women who exhibited tendencies to isolate themselves were also experiencing dissatisfaction with their treatment

outcome and had been abandoned by close relatives and friends. Meaning, chronic social isolation is perpetuated by undesirable experiences and failure to adjust and cope with challenges that cancer brings to an individual's life.

Recommendations for practice

Granted the immediate development of breast cancer facilities in the city of Gweru might not ensue in the short term, the available breast cancer associations in Zimbabwe; particularly in Bulawayo and Harare could attempt to focus on encouraging communication about breast cancer survivorship within local communities in Gweru. As expected, there appeared to be inadequate communication addressing women who are surviving breast cancer and the solutions to achieving and maintaining healthy lifestyles.

There was a broad confidence that support from family and immediate relatives was sufficient to ensure a satisfactory survivorship experience; to the extent that specialised consultancy was acutely disregarded. The researcher recommends to the breast cancer community in Gweru, that expert counselling and evaluation must be prioritised in order to address cognitive and behavioural repercussions which may under normal circumstances, be difficult to confront without the aid of competent and trained health care givers. This may improve the overall health-related Quality of Life of survivors in the long run.

The private health sector and other non-governmental organisations for the cancer community should endeavour in filling gaps left by government health services. They must strive to physically address breast cancer survivors during their routine home visits of those affected. The poor economic environment in Zimbabwe might create considerable barriers to funding nationwide breast cancer awareness campaigns, but on a local scale, health workers must take the initiative and spread awareness in-order to empower the few people they have access to because it is guaranteed to make ample difference.

Lastly the research noted that there are many barriers to accessing information on breast cancer survivorship. Interviews carried out with professional respondents indicated that generally they have the necessary knowledge and information on survivorship but inadequate channels to share it to the community. The media must be sensitised on the issues of breast cancer survivorship. There must be a collaborative effort between health care

personnel and the media in publicising information related to cancer survivorship.

Furthermore, there are cheaper and more efficient channels and platforms for sharing this important information such as Radio Broadcast, SMS, WhatsApp, Facebook, Twitter and Instagram. As such, the community could potentially benefit from a wider distribution of educational pamphlets and booklets on breast cancer survivorship. The availability of this information could potentially increase the chances of women reading this information. Creating awareness, providing knowledge and creating opportunities for behavioural change would increase Quality of Life and survivorship outcomes for women living with breast cancer.

Recommendations for future research

The study was limited to a small population of women in the City of Gweru. Whilst significant conclusions can be drawn from this sample, there is a growing need for future studies to focus on regional populations in Zimbabwe so as to gain a much deeper understanding of the dynamics of breast cancer survivorship amongst women in the country. An all-round empirical study that can be generalizable to the entire population will help in generating survivorship data and usable statistics which can be utilised by cancer care institutions for excellent patient navigation and surveillance.

An in-depth qualitative study that primarily focuses on a comparison of the cancer survivorship outcomes of women from different socio-economic environments should be considered. This research would comprehensively focus on the role played by aspects such as employment, marriage and household characteristics in influencing various survivorship outcomes amongst women surviving gynaecological cancer. This information could go a long way in assisting with the identification of the unique survivorship needs of women from dissimilar socio-economic backgrounds.

During the interviews carried out with participants, it was evident that there were numerous underlying structural concerns that women had. For example, the majority of the participants expressed the lack of follow up support from their respective institutions of diagnosis, poor and inadequate communication channels with health care personnel and referrals to doctors they could not afford for treatment. There is need for research which investigates the services and structures available for cancer care and support,

how they operate and who they target. It was evident during the preliminary investigations of this study that there was absence of information of breast cancer services in Gweru.

Finally, there is a need to study on the appropriate and most suitable communication channels in the country. Researchers should consider investigating what type of media is most fundamental in addressing the health care management demands of breast cancer survivors in Zimbabwe. Focus will then be made in ensuring effective communication via this preferred media in order to be both cost-efficient and effective in targeting large populations as possible. Generally, the majority of Zimbabweans have no access to foreign digital satellite television; as such communication initiatives through television may not be successful in reaching the masses.

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