Effect of Breast Cancer on Couples' Marital Satisfaction in Pakistan

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AUTHOR’S DECLARATION

I, the undersigned, hereby declare that the thesis titled “Effect of Breast Cancer on Couples’ Marital Satisfaction in Pakistan” is my own work. All consulted sources in the thesis are fully acknowledged. The thesis has not been submitted by me or another person, in whole or in part, for obtaining any other degree.

______________________.

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14

DEDICATION

This research work is dedicated to

My late father Ch. Mushtaq Ali and my mother Mrs. Nasim Akhtar,

(I will never forget the sacrifices they made for me)

And to my daughter Zainab Fatima

(My only ray of happiness)

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(Nudrat Mushtaq)

Abstract

Breast cancer worldwide is the most commonly found invasive cancer in women. It accounts for 16% of all female cancers in addition to 22.9% of invasive cancers in females. Worldwide 18.2% of all cancer deaths are occurred from breast cancer. In Asia, Pakistan has one of the highest occurrence rates of breast cancer, as different studies show it kills nearly 40,000 women every year. One in every eight females in Pakistan is likely to suffer from breast cancer besides in Pakistan breast cancer occurs at a young age while in West it is more common in old age (after 60 years). This second leading death cause among females also affects femininity and marital life as the treatment has many side effects. Moreover, it's not only the breast cancer patients but their husbands also face an array of problems creating complications in their marital life and intimate relations. The present study explored the effects of breast cancer on couples' marital satisfaction by using mix methods of research. The study was conducted in NORI hospital Islamabad. Data was collected from female patients of breast cancer and their husbands to determine both partners' marital satisfaction. In-depth interviews of 12 couples selected through purposive sampling were conducted to gain a better understanding of the phenomenon and were thematically analyzed. Marital satisfaction of 279 couples was quantitatively measured by using 47 items 5 point Likert scale designed by converting themes into variables and was statistically analyzed by applying descriptive statistics. Sample size for quantitative data was determined by applying the formula given by Yamane (1967). The qualitative findings strongly complemented the quantitative findings, with female cancer patients and their husbands reporting several aspects of their marital life being affected by breast cancer including spousal interaction, deserted romantic and intimate relation, household management, derelict social & spousal support, sexual dissatisfaction and turmoil in marriage. The findings of both data supported the prediction that marital satisfaction of both cancer patients and their spouses is impacted by breast cancer and its effects.

Table of Contents

Content **Page**
No.

1. Introduction 1
1.1. Marital Satisfaction 4
1.2. Components and Mechanisms of Marital Satisfaction 5
1.2.1. Cognition...5
1.2.2. Physiology...6
1.2.3. Interaction Patterns 7
1.2.4. Spousal Support Factors 7
1.2.5. Spousal Personality Characteristics 9
1.2.6. Mate Value...10
1.2.7. Sexual Satisfaction...11
1.2.8. Love and Intimacy 12
1.2.9. Psychological Health 13
1.3. Rationale of the Study 15
1.4. Statement of the Problem 15
1.5. Objectives..16
1.6. Research Questions 16
1.7. Significance of the Study 16
1.8. Conceptual Framework of the Study...18
2. Review of Literature 19
2.1. Theoretical Framework 27
2.1.1. Social Exchange Theory 28
2.1.2. Bury's Theory of Biological Disruption...30
2.1.3. Self-Objectification Theory 31
3. Research Methodology 34

3.1. Theoretical Underpinnings 34
3.2. Research Design 36
3.2.1. Sequential Exploratory Mixed Method Research Design 38
3.3. Qualitative Design 40
3.3.1. Sample Size 40
3.3.2 Study Participants and Demographics 41
3.3.3. Study Area 42
3.3.4. Time Frame 42
3.3.5 Data Collection Procedure 42
3.4. Qualitative Analysis 42
3.4.1. Data Preparation 43
3.4.2. Coding 43
3.4.3. Thematic Development 44
3.4.4. Interpretation of Data 46
3.5. Quantitative Research Design 46
3.5.1. Research Design 47
3.5.2. Sample Size 47
3.5.3. Sampling Techniques 48
3.5.4. Data Collection Method 48
3.5.5. Development of Research Instrument 48
3.5.6. Steps in Designing the Research Instrument 49
3.5.7. Likert Scale 49
3.5.8. Reliability Analysis 50
3.5.9. Alpha Test 50
3.5.10. Field Experience 51
3.6 Ethical Considerations 52
3.6.1 Informed Consent 52
3.6.2 Confidentiality 53
4. Study Findings and Data Analysis 54

4.1. Qualitative Findings 54
4.1.1. Theme 1: Despair and Chaos: Reaction on Breast Cancer Diagnosis ... 54
4.1.2. Theme 2: Communication and Interaction; Effective & Ineffective Communication Patterns 60
4.1.3. Theme 3: Deserted Romantic Relationship & Emotional Intimacy 80
4.1.4. Theme 4: Dealing with Physical Deformity & Psychological Issues 92
4.1.5. Theme 5: Derelict Social & Spousal Support 97
4.1.6. Theme 6: Sexual Frustration and Dissatisfied Couple Relationship ... 105
4.1.7. Theme 7: Leisure, Spousal Shared Time and Breast Cancer 112
4.1.8. Theme 8: Breast Cancer and Marital Turmoil 115
4.2 Part II: Quantitative Analysis 120
4.2.1 Demographic Profile of Study Participants 120
4.3 Descriptive Statistics 124
5. Discussion, Conclusion and Recommendations 162
5.1. Discussion 162
5.2. Conclusion 183
5.3. Study Implications and Directions for Further Study 184
5.4. Suggestions 185
References 187

List of Tables

Title **Page No.**

Table 3.1 A Sample of Coding from Raw Data (Participants' Responses) 44

Table 3.2 Themes Derived from Respondents' Responses 45

Table 3.3 Reliability Statistics 50

Table 4.2.1 Distribution of Respondents according to their Age 120

Table 4.2.2 Distribution of Respondents According to their Education....................121

Table 4.2.3 Distribution of Respondents According to their Employment Status.....122

Table 4.2.4 Distribution of Respondents According to their Marriage Year.............123

Table 4.2 5 Distribution of Respondents According to Breast Cancer Stage............123

Table 4.3.1 The Distribution of Respondents According to Their Communication & Conflict Resolution 125

Table 4.3.2 The Distribution of Respondents According to Their Spouse's Personality & Behavior..128

Table 4.3.3 The Distribution of Respondents According to Their Emotional Bonding & Intimacy 131

Table 4.3.4 The Distribution of Respondents According to Their Social Life & Recreational Activities..135

Table 4.3.5 The Distribution of Respondents According to Their Sexual Relationship 137

Table 4.3.6 Indicating Mean and Standard Deviation for Couples Communication & Conflict Resolution 140

Table 4.3 7 Indicating Mean and Standard Deviation for Spouse's Personality & Behavior of the Study Respondents..142

Table 4.3 8 Indicating Mean and Standard Deviation for Emotional Bonding & Intimacy 144

Table 4.3 9 Indicating Mean and Standard Deviation for Social Life & Recreational Activities 145
Table 4.3 10 Indicating Mean and Standard Deviation for Sexual Relationship & Issues 146

List of Figures

Figure No. **Page No.**

Fig 3.1 The Sequential Exploratory Design... 39

Chapter 1

Introduction

Breast cancer is widely spread cancer among females which is known to bring several physical, emotional and psychological complications. These complications and changes affect almost every sphere of women's life especially their intimate and spousal relationships. Spouses of breast cancer patients also confront with psychological, social and economic challenges. This situation often results in distressed spousal relationships and marital dissatisfaction which disturbs the family functioning and weakens familial relationships. Although research has focused on psychological, emotional, social, spiritual, economic and intimate issues of women's suffering from breast cancer but studies on the effect faced by husbands or partners are limited and hardly existent in Pakistan despite the fact that husbands are directly affected by their wives' disease. I therefore aimed to explore the phenomenon from the perspective of both patients and their husbands to add to available knowledge of how patient and their spouses experience marital satisfaction after breast cancer; individually as well as a couple.

Global Scenario

Breast cancer is one of the most frequently found invasive cancers in women worldwide. It accounts for 16% of all female cancers in addition to 22.9% of invasive cancers in females. Worldwide 18.2% of all cancer deaths are occurred from breast cancer (Nordqvist, 2016). Breast carcinoma comprises 18% of all women cancer with occurrence of one million new cases each year worldwide (McPherson, Steel, & Dixon., 2000). The number of breast cancer cases since 2008 has increased by 20% and the number of deaths because of it has increased by 14% globally. The death incidences resulting from breast cancer are higher in developing countries which are somewhat because of changing lifestyle of people in these countries (Breast Cancer Incidence Alarming, 2015).

Breast cancer has become a severe health concern for Pakistani females as every year thousands of women in Pakistan are diagnosed with this life-threatening disease. It is affecting about one out of every eight women in Pakistan. For any Asian

population, Karachi (Pakistan) was reported for having the highest frequency of breast cancer (Bhurgri et al., 2000). A startling increase has been witnessed in registering of young girls in Pakistan, diagnosed with breast cancer. Females as young as 20 years of age have been reported of being diagnosed with breast cancer in several cases. Exact data of total cancer patients in Pakistan is not available because of the absence of any national cancer registry (Qasim, 2013) yet estimated 83,000 cases are being annually reported in our country, and over 40,000 deaths are caused by it (The Nation, 03 October 2018).

The term "breast cancer" denotes to a malignant tumor grown-up as of cells in the breast; breast cells in breast cancer produce uncontrollable. Breast cancer results from the unusual and unrestrained growth of cells due to different factors for instance genetic, glandular, then environmental factors (Sarafino & Smith, 2014). Usually breast cancer either begins in the cells of the lobules, which are the milk-producing glands, or the ducts, the passages that drain milk from the lobules to the nipple. Less commonly, breast cancer can begin in the stromal tissues, which include the fatty and fibrous connective tissues of the breast (www.breastcancer.org, 2018).

The prevalence of breast cancer has been reported to be 30% to 40% among Pakistani women in 40-year age bracket. It is argued that due to cultural expectations of *purdah* in the Pakistani society patients are often reluctant to discuss the issue and visit hospitals for screening and medical checkup until the very last stage (Pakistan has Highest Incidence, 2014).

As a disease breast cancer can potentially affect numerous dimensions of a woman's life. The physical abilities of patient, her domestic life, her career, the way she identifies her social world and her leisureliness get affected when the breast cancer is diagnosed. A number of disciplines have examined these effects including medicine, psychology, as well as sociology. Researchers have explored several issues resulting from breast cancer treatment diagnosis and treatment including stressful condition and psychological weakness (Linley, 2006), emotional turmoil in patients in females undergone biopsy (Montgomery & McCrone, 2010), feelings of shame and embarrassment (Kayser & Sormanti, 2002: Venter et al., 2008), psychological impacts

of losing a breast and cosmetic as side effects of mastectomy (Giuliano & Hurvits, 2013) and reduced social as well as job-related activities (Bloom & Speigel, 1984).

Montgomery and McCrone (2010) explored that psychological distress following breast cancer diagnosis in women can negatively influence their performance of everyday tasks. Similar findings were made by Luoma and Hakamies (2004) that cancer treatment result in limited daily activities performance i.e. walking, housework, family activities, driving, leisure activities and self-care along with living through transformed roles besides feelings of vulnerability. Cheville et al. (2008) listed social, psychological, vocational, and economic problems emerging from cancer diagnosis and treatments and effecting the personal and social functioning of cancer patients. Semple and McCance (2010) further stated that cancer treatment doesn't only affect the patients but also bring physical, social, sexual and emotional challenges for their families. Greenstein (2018) stated that despite exceptional developments in both breast cancer treatment as well as post-treatment care medical professionals provide, several females still suffer from substantial psychological and social problems, both during treatment and after their treatment is completed.

Breast cancer and the treatment it involves reported to have influence on marital satisfaction. It ought to effect patients physically and emotionally that might upset sex then sexual desire. For instance, pain and sensitivity are the outcomes of certain treatments, whereas other effects include menopausal symptoms, for instance vaginal dryness (www.breastcancercare.org.uk, 2019).Though surgery is not the only way out yet surgical treatment is most common for breast carcinoma, which is of two types: mastectomy (breast is completely removed) and lumpectomy (removal of cancer and small amount of tissue around it). Cancer diagnosed at early stage, can be treated through chemotherapy without any surgery and breast removal (Qasim, 2013).

Women who have been diagnosed with then treated for breast cancer are found experiencing a range of complications, with anxiety, depression, and worries related to body image, in addition to sexual dysfunction (Gordon, Baucom, & Snyder, 2005; O'Mahoney & Carroll, 1997). Earlier studies have demonstrated two ways breast cancer diagnosis impacts psychosocial aspect of patients′ life: 1) Psychiatric problems

like anxiety, depression, somatization and anger. 2) Modifications in social as well as family life patterns for example dissatisfied or disrupted marital and sexual life (Kunkel & Chen, 2003). The psychological effects of breast cancer have developed it in the most feared cancer in women. The perception of sexuality and self-image is effected to greatest degree compared to any other cancer (Scanlon, 1991).

1.1. Marital Satisfaction

Marital satisfaction is defined as a mindset of an individual in which he/she reflects perceived benefits and costs of marriage. The more costs a spouse inflicts on a marriage partner, the less pleased individual usually is with the marriage as well as with the life partner/spouse. In the same way, the greater perceived benefits reflect that the individual is more satisfied with the spouse and the marriage (Baumeister, 2007). According to Sousou (2004), marital satisfaction can be perceived as a multidimensional construction containing multifarious components including communication quality, leisure collaborations, cohesiveness on family or relationship matters (e.g., finances and child rearing), besides family history of torment and distress. Hendrick and Hendrick (1997) defined marital satisfaction as "a subjective experiencing of one’s own personal happiness and contentment in the marital relationship".

Kaplan and Maddux (2002) defined marital satisfaction as permanence of pleasure, gratification and enjoyment of relationship. They further added that marital satisfaction is a personal experience of being married that can merely be evaluated through an individual’s own acclamation of the quantity of marital satisfaction and to a great degree depends on person's own desires and expectations. It appears that several aspects are effective to marital satisfaction and fulfilling life including the spouses’ personality, intellectual maturity, the degree of reciprocal understanding, enough mental stability, financial aspects, computability, love, passion and sexual satisfaction. The subjective nature of the conception of marital satisfaction according to Sharaievska and Stodolska (2013) creates difficulties in identification of a set of characteristics obligatory to the relationship or a spouse in order to consider the marriage to be satisfactory. A number of studies, notwithstanding this problem of subjectivity have endeavored to categorize marital satisfaction’s characteristics. As, Rosen-Grandon,

Myers, and Hattie (2004) listed imperative components of satisfactory marriage including love, loyalty, respect, forgiveness, support, shared values, romance, intimacy/sexuality along with open communication besides agreement on expression of affection. Lawrence et al. (2008) emphasized that mutual support played vital role in affecting marriage quality and spousal relationship while Dew's research (2007; 2008; 2009) concentrated on dissimilarities in spouses' opinions on issues related to finance. I have here presented a list and description of factors and components found to be greatly related to marital satisfaction.

1.2. Components and Mechanisms of Marital Satisfaction

1.2.1. Cognition

Baucom (1989) stated that a number of researchers have endeavored to ascertain then operationalize fundamental cognitive variables interrelated to couples' marital satisfaction. Epstein and Baucom (2002) suggested that the beliefs and perceptions partners hold about intimate relationships and each other can affect relationship outcomes, together with behaviors related to relationship, relationship quality, besides relationship stability. The interpretation of behavior by individuals appears to be interrelated with their satisfaction in their marriage. How an individual feels about behaviors or how he sees the effect of these behaviors remain closely related to what an individual thinks of marital satisfaction. Few research have explored the interrelatedness of negative affect and decreased marital satisfaction (Baumeister, 2007). These relationship cognitions in general, simultaneously serve as the information's background against which a current interaction takes place, as well as the cognitive filters that encourage swiftly attending explicit information however ignoring further information (Be, 2014). For instance, if a person anticipates her/his life partner to be kind and caring, inquiry from the spouse about one's health would be interpreted as a gesture of care otherwise of concern and countered with deliberated thought and balminess.

On the contrary, if spouse is expected to be critical or seeking a possibility to mention shortcomings in his/her behavior, the same query might be deduced as a trap to attack. When understood as indicators of denunciation, the individual might

supposedly make a fortified or contemptuous declaration to the spouse, thus constructing besides strengthening disengaging interactions' patterns in the relationship then gradually deteriorate quality of relationship. Murray, Holmes, and Pinkus (2010) explained that every different interpretation results from distinctive cliques of relationship cognitions and could expectedly lead to altered interaction patterns in relationships gradually besides variants in satisfaction within those relationships. Cognitions or thoughts about the behavior are important in recognizing whether a partner's behavior is costly or beneficial. The costly (negative) behavior of a spouse could be accredited to spouse's characteristics e.g. she or he is slothful, spouse's behavior instead to circumstances surrounding such as it remained a particularly exhausting day in office, and she doesn't want to cook dinner. On the assumption of marital satisfaction, costly behavior (negative) attribution to one's spouse's nature rather than circumstances surrounding associated with his/her behavior declined marital satisfaction, along with marital breakage. These flawed provenances arise more frequently with undesirable attitudes in spousal problem resolving negotiations.

Johnson et al. (2001) developed a cognitive- behavioral model of marriage, one mechanism of which posits that emotionally communicative bilateral behaviors which regulate marital satisfaction are led by cognition. Epstein and Baucom (2002) states that undoubtedly there is a reciprocated and mutually influenced relationship between these variables; however one pathway identifying a progressive assembling is that behavior is influenced by cognitions, while marital satisfaction in turn is determined by behaviors.

1.2.2 Physiology

There exists a firm relationship between preserving physical well-being besides being wedded. This is established instantaneously through the physiological functioning of both spouses. Recent study has explored that wedded couples who are greatly synchronized physiologically are more pleased and satisfied in their relationship in comparison of less satisfied married couples. To be precise, couples martially satisfied are more to be expected to sustain synchrony amongst every partner's electrodermal (or electrical resistance of the skin) in addition to heart rate systems, a mechanism by which

married couples able to sustain better physical health as those of single/unmarried persons (Baumeister, 2007).

1.2.3. Interaction Patterns

Another component related to marital satisfaction is the communication between spouses**.** How satisfied a couple is with their marriage is affected by interaction patterns between them. Demand and withdrawal is one of the patterns most frequently associated to marital dissatisfaction. One spouse (usually the female) in this pattern nags or criticizes the other spouse about change; however the other partner (often the male) escapes the conversation besides the conflict or confrontation. It functions just as at first condemnation causes detachment promoting further hostility then augmented detachment. This pattern through parties' mutually developing dissatisfaction has clear consequences for marital satisfaction (Baumeister, 2007). Bischoff (2008) designated constructivist communication among key components of marital satisfaction and relationship adjustment, on the other hand Gur-Aryeh (2010) listed weak communication instigating an array of problems between spouses which may cause marital dissatisfaction.

Quality communication between partners is an important aspect of a satisfying relationship. Communication, in research has been proved that irrespective of patient's age is a significant element for cancer survivors' psychosomatic wellbeing. Cancer survivors who faced not as much of perceived criticism and avoidance in their relations ought to have improved mental health, which in turn possibly will relate to greater satisfaction in relationship (Mallinger, Griggs, & Shields, 2006). Study findings by Manne et al. (1999) presented that marital satisfaction was persistently correlated with apparently undesirable and negative actions by the husband of a patient; patients whose marriages were satisfying were not as much pretentious by negative actions and spousal distress.

1.2.4. Spousal Support Factors

The degree of social support for each of the partners in addition to the relationship is additional significant element of satisfaction in a marriage. Support procedures consistently stay associated with better marital functioning, other than by healthy and

beneficial outcomes inside families. A companion who offers greater degree of social support in marriage for his/her partner enhances the partner's marital satisfaction. House (1981) listed provision of instrumental, emotional, appraisal and informational support included in social support. Yedirir and Hamarta (2015) conducted a study to describe the extent marital satisfaction can be predicted by emotional expression and spousal support, and observed a positive correlation amid spousal support and marital satisfaction and found emotional support, social companionship support and appraisal support as the most influential sub-dimensions of partners' support able to best envisage marital satisfaction. Thus, spousal support could predict marital satisfaction.

Cutrona, Russell, and Gardner (2005) stated that the influence of spousal support relationship functioning is not confined to a stressful event or trauma rather it inspires behaviors, emotions, and attitudes all through the relationship course. Gardner and Cutrona (2004) found individual differences and uniqueness in needed spousal/partner support and its preferred amount. Dehle, Larsen, and Landers (2001) added that this opinion of sufficient partner support enhance marital satisfaction. Many social support researchers including Xu and Burleson (2001) have related their considerable work to the support gap hypothesis which theorizes that received spousal support differs on the basis of gender and men receive more support from their female life partners than do women, besides the support male partners provide is less helpful than they receive from their female spouses. This perspective also suggests difference in men and women's manner of providing spousal support as females are more likely to offer emotional support while males provide more instrumental support. Although the empirical support in the favor of gap hypothesis show a discrepancy depending on the methodology yet evidence supporting the support gap hypothesis are comparatively strong and constant (Verhofstadt, Buysse, & Ickes, 2007).

In marital relationships the support one receives from their spouse depicts marital satisfaction and is greatly valued. In the lives of married couples a significant other is regarded as most important part of life. People expect adequate and more support from their life partners compared to another support system i.e. family or friends.

1.2.5. Spousal Personality Characteristics

How satisfied and content an individual is with his or her marital life appears to be interrelated with, to a certain extent, the personality characteristics of his/her marriage partner. Chamorro-Premuzic (2016) summarized by former authors' studies that personality traits significantly influence all aspects of intimate relationships together with partners' compatibility and relationship satisfaction. Norman (1963) identified five dimensions by using these, a personality is determined, these dimensions include: Extraversion (surgency, dominance, extraversion vs. submissiveness, introversion), Agreeableness (sincere, trusting vs. unsympathetic, distrustful), Conscientiousness (trustworthy, well organized vs. unreliable, disorganized), Neuroticism (emotionally stable, even-tempered, confident, vs. temperamental, nervous) and Openness to Experience (intelligence, understanding, inquisitive vs. imperceptive).

Previous studies on marital satisfaction and personality characteristics majorly focused on exploring the correlation between these five personal factors and marital satisfaction. The results concluded from most studies designated a reverse yet substantial relationship amid neuroticism and matrimonial contentment (Attari, Amanollahi & Mehrabizadeh, 2006; Golestani et al., 2012). Javanmard and Garegozlo (2013) found a significant yet negative correlation between marital satisfaction and neuroticism. On the basis of the findings of their study they recognized Neuroticism as a substantial predictive of marital satisfaction which leads to marital discontentment. Their results were in agreement with the verdicts of preceding inquiries (Donnellan, Conger, & Bryant, 2004; Gattiset al., 2004; Luo & Klohnen, 2005). Fani and Kheirabadi (2011) also observed negative relationship between neuroticism (nervousness) and marital satisfaction indices altogether. Their research too showed that people with lower level in neurosis in addition to higher levels of extraversion, openness, agreeableness and conscientiousness exhibited less rates of mental divorce (marital instability). Other researches also testified high conscientiousness is positively correlated with marital satisfaction (Malouff et al., 2010; Robins, Caspi & Moffitt, 2000). In their research of personality types and marital satisfaction, Najarpourian et al. (2012) found that individual with insecure personality type showed the least marital satisfaction.

The utmost reliable prognosticator of to which degree a marriage is dissatisfied, is the emotional instability of one of the spouses (Buss, 1991; Karney & Bradbury, 1995). Marital dissatisfaction is most frequently associated with a partner's emotional unsteadiness; nevertheless, dissatisfaction is correspondingly interrelated with low conscientiousness of a spouse, truncated in agreeableness, with low intellect and openness (Bentler & Newcomb, 1978; Buss, 1991). People wedded to persons having these personality features repeatedly complain about their spouses being negligent and careless, dependent, possessive, condescending, covetous, unfaithful, untrustworthy, expressively constricted, egocentric, sexualizing of others, and abusive of alcohol. Hence, each spouse's personality characteristics significantly contribute towards the couple's relationship, accomplishing a satisfied marriage or ending it in separation or divorce. Global evaluations have identified that individuals' personality characteristics vary among people satisfied or dissatisfied with their married life (Alipour, Rahimi, & Zare, 2013).

1.2.6. Mate Value

Mate value is composed of a number of characteristics and can be understood as the attractiveness of a spouse. Physical desirability, intellect, behavior and personality are included in mate value (Lippa, 2007). Marriages in which an inconsistency exists concerning the spouses in mate value remain matrimonies in which spouses are more expected to be disloyal, signing discontent in marriage. While a husband, for instance, is supposed to have a greater mate value as of his wife, he, other than she (conceivably aimed at revengeful motives) is to be expected treacherous to their matrimony. The lesser marital satisfaction related with this circumstantial spousal suffering, of conflicting mate values among the life partners, seems as a sign to the greater mate value person that she or he might search for a evenly matched companion somewhere else (Nowak & Danel, 2014). They further stated a positive correlation between females' relationship satisfaction and their perception of their partners' mate value besides females are more discontented in their relationship when cognizant of their partners mate value inferior to theirs.

However, Eastwick et al. (2014) in a meta-analysis disclosed that two most frequently adduced measures of mate value physical attractiveness and earning

prospects valued more by men and by women respectively equally prevised romantic evaluations among men and women of their partner. Edlund and Sagarin (2010) suggested some common predispositions in mate preferences and found that partners with higher mate value always tend to be extra demanding in their relationships.

1.2.7. Sexual Satisfaction

Sexual satisfaction has been connected to relationship satisfaction in several cross-sectional studies in both genders. These researches furthermore indicate that sexual problems noticeably influence the couples' spousal and social relationships and quality of life and result in high rate of divorce or separation (Ali-Akbari, 2010; Brezsnyak & Whisman, 2004; Byers, 2005; Carvalho & Nobre, 2011; Dzara, 2010; Foroutan & Jadid Milani, 2008; McNulty & Fisher, 2008; Movahed & Azizi, 2011; Nichols, 2005; Nourani et al., 2008; Sevène et al., 2009; Slosarz, 2000; Sprecher, 2002; Trompeter, Bettencourt & Barrett-Connor, 2012; Yeh et al., 2006; Young et al., 1998). Sexual satisfaction is defined as an implicit feeling rising from an individual's subjective assessment of both the positive as well as negative dimensions related to his/her sexual relationship (Ji & Norling, 2004).

A number of researches have presented a progressive relationship concerning sexual satisfaction then relationship satisfaction i.e. Young et al. (1998) in a study of association between sexual satisfaction and marriage, they proved the maximum correlation between sexual satisfaction and satisfaction with the marriage. Nevertheless it is challenging to determine whether sexual fulfillment leads to marital satisfaction or else whether marital satisfaction adds to sexual satisfaction, or together. This dilemma might be answered as partially related to the gender issue. Przybyla and Byrne (1981) found that sexual relationship remained central for husbands in describing the inclusive satisfaction they perceived in their marriages, however, the wives' all-inclusive satisfaction with their marriages, stood an imperative feature influential to their satisfaction with their sexual relationship according to Young et al. (1998). Carvalho and Nobre (2011) on the other hand, indicated that in both genders marital satisfaction is consistent with high sexual desire and better sexual function. Their findings showed that study participants with high sexual desire had considerably greater dyadic consensus, cohesion, satisfaction, and affection.

Alahveriani et al. (2010) found that sexual affairs hold first position in married life concerns besides sexual satisfaction can lead to a convenient and satisfactory marital life. Francoeur (2001) also suggested that sexual and marital satisfaction is related. Previous studies showed that marital and sexual satisfaction is considerably correlated and notified that certain characteristic of sexual satisfaction have substantial influence on marital satisfaction (Alahveriani et al., 2010; Rahmani, Alahgholi, & Khuee, 2009; Shakerian, 2010; Ziaee et al., 2014).The research administered by Trudel and Goldfarb (2010) showed that improved sexual functioning doesn't only heighten the marital function but it also can moderate psychological distress's symptoms. Nichols (2005) suggested satisfactory sexual relation for both spouses in a couple among definite necessities for the attainment of consent in marital relationship.

Fallis et al. (2016) revealed that compared to women, sexual satisfaction was a stronger predictor of consequent relationship satisfaction for men. Cao et al. (2018) anticipated on the basis of preponderance existing theoretical perspectives and empirical findings that men compared to women, on the verge use the eminent sexual relationship as a measure aimed at their entire relationship quality; on the other hand, for women, satisfied relationship stimulates satisfying sex. Shakerian et al. (2016) revealed in their study that through enhancing quality of married life and reducing couples' relationship problems high sexual satisfaction can correspondingly lessen the marital instability and decline divorce rate. Satisfactory sexual relationship is so imperative feature of marital behavior that Yucel and Gassanov (2010) claimed that sexual complications in couples cause marital infidelity.

1.2.8 Love and Intimacy

Love and intimacy are defined and found as significant elements of marital satisfaction. Tang (2007) in his research found that love played a significant role and was positively related to the satisfaction experienced by couples in their relationship. Intimacy is defined as an individual's feelings of closeness and attachment to another individual which confiscates psychological borders amid people then invokes the need of sharing his/her personal and unrevealed perceptions with the other person. A multiple regression statistical analysis revealed that relationship satisfaction was strongly predicted by the three major components of love naming intimacy, passion, and

commitment (Lewis, 2011). A significantly positive correlation is existent between the components of love and relationship satisfaction (Kochar & Sharma, 2015). Sanderson and Cantor (2001) established that in the married couples, marital satisfaction was associated with determining intimacy goals of both partners in a couple. In agreement of their results, Patrick et al. (2007) showed spousal support and intimacy as significant measures of marital satisfaction according to them couples with higher levels of intimacy can create more satisfying relationship while adeptly dealing with relationship stressors and struggles, as well as changes within the relationship. Douglas (2013) showed that couples who use intimacy, commitment and passion altogether in their relationship verify a higher level of marital satisfaction.

The concept of love and intimacy differs across genders. Greeff and Malherbe (2001) found substantial dissimilarities between males and females on different aspects of intimacy. Stahmann, Young, and Grover (2004) noted that females are frequently described as longing for emotional intimacy whereas males are shown as only in need of sexual intimacy. Underwood and Rosen (2009) too stated that females focused more on the intimacy while for males, nonverbal then indirect expressions of intimacy in addition to sexuality was major focus. They (males) also neglected the importance of self-disclosure in an intimate relationship.

1.2.9 Psychological Health

With other components of marital satisfaction psychological health is also found to have a positive interaction with marital satisfaction. Poor psychological health and disorders decreases the satisfaction level of a relationship (Shaheen et al., 2011). Ghazivakili et al. (2014) found in their research that the spouses who are certain of their partner's psychological health tend to have more successful and stable marriage. It was observed by Mansouri et al. (2011) that the dissatisfied and incompatible couples had unfavorable psychological profile and a higher frequency of anxiety and mood disorders as compared to control group. Besides, researchers have found that marital satisfaction is inversely related to couples' anxiety and depression (Bakhshi et al., 2007).

In addition to above mentioned components of marital satisfaction many other factors too contribute in satisfied marital relationship i.e. according to Carlson et al. (2013) a healthy marriage is determined by how married couples get through the different phases of their relationship besides a strong marriage depends on successful intervention of expected as well as unexpected personal and interpersonal challenges. Marital satisfaction is determined by whether the marital ends, chiefly the deliberated ones, are met or not (Pierce, 2016). According to Butzer and Campbell (2008), marital satisfaction largely depends on whether the expectations and needs from marital relationship are met. As stated by Julien et al. (2003) good communication along with spousal support and conflict resolution is related to the relationship quality and indispensable to the satisfaction level of individuals in married life.

Self-disclosure of spouses and their response to each other are related to healthy and sustainable marriages. Marital satisfaction and self-disclosure are highly associated in addition to partner's receptiveness to disclosure, developed intensities of mutual support, as well as further interdependence in rewarding support needs as stated by Laurenceau et al. (2004) and Lippert and Prager (2001). Gottman (2013) revealed that married couples who treat each other as good friends live happily as their relationship is characterized by empathy, affection and respect, besides, they resolve spousal conflict in a constructive and tender manner. Other researchers have extended that behaving like good friends comprehends overlooking a spouse's imperfections and flaws, concentrating on winsome qualities of each other, accepting one another entirely, in addition to granting spouse with commendations (Appleton & Bohm, 2001; Canary, Stafford, & Semic, 2002).

Affection is also related to marital satisfaction. Both Affection and enmity have been individually interrelated to spouses' levels of marital satisfaction, for instance people who have affectionate spouses reported to be greatly satisfied with their relationships (Horan & Booth, 2010; Miller, Caughlin, & Huston, 2003) on the other hand individuals who face enmity of their partners, reported declined marital satisfaction (e.g., Caughlin et al., 2000; Karney & Bradbury, 1995).

1.3 Rationale of the Study

Considering literature, we can say that couples confronting breast cancer face a number of problems in their marital relationship. Inquiries about the breast cancer as a threat to marital stability have stimulated considerable exploration in contemporary time. However, in Pakistan, less research has done to investigate the problem by including both partners' perspective. Aimed at this intention, the main objective of the present study was to examine marital satisfaction not only of breast cancer patients but of their spouses too. The study aims to give a sociological analysis of the disease as a social issue faced by a number of people in society and has attempted to explore if breast cancer really is a threat to marital satisfaction.

1.4 Statement of the Problem

Inquiries about the breast cancer as a threat to marital stability have stimulated considerable exploration in contemporary time. Aimed at this intention, the main objective of the proposed study was to examine marital satisfaction not only of breast cancer patients but of their spouses too. The study aims to give a sociological analysis of the disease as a social issue faced by a number of people in society and has attempted to explore if breast cancer really is a threat to marital satisfaction.

In Pakistan, the most common cancer is breast cancer as shown in various studies every year it kills nearly 40,000 women (Dawn, 2014). The diagnosis and treatment of breast cancer result in many psychosocial problems not only it places stress on intimate relation. Breast cancer disrupts physical appearance, emotional stability and sexual functioning of females that is closely tied to marital satisfaction, resulting in marriage discord. As compared to West, in Pakistan breast cancer develops at early stage which potentially affects not only the females but the couples' marital satisfaction negatively. Family is the most important unit of Pakistani society and marriage serves as the base of family. Problems in marital life disrupt the whole family functioning. There is need to address the issue in order to increase peoples' understanding for coping the problems.

1.5 Objectives

The major aim of this multi method study is to assess the marital satisfaction in patients with breast cancer and their husbands. The following are the objectives

1. To study the socio-economic and demographic characteristics of the respondents.
2. To explore the nuanced experiences of patients of breast cancer and their spouses regarding their marital satisfaction through in-depth analysis of their lives.
   - 2.1. To determine the effects of breast cancer on marital satisfaction of breast cancer patients
   - 2.2. To find out the influence of breast cancer on marital satisfaction for husbands of breast cancer patients
3. To assess the occurrence of qualitative findings in a larger population of breast cancer patients and their husbands through survey research.
4. To suggest recommendations in the light of the findings.

1.6 Research Questions

1. How do cancer patients and their husbands experience marital satisfaction?
2. Does breast cancer change the spousal relationship of couples?
3. Does breast cancer intimidate marital relationship and stability?

1.7 Significance of the Study

This study was an attempt to develop an understanding of the marital experiences of couples confronted with breast cancer with a focus on both spouses. In Pakistan, little is known about the social, psychological and emotional experiences of male spouses of female breast cancer patients. This study aimed to fill this important gap and add to an existing body of literature about the marital and spousal issues faced by couples by including both partners in the study. In addition to adding a qualitative perspective that enabled me to examine and describe how participants experienced the effects of breast cancer on their spousal relationships and marital satisfaction.

The study investigated the phenomenon from both partners' point of view and attempted to epitomize their relationship complications and represented their experiences as individuals besides as a unit. This approach will be advantageous in developing an absolute picture of the marital satisfaction–effect of breast cancer and will provide beneficial additions to the literature. In Pakistan, very little research has been devoted to the implications of cancer for spouses and research on couples i.e. patients and spouses are nearly non-existent. Spouse is directly affected by the disease of his wife, thereby the way spouse deals and appraise his wife's disease may influence patient's outlook towards her condition. The presented study, therefore, aimed to examine marital satisfaction in patients and their spouses subsequent to breast cancer diagnosis in patients. It is indispensable to examine the influence of the illness on the matrimonial relations because satisfactory marriages tend to guard partners from mental distress (Bookwala & Jacobs, 2004).

1.8 Conceptual Framework

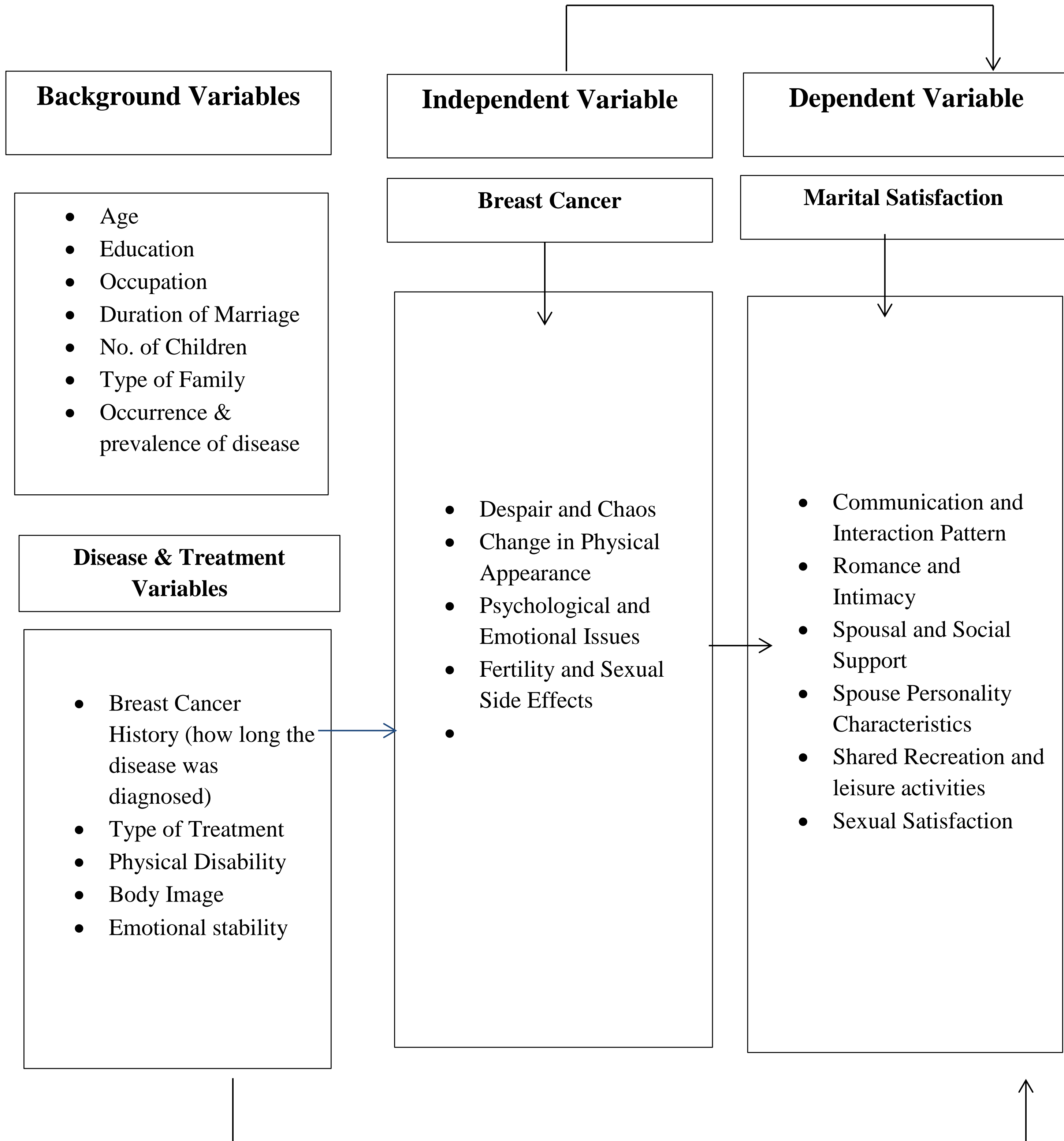

Figure 1: Conceptual Framework of Research

Chapter 2

Review of Literature

This chapter will discuss available literature related to the objectives of the present study. Research has provided an understanding of breast cancer effecting individual's emotional and psychological health resulting in relationship problems for couples. The studies examined how breast cancer influences marital satisfaction not only for patients but for their life partners as well. Some of the listed studies focused more than one component of marital satisfaction i.e. intimacy and love, sexual satisfaction, emotional and social support for female breast cancer patients, the gap in literature was the impact of breast cancer experienced by male spouses and their role in satisfied marital relationship for both partners. Here, I attempt to address this gap in this thesis by explaining the perception of both the cancer patients and their spouses.

Breast cancer identification disturbs a female, her spouse and entire family. The framework of illness as well as of the treatment is extremely traumatic. The couples essentially face an extensive array of modifications: biological besides physiological, intrapersonal as well as interpersonal. As a result, spouses together undergo further emotional suffering. It remains of worth to consider partners' distress. Several contending demands can be overwhelming for male spouses of young females. They are expected to provide emotional support to females while confronting with their personal suffering, responding to needs of children, and assisting the family members who are generally uninformed or ignorant by what means to best support the patient.

Breast is a vital representation of beauty as well as sexuality in womenfolk. A depressing effect of mastectomy on the couple relation could lead patients to dread of husband desert (Taylor-Brown et al., 2000). Conversely, chemotherapy as well as radiation has severe side effects which alter appearance of woman and distress couple's life. Husbands of breast cancer patients, in this situation, experience severe stress and agony as high as patients' sometimes higher (Baider et al., 1998; Bigatti et al., 2011; Hoskins et al., 1995; Mikulincer, Rydall, & WaBraun, 2007; Northouse et al., 2000; Wagner, Bigatti, & Storniolo, 2006). Nevertheless, there is debate concerning the attitude of breast cancer patients to marital satisfaction. A number of studies

demonstrated lack of marital satisfaction following breast cancer (Hinnen et al., 2008; Romero et al., 2008). In dissimilarity, there are different researches reporting marital satisfaction similar both in general population and breast cancer patients (Dorval et al., 1999; Jun et al., 2011).

Some researchers consider that facing every cancer type can lessen relationship satisfaction being a traumatic experience. Besides, female patients who have undergone radical mastectomy and chemo-radiotherapy face further psychosocial agony. Moreover, studies have revealed losing an organ in the result of mastectomy; that is symbol of femininity and sexuality causes alteration in patients' view of self in addition to body image and as a result agitates females' psychological well-being (Helms, O'Hea & Corso, 2008; Ohaeri & Campbell, 2012).

There are studies to provide confirmation that diagnosis then treatment of breast cancer can result in placing relationship stresses, possibly resulting in marital dispute (Carter & Siliunas, 1993; Northouse et al., 1998). When one partner of an intimate relationship suffers from a serious illness, distress is mutually faced by both partners (Northouse et al., 1998). Moreover, this suffering may influence both communication and sexual relationship of a couple, adversely (Ben-Zur, Gilbar, & Lev, 2001; Holmberg et al., 2001; Lindholm et al., 2002; O'Mahoney, & Carroll, 1997).

Research outcomes discussing interdependence approach reactions specify that the diagnosis then treatment of breast cancer frequently prompts undesirable interpersonal relationships problems in maintaining the previously upheld the interpersonal relationships' quality with spouses, accompanying with a sense of seclusion and disaffection, or feelings of lonesomeness, has been stated (Hurley-Wilson & Gates, 1987; Knobf, 1986). Furthermore, females have specified that preceding social relations regularly were uncooperative subsequent to the diagnosis of breast cancer (Lugton, 1997) especially; retreating their support in the response of the females' emotional requirements (Bolger et al., 1996). Problems in interactive relations generally continue for more than one year (Wolberg et al., 1989).

Shaheen et al. (2011) examined how breast cancer influences on physical as well as psychosomatic wellbeing of patients. The study revealed that marital life of

several patients becomes distressed when breast cancer is diagnosed because of possible treatment procedures of the illness for example mastectomy which results in the body image distortion. Accompanied by this treatment expense, changes in behavior in addition to depression further deteriorate the relationships. In their research, 100 patients were questioned the way breast cancer had affected their marital life. 80 patients out of 100 responded that their marital life had distressed by this illness, 19 patients believed that breast cancer did not affect their marital life, however one patient was single.

In an investigation of young females facing breast cancer, Avis, Crawford and Manuel (2004), inveterate that among their study participants (women age 50 or younger), sexual complications (accompanied by matrimonial issues and concern with body image) were prognostic of inclusive life quality. Recent studies too advocate that among female breast cancer patients, adjustment over time was strongly influenced by female's perception of their male companions' response to her breast cancer (Wimberly et al., 2005). Sexual apprehensions remain common for females confronting breast cancer and their partners resulting from individual psychological distress related issues, relational disputes and physiological alterations for women cancer patients, and have to be reflected in appropriate interventions altogether. While sexual concerns remain existent for several females with breast cancer, they do not discuss the issue frequently with physicians if not asked specifically, and despite this many stand reluctant in acknowledging such complications.

Besides married females with cancer, their husbands too experience a number of psychological problems (Hoskins et al., 1996; Northouse, 1992; Omne-Ponten et al., 1993). Some husbands actually reported to undergo more emotional distress compared to female patients themselves (Baider et al., 1998; Northouse et al., 2000). Aslo there is a high positive correlation between the partner antecedes the breast cancer, further inclined, these verdicts designate that spouses prominently influence one another whilst confronting the breast cancer experience as one spouse's suffering raises the other partner's distress; a phenomena comprehended extensively in various matrimonial domains (Hodges, Humphris, & Macfarlane, 2005). In a longitudinal research on couple's adjustment with breast cancer, Northhouse et al. (2001) actually found that

every companion's level of psychological adaptation with time; this remained accurate for both females breast cancer patients and also their male partners. Since their male partners or husbands can experience as much as distress or more than the females themselves, the reorganization of the appropriate intervention including male partners is needed.

Klauber-DeMore (2006) stated that among married females confronting cancer, spousal support is regarded as the fundamental support source besides foresees lower levels of anxiety and depression as well as improved life quality. Two major types of support from partners include emotional (e.g. listening empathatically, consoling when distressed) and practical support (e.g. performing household tasks, bringing the patient to hospital visits). While both kinds of support are valuable, cancer patients be inclined to consider emotional support as the utmost cooperative kind of societal support from family members. Actually emotional support has been reliably associated with better psychosomatic adjustment in cancer patients besides has been found even to foresee survival among females patients of breast cancer. Boeding et al. (2014) also revealed in their research that higher levels of perceived partner support for females confronting breast cancer resulted in higher levels of marital satisfaction for their husbands.

Nevertheless, while speaking their cancer, lots of breast cancer facing females belief their communications with their spouses as disconcerting, even in the perspective of inclusive pleasing relations. Such as, commonly cancer patients and their spouses/partners mutually involve in "protective buffering", which is the escaping from conversation of reservations and fears with the intention of protecting the other partner. An essential question is as if the marital communication related to cancer is associated with both patient and partner psychosomatic alteration to cancer. There are comparatively a small number of studies investigative these relations. Manne and colleagues (1999) carried out a longitudinal study on protective buffering. Protective buffering is when one partner attempts to protect the other mate as of uncertainties and conflicts, by means of a paper and pencil measure of this construct. When female cancer patients as wives involved in protective buffering, they recounted further suffering three months later. On contrary, protective buffering of male patients as husband was not suggestively accompanying with their suffering. Hagedoorn and colleagues (2000)

considered protective buffering along with active engagement then overprotection. They concluded that active engagement was related with greater quality of relationship, also that protective buffering was allied with lesser married satisfaction once patients were either emotionally upset or further physically impaired.

From a medical viewpoint it is important how the couple's correspondence with each other concerning their opinions of what measures can be taken to manage their difficulties and stressors. Inconsistencies between perceptions of spouses regarding their communication behaviors could intensify the conflicts rising in a relation then decrease marital satisfaction (Gottman & Krokoff, 1989).

Patients frequently report of not being able to have open dialogue with their partners and family members as they would like, and that their discussion with partner is less helpful as compared to other people (Klauber-DeMore, 2006). These complications are revealed in both cancer patients' as well as spouses/partners' reports that social support from family reduced after the first year following cancer diagnosis, in spite of developments in individual adjustment (Northouse et al., 2000). Hagedoorn and colleagues (2000) in a cross-sectional study surveyed for possible moderating effects for patient physical impairment on the association between active engagement, overprotection and protective buffering effects on patient marital satisfaction. They found stronger associations between spouse's support too patient marital satisfactions for the patients who reported greater physical impairment.

Hilton (1994) categorized couples' conversation patterns while dealing with emotional problems interrelated with breast cancer at early stage and found two elementary patterns of communication, which were established on whether spouses shared analogous understandings on the significance of conversation. Couples, for whom conversation was mutually significant, communicated amenably. For couples, who did not consider that having conversation was important, complications were demonstrated in their communication.

Mann et al. (2004) observed interactions of female patients of breast cancer besides their male spouses too, while conversing topics related to cancer related. Their conclusions showed that for women, the important aspect in feeling further intimate

with male spouses was not in what way the females revealed their emotions and considerations; in its place, the women felt more intimate when their male partners or husbands expressed their feelings more often. Thus it might not only be important for women to express their own feelings, but when male partners share their own feelings, women with breast cancer have a greater experience of being accepted, understood and cared for by their male partners.

In a similar study of women with early stage breast cancer, conferring cancer related issues with them and with their male partners, Manne et al. (2004) found that certain responses from spouse were supportive to females once the females unveiled the feelings they possessed. Once men instantaneously reacted through disclosing their personal feelings or with comicalness, the women recounted a low level of distress; contrariwise, if men reacted with unsolicited or spontaneous recommended solutions, females went through increased distress. Accordingly, spouses reacting to women's emotional distress through continuing in the demonstrative realm seemed to be supportive. In other investigations, further explicitly negative otherwise uncooperative communication patterns, for instance partner escaping and disapproval, remain concomitant with lesser patient adjustment, as well as greater distress maladaptive managing policies, besides invasive feelings about disease (Klauber-DeMore, 2006). Consistent with these outcomes, Avis, Crawford and Manuel (2004) showed that for young female breast cancer patients, anxieties related to intercommunication with their partners were recorded as the greatest problem challenging the relationship.

Many previous researches have exposed the sexual functioning of females following breast cancer treatment. The result of these inquiries validate that females face an extensive range of sexual complications which remain heightened for young patients (Avis, Crawford, & Manuel, 2005; Ganzet al.,1998; Meyerowitz et al., 1999; Spencer et al., 1999; Walsh, Manuel, & Avis, 2005). Generally, it seems that nearly one third of both patients of breast cancer and their husbands experience sexual difficulties (Northouse, 1994). In addition, findings often demonstrate that young patients experience a predominantly great degree of sexual complications (Avis et al., 2004; Bloom et al., 2004; Kroenke et al., 2004; Schover, 1994; Schover et al., 1995; Walsh et al., 2005). Moreover, such sexual problems don't seem to be a momentary difficult.

Ganz et al. (2003) confirmed in a large scale investigation of cured breast cancer survivors that even five to ten years later following diagnosis, females remained to experience sexual problems together with vaginal dryness, reduced sexual activity, as well as reduced breast sensitivity. Similarly, Bloom et al. (2004) concluded that amongst young females treated for and free of breast cancer following for five years of diagnosis, sexual activity was not improved or regular.

Even though some studies ascertain that young breast cancer female patients do not exhibit inclusive difficulties in relationship beyond general public's experience (Avis et al., 2004). In case of such problems existing, the influence of matrimonial complications for young breast cancer female patients are noteworthy. Avis et al. (2005) also revealed that younger females with greater numbers of matrimonial difficulties state lesser comprehensive, physical, emotional and breast cancer specific Quality of life (QOL); actually, these females fared worse than females living without a partner. Walsh et al. (2005) revealed that 12% of young females were separated or divorced in the two years subsequent to the diagnosis of breast cancer. The females informed that their spouses initiated preponderance of these separations, predominantly for the reason of their partners' incompetence to cope with the cancer.

Given the surgery for breast carcinoma a body part is removed and typically alters physical appearance of a woman in a part that is greatly valued, it is comprehensible that females with breast cancer frequently present apprehensions about their body image. Ganz et al. (1998) revealed that nearly two third of females confronting breast cancer were unhappy with their physical appearance as it was found second most common symptom females described. Not unexpectedly, body and physical appearance anxieties were frequently recorded among females undergone a mastectomy only, subsequently females with a mastectomy in addition to reconstruction, and then females with a lumpectomy (Ganz et al., 1998). Maximum inquiries specified that body related apprehensions remain a particular fear of younger females with breast cancer (Avis et al., 2004; Avis et al., 2005; Ganz et al., 1999).

Physical beauty is significantly appreciated and esteemed in our culture, thus, females particularly face misery on losing their breast or modifications to their breast

appearance. In addition, premature menopause is often experienced by young women as the side-effect of cancer treatments they get; besides they might experience a general feeling of rapid/early aging with regard to their bodies, skin, bone density, etc. Carver et al. (1998) found that females who stated a great investment in body appearance earlier to surgical treatment revealed further emotional suffering both earlier to the surgery as well as during the subsequent year of surgery. Other than the female's concerns related to her body image, her partner's opinions of her body are imperative too. Ming (2002) revealed that in couples confronting with breast cancer, the spouse's appraisal of his wife's physical appearance forecasted his wife's contentment regarding marriage even better compared to her personal opinion of her body image.

A number of dreads are associated with sexuality, for example woman fears about her spouse's response to breast cancer itself, body deformity, concerns about rejection, besides concerns of male about whichever changes in female's physique (if he will accept any of them), loss of wife or recurrence, how to not hurt the spouse all through a sexual intercourse, about caressing insensitive breast. Marshall and Kiemle's (2005) shed some light on the experience of partners of breast cancer patients, who need to adjust with a different situation through a qualitative study on the effect of breast reconstruction subsequent of cancer on females' and spouses' sexual functioning. Concerns about hurting the reconstructed breast, ache while touching or doing a mistake when being intimate might effect on their desire and arousal. Changes in touching and caressing due to insensitive breast, time consumed to arouse the mate are great challenges for spouses, although primarily the wife's survival was found to be a priority for majority of husbands, rather than sexual anxieties. According to Marshall and Kiemle (2005), what is more startling is that not only females but their husbands too can experience problems with arousal while their concerns disturb their sexual desire and pleasure, they might feel uncomfortable and embarrassed consequently.

According to Baucom et al. (2006), particularly high rate of sexual difficulties is experienced by young females and it does not seem to be a short term problem in addition concerns related to communication remained to be the most problematical relationship difficulties. It is acknowledged that an inclusive good spousal relationship is insufficient for sexual adaptation. Certain types of communications are crucial

including; open communication about cancer related topics, the aptitude of expressing emotions as well as to have partner listening sympathetically, effective skills of problem resolving, greater understanding from partners, the more male partners disclose (sharing his feelings and thoughts about cancer), the more intimate women felt and partner's instant reaction to cancer related topic with their own revelation or with humor was more useful than spontaneous task oriented or intellectual response.

Alder et al. (2008) conducted a study in which sexual dysfunction was reported by 68% of breast cancer survivors a few years later to surgery which was far greater a ratio in comparison of healthy females. The quality of relation was the single significant predictor for sex desire, instead of androgen level which is thought to be related with sex interest.

A study found that depression severity impacted marital satisfaction; the more satisfactory marriages were those associated with less depression (Whisman, 2000). Song and Ryu (2014) conducted a cross-sectional comparative survey design study with 57 couples with the purpose of identifying if the couple observed breast cancer as a traumatic incident, to assess the relationship amongst posttraumatic growth, dyadic adjustment, besides quality of life in addition to discover the predictors influencing the couple's quality of life. The results showed that female breast cancers survivors and their partners experienced breast cancer as a traumatic event (43.9% and 24.6%, respectively).

2.1 Theoretical Framework

In this section I delineated theoretical perspectives relevant to my study. Theoretical framework introduces and describes the theory that explicates why the research problem under study occurs. Marital satisfaction is a complex and multidimensional phenomenon; not only defined as a subjective experience of an individual besides it is understood as a state of mind reflecting the apparent costs and benefits of marital relationship to an individual and the degree to which an individual's needs, expectations, and desires are being gratified in his/her marriage. Keeping in view the multidimensionality of phenomenon understudy three theories are selected to provide the basis for carrying out the study.

2.1.1 Social Exchange Theory

Chavannes (1901) was one of the leading contemporary sociologists who explicitly used the idea of social exchange, arguing exchange as the base of all human relations, thus it is the exchange on which society is fabricated. Miller and Bermudez (2004) considered it one of the most prominent theory and a practicable theoretical framework to examine relational processes in spousal as well as family relations as it offers an extensive description of in what way individuals interrelate and make choices in relationships.

The theory strive to describe the development, maintenance (e.g., solidarity, power), as well falling-off of exchange relations in terms of the equilibrium between the rewards that spouses attain besides the costs incurred by them selecting themselves into married relations. Costs denotes to the factors that prevent or discourage an enactment of a series of conducts in a marriage, while rewards are the gratifications, satisfactions and pleasures enjoyed by an individual being a married person (Thibaut & Kelley, 1959). Miller and Bermudez (2004) added that people select partners and build and sustain their relationship established on alleged maximum benefits and least costs for each partner in that particular relationship, people either intentionally or unintentionally estimate existing relationships by equating the rewards of the relationship (Osborn, 2012).

The social exchange theory advocates that people decide on participating in a specific relationship for the ability of that relationship to offer an adequate level of outcomes defined as the "rewards" minus "costs" (Homans, 1974; Nye, 1979; Rusbult, 1980; Sabatelli, 1984; Thibaut & Kelley, 1959). Marital satisfaction is understood and defined as a state of mind in which the alleged costs and benefits of marriage are reflected individually. Every partner is attracted to the relationship differently depending directly on the anticipated rewards and inversely to the costs of the marital relationship. Hence, married couples assess their satisfaction subjectively (Nakonezny & Denton, 2008). Married couples' equally receiving positive costs and rewards outcome— the ratio of distributed costs and rewards is fair to each other—remain to be more satisfied with their marriage (Homans, 1974). The extra costs a marital spouse imposes on an individual, the one is generally less satisfied with the spouse and with

the marriage. Correspondingly one is more satisfied with the marriage and marriage partner with the greater perceived benefits. Nye (1979) and Sabatelli (1984) likewise proposed that the marital satisfaction is derived through rewards deducting the costs in the marriage minus considered by individuals as persuasively attainable in a marriage. People in a relationship likely to be satisfied when outcomes constantly incline to "fall above expectations" on the contrary the relationship become dissatisfied for individuals when relationship outcomes steadily tend to "fall below expectations". These expectation levels are neither fixed nor same for every individual and differ significantly from person to person on the basis of their experiences and the characteristic they believe to be more significant (Sabatelli, 1988). Consequently people assess their relationships by way of comparing the outcomes they may offer to their own expectations from a relationship. The differences in expectation levels can be helpful in understanding that why some individuals are happy and satisfied in a relationship considered poor by others besides why some people are dissatisfied with apparently a good relationship. Incidentally satisfaction must be regarded as a result of interaction amid an individual's expectations and his or her companion's behavior.

Breast cancer is the disease that affects women in a number of ways; physical, psychological, social and sexual. Females affected with breast cancer find it difficult to fulfill or to complete their routine tasks and perform their duties. This situation shifts the burden on husbands of breast cancer patients; increased financial expenditures, performing household chores, taking care of children, tackling with emotional instability, mood swings, anxiety and depression of their wives, adjusting to the altered physical appearance of their wives and managing with sexual problems of their better halves increase the cost of relationship on the husbands' end raising the feeling of being "under-benefited" from their marriage which results in dissatisfaction with their relationship/ marriage. Marital satisfaction is the degree to which an individual's needs, expectations, and desires are being satisfied in their marriage. The physical and mental condition of breast cancer patients increases the demand for husband's care and social support of breast cancer patients. An unbalanced relationship gets developed when husbands fail to satisfy these needs and expectations, resulting in dissatisfaction.

Dissatisfaction of one member in this reciprocal relationship of marriage inevitably results in the dissatisfaction of other member.

2.1.2. Bury's Theory of Biographical Disruption

The theory of biographical disruption of illness was primarily developed by Bury (1982, 1991, and 2001) and was extended by Williams (2000). Bury (1982), perceives chronic illness rather a disruptive experience that disturbs normality of daily life for people experiencing that illness i.e. rheumatoid arthritis. Bury (1991) suggested three disruptive happenings that transpire with the unfolding of a chronic illness; the disruptive presupposed assumptions of one's self and the world and disturbed behavior, reconsidering individual's biography besides self-concept and thirdly the mobilization or practical utilization of including physical, medical, financial, temporal, social, or/and cultural resources available to people while suffering (Williams, 2000). Bury (1991), advocated that within the interpretive sociology of chronic illness, attention must be paid how individuals encounter with their illnesses' effects which he termed as 'strategic management'.

The previous studies have shown the utility of biographical disruption construct for unfolding and elucidating the acute along with the terminal stage of cancer (Cayless et al., 2010; Exley & Letherby, 2001; Hubbard, Kidd, & Kearney, 2010; Leveälahti, Tishelman, Öhlén., 2007). The research has also highlighted that cancer experience results in identity altering (Mathieson, & Stam, 1995); lost/declined body functions were found symbolically significant in representing lost "civilized self" (Rozmovits & Ziebland, 2004); however Sinding and Wiernikowski (2008) claimed that cancer patients/survivors who had faced adversities during life course didn't essentially experience it as biographical disruption.

Studies focusing particularly on breast cancer also suggested that females diagnosed with breast cancer observed it as biographical disruption (Balmer et al., 2015; Bury, 2001; Holmberg, 2014; Liamputtong & Suwankhong., 2015; McKenzie & Crouch., 2004; Williams, 2000). Breast cancer as a chronic illness encounters females with particular challenges including physical, psychological, emotional, relational and social problems. In present study I strived to explore from a cancer patient and/or

survivor standpoint the changes in their lives that they ascribe to breast cancer and whether they construct it as biographical disruption in addition to find out how cancer patients and survivors managed to deal with these challenges and established a new "normal" (Balmer et al., 2015) and how their husbands supported them in this process.

2.1.3 Self-Objectification Theory

Fredrickson and Roberts (1997) developed objectification theory to provide a framework to comprehend female experience in a sociocultural environment where female body is sexually objectified. Objectification theory proposes that women are greatly objectified sexually and considered as a thing being valued for its usage to others. Objectification theory as a persuasive feminist theory describes the course through which those subjected to such objectification internalize the outsider perspective (McKinley & Hyde, 1996) this phenomenon is called "self-objectification" (Fredrickson & Roberts, 1997) occurring to women perpetually (Aubrey, 2006; Fredrickson et al., 1998; McKinley, 2006; Swim, 2001) and leads to internalization of sexual objectification. Sexual objectification occurs when a woman instead of being viewed a whole person is primarily perceived as a physical object of male sexual desire (Barry, 1984; LeMoncheck, 1997; Szymanski, Moffitt, & Carr, 2011); her body is separated from her inclusive personality (Bartky, 1990). Self-objectification results in low self-esteem (Breines, et al., 2008; Hurt et al., 2007; Mercurio & Landry, 2008) depression (Grabe & Jackson, 2009) decreased relationship and life satisfaction, body shame (McKinley, 2006), increased anxiety about physical appearance (Roberts & Gettman, 2004) and sexual dysfunction (Harper & Tiggemann, 2008; Mercurio & Landry, 2008; Moradi & Huang, 2008) and impaired cognitive performance (Fredrickson et al., 1998; Quinn et al., 2006).

Evidence for the sexual objectification of womenfolk are practically found universally i.e. in media, in females' social experiences, and in particular environments. Those with a superior disposition to self-objectify display an enduring obsession with their physical looks, by the conviction that others observe and evaluate their bodies (Choma et al., 2010). In a romantic relationship objectification takes another shape when a partner is being objectified by other partner; partner-objectification and it may bring certain consequences to a relationship i.e. relationship dissatisfaction. The

emphasis on physical appearance and bodily attraction in intimate/sexual relationships increases the possibility of people objectifying their romantic partners/spouses as Sanchez et al. (2008) reported that while females showed more signs of body shame compared to males, male partners seemed to express further apprehensions about their romantic partner's physical appearance than females. Zurbriggen, Ramsey and Jaworski (2011) reported that observing one's mate as an object negatively influence their relationship. Objectification of a partner in a physical relationship leads to sexual objectification. The notion of sexual objectification was first appeared in philosophy in the work of Immanuel Kant. For Kant (1785) sexual objectification happens when a person is not consider as an "end-in-itself," nevertheless merely a source of sustaining sexual needs and desire of ours. Starting with this viewpoint, sexual objectification is mostly expected to occur while a partner is perceived of exclusively with reference to their sexual utility. Based on objectification theory females are believed to be socialized through their sexual objectification experiences to consider themselves as objects to be viewed and appraised by their physical appearance (Fredrickson & Roberts, 1997). Ramseyer (2015) described that females internalize objectification from their spouses/partners that relates with feeling of body shame and them being less expressive about their sexual desires and issues. Besides females who particularly internalize conventional gender roles are theorized to be exposed to the deleterious repercussions of self-objectification (Choma et al., 2010).

The research on self-objectification has particularly followed the domain of sexuality which has also been discussed as major contributor of marital satisfaction. Fredrickson and Roberts (1997) on the basis of theoretical grounds made explicit prophecies that self-objectification would cause declined sexual satisfaction; sexual dysfunction is reported to be an important factor in the marital dissatisfaction among married couples (Faizal et al., 2017). Zurbriggen et al. (2011) found partner-objectification associated with decreased relationship satisfaction for both partners in a couple irrespective of their gender.

The impact of self-objectification and the partner objectification in an intimate romantic relationship have got little attention even though it can underline significant concerns of objectification glutted culture. In the present study I related self-

objectification to marital satisfaction in context of partner and sexual objectification and its impact on women with breast cancer with the assumption that women with breast cancer will face emotional distress and anxiety due to altered appearance and body image and their marital relationship would be affected credited to their sexual functioning and their husband's sexual objectification of them. Self and partner objectification of women with breast cancer effects their body image persistently because they face the challenge of coping with their altered body appearance and numerous changes to physical function as side effects of treatment. Breast cancer treatments including surgery, chemotherapy and radiotherapy can cause considerable disfiguring including deformity, scarring, loss of breast(s), hair loss and lymphedema. These significant physiological and body changes can radically disturb a female's body image in addition to sturdily challenging related core values and views. Studies on breast cancer revealed that breast cancer survivors experienced lost physical integrity and body functioning, perceived femininity, self-image and self-confidence (Fobair et al., 2006; Wilmoth, 2001). Body image can be influenced by self-objectification which is fundamental to the idea of objectified body consciousness, body shame besides appearance anxiety with sexual functioning (Knauss, Paxton, & Alsaker, 2008; McKinley, & Hyde, 1996; Steer & Tiggemann, 2008). Thus self and partner objectification can influence marital satisfaction of breast cancer patients in many domains.

Chapter 3
Research Methodology

In this chapter I will discuss the research methodology used in this thesis. While separate methodology sections for each used method are presented to document the study in sequential style the first section of this chapter describes the mixed methodology. In this chapter philosophical underpinnings of mixed method research which inspired my methodology are also discussed. After the mixed methods, in order to offer better understanding both qualitative and quantitative data collection and analysis procedures applied to the study are also separately described in detail.

3.1. Theoretical Underpinnings

To begin with the ontological position or stance can be understood and explicated by answering the question about the nature of reality i.e. 'what is the nature of reality'? Epistemology on the other hand is related to knowledge acquiring process through which researchers determine reality. According to Creswell (2003), a researcher's epistemological position is identified by his relationship with the researched. If an investigator pursues for information by keeping his/her perceptions and standpoints aside; 'positivism' is the term used for this epistemological path. As positivists believe in one objective reality they determine it through the systematic or scientific research methods. On the contrary, the research would follow the interpretive epistemology in case of the interaction occurring between researchers and their subjects.

Morehouse and Maykut (2002) on the difference between two paradigms stated that it is basic and effect general research approach in addition to research tradition. They described that hypothetically for positivists the world is simple if appropriately studied besides properly broken apart so they comparatively take an objective stance then consider quantifiable variables (Collis & Hussey, 2013) and mainly emphasize on evidence too explanation (Morehouse & Maykut, 2002). Onwuegbuzie and Leech (2005) stated that positivists in general consider the context free generalizations derived from study results and outcomes. According to Maxwell (2004), positivists claim that the causal relationships cannot alone be studied or explored by methods of qualitative research. Interpretivists on the other hand, believe that world is a complex entity which

cannot be understood without the knowledge and understanding of the subjective meanings attached or assigned to the social actions by people in a specific situation or particular social setting (Bryman, 2004). Collis and Hussey (2003) articulated that interpretivists interact with their subjects with the intention of decreasing the gap between the researcher and the researched. Morse (2010); Teddlie and Tashakkori (2012) argued that the combination of quantitative and qualitative methods allow the researcher to simultaneously design confirmatory as well as exploratory questions besides generating and attesting theory in a single study.

In the current study my focus was on exploring the experiences not only of the females who were suffering from breast cancer but also of their husbands in regard to marital satisfaction and its effect on their mutual relationship. However, I was also interested to derive inferences applicable to a larger population. Hence I decided to employ a mix method approach in this study. Bergman (2008) suggests that at least one quantitative in addition to at least one qualitative component must be combined in a mixed methods research.

Generally a researcher's ontological perspective may be either positioned fully objective or fully subjective. However in a mixed method inquiry researchers can acquire an intermediary ontological position admitting the fact that in a social science study, subjective and objective standpoints of the reality are equally advantageous. As a researcher I too acknowledge the significance of both ontological standpoints. I measured the relationship between breast cancer and marital satisfaction as a single reality. Using in-depth interviews, I explored the "multiple realities" of the participants related to the study topic as every participant experienced this phenomenon differently than others. Consequently, the study as one, attempts to provide a full understanding of the respondents' experience of effects of breast cancer on their marital relationship.

Analogous to the intercessor ontological position an intermediary viewpoint was adopted in epistemology too. As a researcher I acknowledge both positivists as well as interpretivists approach and adopted an intermediate epistemological standpoint for this study. This intermediary perspective helped me to empirically examine the effects of breast cancer on marital satisfaction of study participants in addition to

offering me an opportunity of interacting with the study participant considering them a part of the social world. Their individual viewpoints were hence forth advantageous in understanding of the phenomenon (effects of breast cancer on marital satisfaction) completely. The interaction with study participants not only enabled me to explore their life experiences it also offered me an understanding of a number of factors influencing their marital satisfaction in special reference of their or their spouses' disease.

3.2. Research Design

Selection of research design among qualitative, quantitative or mixed methods to carry out research is one of the most critical elements of any research study. According to Silverman (2016) research methodology is the comprehensive approach that researchers use to carry their research study consisting of the data collection methods and data analysis.

In social sciences, two well-known and extensively applied research approaches are qualitative and quantitative and both are completely in contrast to one another. In qualitative approach, According to Dörnyei (2007), verbal data instead of numeric data is used besides less predefined categories are created in comparison of open-ended categories. Despite small sample size qualitative research generates rich data by using human interpretations (Collis & Hussey, 2003) and involving the researcher and study participants in exploring social phenomenon under study. The quantitative method explained by Morehouse and Maykut (2002) on the other hand, uses observations and converts them into discrete units comparable to other units by means of statistical analysis. Qualitative research methods are applied to understand the occurrence and process of a phenomenon, to narrate the essence of an individual's ordeal, or to develop a theory, whereas quantitative methods address queries related to generalizability, causality, or extent of effect (Fetters, Curry, & Creswell, 2013).

In summary, the qualitative approach generally adopts inductive methods of inquiry to explore and understand a social phenomenon then produces theories and is the main source for data collection is human participation. On the contrary the quantitative study follows deductive methods of inquiry and analyses numeric data in order to investigate the relationship among the predetermined variables.

In general both the quantitative and qualitative approaches while used in isolation may show certain weaknesses or deficiencies. For instance, a qualitative research's findings attributable to its small sample size may not be applicable to the larger population. On the other hand, the quantitative approach when used unaccompanied possibly will not explain the complex social world completely.

The underlying weaknesses in both approaches evidently support the need of a novel approach that may in the words of Dornyie (2007) offer 'the best of both worlds' by combining both the quantitative and qualitative approaches. Nevertheless determining whether or not the quantitative and qualitative approaches can be mixed in one study is very essential owing to their ontological and epistemological differences.

Teddlie and Tashakkori (2008) referred mixed methods research as the "third methodological orientation". It begets the strengths of both research methods namely qualitative and quantitative however no universal definition of mixed methods research exists, Creswell and Clark (2011) outlined that core characteristics is in order to address the research question separately collect and analyze both strands of data (qualitative and quantitative) in a single research study, and integrate either sequentially or concurrently. Onwuegbuzie and Combs (2010) stated that both quantitative and qualitative analysis types are required to conduct a mixed analysis as it implicate the application of no less than one of both analyses. Patton (2001) advocates the notion of triangulation by affirming that a research is strengthened by combining methods. This can be applied by using various approaches or research data, including both qualitative and quantitative methods.

Mixed methods research is broadly defined by Tashakkori and Creswell (2007) as a research in which the researcher gathers then examines data, incorporates the results and induces conclusions utilizing qualitative and quantitative approaches together. Kroll and Neri (2009) argued that truly mixed methods studies are distinctive only if they integrate the qualitative and quantitative findings in any phase of the study whether during data collection, analysis or at the interpretive stage of the research. According to Johnson and Onwuegbuzie (2004), mixed methods research can be looked at as a method appealing the perspectives and strengths of each method. Mixed methods

research recognizes the existence and significance of the physical, natural world in addition to the significance of reality and impact of human experience.

Bryman (2007) suggested that the combination of qualitative and quantitative findings can be forged into an inclusive or negotiated explanation of the findings which is impossible by practicing a singular approach. Mixed methods design includes concurrent and sequential data collection together. Myers and Oetzel (2003) demonstrated that in sequential design data of one form characterizes and supports a following phase(s). In sequential designs analysis of one type of data is used to acquaint the gather the data of second form. The second phase of study should confirm or validate the qualitative findings of initial phase. Mixed methods approach is advantageous as it offers the researcher flexibility to execute the best suited techniques of data collection and analysis in the context of research problem or understudy phenomenon. The methodology I adopted is sequential exploratory mixed methods design.

3.2.1 Sequential Exploratory Mixed Method Research Design

In this study I used sequential exploratory mixed method research to broadly investigate and understand relationship between breast cancer and marital satisfaction then its impact on couples' life. According to Hesse-Biber (2010), in this method prominence is given to the qualitative phase whose outcomes are verified in the second phase of quantitative data collection and analysis. An exploratory design is consisted of three phases – firstly qualitative data is collected and analyzed, secondly derived themes are used to develop a quantitative instrument for further exploration of the phenomenon understudy and third and final stage is the integration phase that combines both data strands and extends the early qualitative exploratory findings (Creswell & Clark 2011; Onwuegbuzie, Bustamante, & Nelson 2010; Teddlie & Tashakkori, 2008).

There were three research questions that guided the present study to help understand the experiences of the married couples where females are confronting breast cancer:

1. How do cancer patients and their husbands experience marital satisfaction?
2. Does breast cancer change the spousal relationship of couples?

3. Does breast cancer intimidate marital relationship and stability?

These research questions required detailed description and knowledge of the experiences of breast cancer confronted couples and the generalizability of the phenomenon. So I applied exploratory sequential mixed method research. The effectiveness of mixed methods approach to research lies under the fact that through this a single study can be designed in order to describe and understand the intricate nature of phenomenon from the respondents' standpoint as well as establishing and identifying relationship among quantifiable variables.

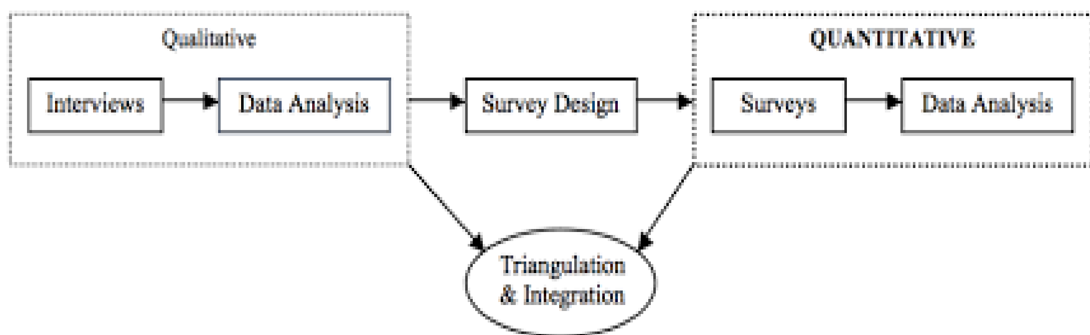

Figure 3:1 The Sequential Exploratory Design Wu, P. F. (2011).

The study with the aim of understanding the perception of couples confronting breast cancer about their marital satisfaction adopted exploratory research design. This design as suggested by the term itself; explores into the phenomenon. The principal goal of exploratory research design is to gain in-depth knowledge and enhanced understanding of a phenomenon or an issue (Cooper & Schindler, 2006; Davis & Cosenza, 2000; Zikmund, 2003). This research design provides rich besides advantageous data to the researcher (Cavana, Delahaye, & Sekaran, 2001).

The research design intended to meet the determined criteria:

- Involving the breast cancer patients and their husbands who were experiencing the effects of breast cancer.
- Facilitating the excogitation of the study respondents (breast cancer patients and their husbands) which will offer enrich interpretative data.

- Providing the researcher an opportunity to acquire deep understandings into identified perceptions and issues.

The study required a comprehension of the lived experiences of married couples confronting with breast cancer so I decided to go for in-depth interview technique of data collection from qualitative research methods and applied thematic analysis. Once the data analysis was completed and themes emerged I developed a quantitative instrument considering these themes as variables and assessed the general prevalence of these variables in a larger population of breast cancer patients and their husbands.

In order to document the study in sequential style, the current chapter is further divided into two parts/sections. Each section separately describes the methodology applied in both phases (qualitative and quantitative) in detail.

3.3 Qualitative Research Design

In this section, I have discussed in detail the qualitative procedures carried out to collect and analyze qualitative data through in-depth interviews which was solely collected from couples where wives were affected by breast cancer; both husbands and wives were individually interviewed and their responses are presented in this chapter. Twelve couples (24 respondents) participated and shared their experiences.

Qualitative research methods possess a shared purpose of understanding participants' standpoint and consequently can influence research positively in ways not likely when merely quantitative techniques are used (Williams et al., 2011). Thematic Analysis (Boyatzis, 1998) is one such approach that has become progressively recognized as a research method in the preceding decade (Clarke et al., 2005). Patton (2001) unlike quantitative methods, qualitative research is the key instrument for the data collection and enables the researcher in obtaining more detail and in-depth about the research topic.

3.3.1 Sample Size

According to Collingridge and Gantt (2008), participant selection in qualitative research must ensure a strong validation and accomplish an explicit purpose associated

to the topic researched. For the collection of qualitative data, 12 couples were selected to gain deeper insight into the essence of lived experiences of study participants. However the saturation point was ensured when amount of variation in data begun to level off and new perception, information or explanation were no longer emerged from the data. I ensured that saturation was achieved using 12 couples (24 participants) by making sure that I didn't hear any new information emerged from the interview in addition to obtaining necessary information to satisfy the formulated research questions.

3.3.2 Study Participants and Demographics

The study was specifically designed to gain better understanding and greater insight of couples who were fighting with cancer and its consequences on their marital life. A total of twenty four interviews led to data saturation. Twelve married couple of breast cancer female patients participated in the study. The demographics of the study participants selected for qualitative data are below described.

The overall mean of age of study participants was 45.8 years while for female participants the age mean was 42.8 with the youngest respondent aged 35 years and the oldest female respondent aged 53 years. The minimum age of male respondents was 42 while the maximum age was 61 years; the mean of male respondents' age was 48.9 years. The mean of couples' married years was 14.16 the maximum married period of couples was 22 whereas one couple was only married for 07 years. The information about employment status shows that only 2 out of 12 female respondents were employed at the time of data collection whereas 1 out of 12 male respondents were unemployed. The educational background of respondents showed that no male or female respondent was uneducated although the education level varied as 5 out of 24 respondents were graduated including 3 females and 7 males. Out of total 24 respondents 10 respondents had Primary to Middle level education (5 males, 5 females). Nevertheless 4 female respondents had secondary education. The sample was heterogeneous in terms of ethnicity, economical background, age, education and their marriage duration.

3.3.3 Study Area

The participants were couples confronting breast cancer recruited from Nuclear Medicine, Oncology and Radiotherapy Institute (NORI) hospital, Islamabad.

3.3.4 Time Frame

Upon approval from administration of NORI hospital the process of data collection begun in April 2017. The data was collected through face-to-face in-depth interviews except three interviews, which were conducted on telephone as the spouses of three breast cancer patients couldn't manage to visit hospital with their wives. Each interview lasted between approximately 60-90 minutes. The interviews were completed over a time period of almost three months.

3.3.5 Data Collection Procedure

To meet the study criteria I decided to adopt in-depth personal interview technique. The advantage of using in-depth interview is that it makes it possible discussing particularly sensitive subjects/topics with informants or study participants (Hair et al., 2003; Stokes & Bergin, 2006). The interview questions were listed down in interview guide with open ended questions that endorsed study participants to response in detailed and an elaborated manner. Follow-up questions were also asked depending on the answers of the predetermined questions. All interviews were conducted separately and participants were requested to allow interviews to be audiotaped. Except interview of one female respondent each interview was recorded as she didn't allow me to audiotape her interview. Along with recording each interview, I also kept field notes documenting non-verbal data as well as my immediate perception of the interview sessions.

3.4 Qualitative Analysis

The analysis of qualitative data can be done through various techniques depending on the type of qualitative research carried out.

Nevertheless, Creswell (2007) pointed out main steps in qualitative data analysis as

- preparing and organizing the data for analysis
- coding the data and summarizing the codes into themes

- demonstrating the data in figures, tables, or a discussion

3.4.1 Data Preparation

Following each interview, all interviews were immediately verbatim transcribed to develop inclusive and complete understanding of the data. In transcribing data, I represented and interpreted in written form what respondents verbally expressed during interviews. Giorgi and Giorgi (2003) demonstrated that transcription of data is the first step among many in understanding the meaning of experience. In order to ensure the accuracy and exactitude of transcripts after verbatim transcription I read and reread each interview besides comparing it with the audio recordings and to get familiar with and understand data.

3.4.2 Coding

Coding of the data was the next step of data analysis process as mentioned by Giorgi and Giorgi (2003) the process of coding initiates with the extraction of meaning units from the data transcribed. Each interview following transcription was immediately coded in order to ensure the accuracy of coding and save data from any misinterpretation or overlooking. Participants' anonymity and confidentiality was maintained by deleting all identifiable information of their. Each interview was coded by founding reoccurring themes emerged in the texts. The alike and similar responses of the participants were summarized and grouped into themes. I incessantly scrutinized the data in addition to highlighting important points in the transcript and coding the data.

Saldana (2009) stated that codes are vital components of the research story not only because they are essence-capturing but rather they vigorously facilitate the development and analysis of data categories resulted as the codes are clustered on the basis of similarity besides regularity –as patterns. I carefully read each interview more than once and highlighted as well as underlined important phrases and responses related to study. I coded each transcript line by line using original words and statements of respondents. It enabled me to summarize and group the responses given by respondents of the study into themes based on their similarity and relevance to the study.

Table 3.1 A Sample of Coding from Raw Data (Participants' Responses)

Raw Data	Codes
"My husband doesn't talk about how he feels about my disease" A female respondent said	Avoidance
"In my experience talking is important and helpful in problem solving and prevents from conflict." Stated by a respondent	Communication
"My husband criticizes me in insulting manner and doesn't care about my feelings…" A female respondent stated	Insulting behavior
"…sometimes I want to withdraw from the whole relationship…" A statement taken from a respondent's verbatim	Turmoil
"..he says he will do anything for me but I know he gets irritated now although he hides his feelings but I understand.."	Insecurity
"I am dissatisfied because he doesn't express affection and doesn't care for me"	Dissatisfaction
I have taken a lot of children responsibilities I look after children so she can have rest;	Assisting in household chores

Source: Participants' Interviews

The above table is illustrating few codes generated from data set and transcription. On initial stage of coding copious codes were generated as I included every code from the interviews so I decided to go for second round of coding in order to reduce the number of codes. I combined identical and similar codes into one code. Coding process also helped me in identifying irrelevant data presented in the interviews; the data was not addressed further. Once the coding was completed, I identified emerging themes developed in the result of categorization of responses. The emerging themes were identified on the number of similar responses presented in interviews; five or more than five similar and consistent responses emerged a theme.

3.4.3 Thematic Development

The next step in data analysis procedure required labeling the themes and meaning units identified after coding. Armstrong et al. (1997) defined themes as patterns through data sets which are related to a particular question under studied and significant for the

explanation of any phenomenon. I reviewed the transcriptions in order to analyze the data set and recognized themes occurring through the participants' responses then grouped and labeled meaning units into themes relevant to the marital satisfaction. These meaning units provided information and understanding about the experience of married couples where wives were suffering with breast cancer. The everyday expressions and lived experiences described by respondents were used to convert these statements into themes. I used verbatim responses from the transcriptions while reporting the data.

Table 3.1 Themes Derived from Respondents' Responses

Theme No.	Theme Title
Theme 1	Despair and Chaos: Reaction on Breast Cancer Diagnosis
Theme 2	Communication and Interaction; Effective & Ineffective Communication Patterns
Theme 3	Deserted Romantic Relationship and Emotional Intimacy
Theme 4	Dealing with Physical Deformity and Psychological Issues
Theme 5	Derelict Social & Spousal Support
Theme 6	Sexual Frustration and Dissatisfied Couple Relationship
Theme 7	Leisure, Spousal Shared Time and Breast Cancer
Theme 8	Breast Cancer and Marital Turmoil

Source: Interviews

The table above lists the themes developed through the codes generated from participants' responses. The above themes and labeled meaning units provided information about and an understanding of the experience of couples after breast cancer. In reporting data, verbatim responses from the transcriptions were used.

Thematic analysis is used by researchers as a mean of gaining knowledge and understanding from gathered data. The technique facilitates investigators towards developing a profounder appreciation aimed at the group or situation they intend exploring. Data is distilled by means of applying thematic analysis; researchers define broad patterns that allow them to carry out more granular research and analysis. Thus,

thematic analysis will be applied to comprehend the results consistent with the conceptual and theoretical structure of the research.

3.4.4 Interpretation of Data

The interpretation of the participants' experience was the final stage for the qualitative data analysis of present study. This was done by constructing how the couples individually defined their experiences. This stage also included examining what every study participant experienced and clustering each interview in order to find the essence of the experience unanimously. This multipart description of married couples delivered an enhanced understanding of the breast cancer experience and its influence on marital satisfaction. A comprehensive depiction of the experiences of the participants is provided through this composite information as I regarded significant connections associated to the phenomenon by apprehending the themes and descriptions of the participants' experience.

The participants of the presented study consisted of twelve married couples to gain deep insight into the essence of life experiences of study participants following breast cancer. During data analysis eight themes emerged in result of participants' responses. These responses and statement given by study participants deliver the knowledge and enhance the understanding of lived experience of study participants about the marital satisfaction. The themes developed are discussed in the chapter of data analysis and are interpreted using verbatim.

3.5 Quantitative Research Design

This section describes the quantitative methodology carried out to meet the objectives of this study. In quantitative research, the researcher acquaints himself with concept to be studied or research problem and possibly generates hypothesis to be tested. According to Bogdan and Biklen (1998), this paradigm emphasizes on facts and causes of behavior, Charles (1995) explained that here information is in numeric form which can be summarized and is quantifiable, numeric data is analyzed through mathematical process and finally the results are stated in statistical terminologies. Winter (2000) explained that researcher in quantitative research endeavors to fragment besides delimit phenomena into calculable or else general categories that maybe applied to a wider

similar situation or to all subjects. Moustakas (1994) states that qualitative designs enable researchers to explore and study "human experiences" not acquiescent through quantitative approaches. According to Creswell (2003), a quantitative research encompasses collection of quantifiable data which can be treated statistically with the intention of supporting or rejecting the developed hypothesis, presuppositions or "alternate knowledge claims". Leedy and Ormrod (2005) classified quantitative research in three broad categories: descriptive, experimental and causal comparative.

This section describes the quantitative methodology adopted in this mixed methods research study. It represents the quantitative data collection procedures including (a) research design, (b) sample size (c) sampling techniques, (d) data collection method, (d) development of research instrument, (e) reliability.

3.5.1 Research Design

A survey research also referred as descriptive research design (Leedy & Ormrod, 2005) was adopted to collect and analyze quantitative data for the present study. Groves et al. (2011) defined descriptive research as a systematic method used to gather data from a sample with the aim of generalizability.

3.5.2 Sample Size

According to Polit and Beck (2004), in the quantitative method the characteristically aim of sampling is to select a sample representative of the target population so that inferences can be made about this population. The sampling frame was obtained from the patient record of NORI hospital. Sample size for quantitative data was determined by applying the formula given by Yamane (1967). His formula has been set as: $n= N/ 1+Ne^2$

Where n=sample size, N=population size, e=the error of sampling.

$n= 920/1+920*(0.05)^2$

n = 920/3.3

n = 278.78

Approx. 279 (Couples)

Total respondents: 558

3.5.3 Sampling Techniques

Since it is not feasible to study every member of a particular group sampling in quantitative research is used to make inferences applicable to the entire population.

A sampling frame of married breast cancer women was designed by using the available list of patients (fulfilling the study criterion) registered in the hospital at the time of data collection. The medical records were reviewed for determining eligibility of research participants. The inclusion criteria for participants included (a) patients who were undergoing the treatment for any stage (I, II, III or IV) of breast cancer or had been treated and were on follow-up at the time of the data collection stage (b) married at the time of data collection and (c) both partners willing to participate in the study. Convenience sampling technique was applied for data collection as most of the patients were not admitted in hospital and didn't visit hospital regularly so probability sampling was not considered appropriate. Convenience sampling enabled the researcher to collect data from a larger population ensuring that the sample was representative of the study population.

The purpose of using convenience sampling was that it made possible to interview and collect data from a larger number of people without being confined to respondents from a specific area or city rather the respondents included were the patients on treatment or who have been treated for breast cancer and visited hospital for their follow-up.

3.5.4 Data Collection Method

The data was collected through researcher administered questionnaire in face-to-face interview with the respondents. This technique enhanced credibility of data and helped the respondents to clear any ambiguity or difficulty instantly.

3.5.5 Development of Research Instrument

The quantitative data was collected using researcher-administered multidimensional 5 point Likert scale of marital satisfaction developed through the identification of variables from themes emerged in qualitative data. These five categories are

communication, sexual relationship, spousal personality and support, intimacy and romantic relationship and leisure activities and represented the major dynamics of marital relationship of study respondents.

The qualitative data was thoroughly scrutinized and understood in order to develop the research instrument. Not every code or theme generated from the qualitative data analysis was included in the questionnaire. The codes related to communication, spouse's behavior, emotional intimacy, sexual relationship and social and family life were finalized and added in the survey questionnaire. Each theme was taken as a separate variable and each variable included different no. of items i.e. communication and conflict resolution, spouse's personality and behavior, and emotional bonding and intimacy included 10 items each while social life and recreational activities variable contained 7 items and the variable of sexual relationship included 9 items.

3.5.6 Steps in Designing the Research instrument

A 5 point Likert scale was designed to address variables derived through the scrutinizing of qualitative data and its reliability was assured by applying appropriate test.

3.5.7 Likert Scale

Likert Scale approach is extensively used survey research with the purpose of scaling responses. Garland (1991) stated that Likert scale allows respondents not only to demonstrate the direction of their outlook but also the strength of their opinion about an issue. Likert scales usually range from 2 to 10 point scales among which 5 or 7 point scales are the most common. I used 5 point Likert scale for data collection because it provides a midpoint to respondents as a neutral level of opinion (Johns, 2005) and can also increase the reliability of research instrument (Adelson & McCoach, 2010). In order to reduce the response biases/extreme response (Baumgartner & Steenkamp, 2006; Lewis & Sauro, 2009; Nunnally, 1994; Salazar, 2015), negatively worded items were also included in the scale. Gul, Qasem, and Bhat (2015) confirmed that inclusion of both positive and negative items enforce respondents to provide a more considerate and meaningful answer thus reducing these biases without losing internal consistency

of a research scale. Once the data was collected, negative items were reverse scored prior to statistical analysis.

Breast cancer patients' and their husbands' responses to each item statement were collected and summed up accordingly. I considered the themes emerged from qualitative data and made sure to touch every major aspect of marital life of couples confronting breast cancer that was narrated by informants in in-depth interviews.

3.5.8 Reliability Analysis

Reliability denotes to the measurement of consistency among identified items and repeatability of gathered data. I applied Alpha test as Cronbach Alpha is considered most valued and reliable test of an instrument's reliability.

3.5.9 Alpha Test

The Alpha test was applied to test the reliability of data collection tool. Ideally, Cronbach's alpha results should range from 0 to 1 indicating the level of consistency. A coefficient range is considered highly reliable when its range is up to 0.8 (George & Mallery, 2000) however Nachmias and Nachmias (1987) stated that in social sciences the acceptable coefficient is up to 0.6. The reliability coefficient of present study stood at 0.716 indicating the internal consistency of data.

Reliability Statistics

Cronbach's Alpha	N of Items
.716	47

Table 3.3: Reliability Statistics of Research Instrument

In the conclusion, mixed method design was a considerable strength of this study. It facilitated the integration of qualitative and quantitative methods which allowed a better understanding of the effect of breast cancer on marital satisfaction in

comparison of if one or the other method was used unaccompanied (Doyle et al., 2009). This study will add to the limited number of mixed method studies on this specific topic.

3.5.10 Field Experience

I selected NORI hospital for my data collection which is located in Islamabad. It provides treatment facilities to the residents of many nearby or far cities including of Hazara District and Azad Kashmir. Presently NORI is providing treatment facilities to 40,000 patients; this large number of patients not only enabled me to draw my study sample easily but it also helped me to collect my data in time and from various socio-economic groups and locality. This diversity provided me with an array of experiences confronted by study respondents belonging to different socio-economic, educational and cultural background. After the selection of topic, I wrote a letter to the administration of NORI hospital asking their permission for data collection from their patients. After completing the necessary procedure (i.e. security clearance and attachment with female doctors) I was allowed for collecting the data.

Both qualitative and quantitative data was collected in individual interview. I ensured the privacy of participants with the help of hospital administration as they provided me a room where I could interview participants without any interference or third person's involvement. The researcher-administered marital satisfaction scale used for quantitative data took 20-25 minutes while in-depth interview conducted with the intention of collecting qualitative data took one and half hour to two hours. For qualitative data I asked open-ended questions and probed when needed. In order to supplement the taped interview data, I also recorded non-verbal communication i.e. expressions, confusion, excitement and hesitation in response of a question by taking written notes consort with audio-taping. The quantitative data was collected by using researcher-administered marital satisfaction scale so no audio-taping was required.

Majority of the respondents answered every question although they were given choice to deny, refuse or withhold any information in case they felt uncomfortable or offended. The male respondents seemed little hesitant while discussing about their feelings towards their wives particularly sexual life. In few couples, the responses of

both partners varied preeminently when cross-checked. Most male respondents expressed deep concern and care for their wives but their wives' responses to same questions told different story.

The overall experience of working in NORI was pleasant as the administration was very cooperative and supportive besides as an institute NORI hospital provides research facilities to researchers and academics so quite a number of admitted or on follow-up patients was already exposed to different research projects and have already had encountered with researchers so their understanding towards research was developed which proved advantageous in my data collection; they were flexible and comfortable in expressing their feelings and sharing their experiences. It saved me a lot of time and allowed me to understand them/ their relationships with their spouses readily.

3.6 Ethical Considerations

Streubert and Carpenter (1999) stated that ethical concerns in research had been critical aspect and should continue to be of this endeavor. Besides it is an obligation to those conducting the research to make sure that the rights of research/study participants are protected who share their information, data and experiences for the sake of study (Polit & Beck, 2004). Keeping in view the sensitivity of the topic under research I took the following steps:

3.6.1 Informed consent

Informed consent is one of the means by which a participant's right to autonomy is protected. Armiger (1977) defined that informed consent is that when an individual gives his consent eloquently, willingly, intelligently, in addition to in a clear as well as manifest way. Nijhawan et al. (2013) stated that informed consent is obligatory preceding every research where human beings are involved as subjects of study. Acquiring consent implicates informing the participants about the study objectives, procedures to be undertaken, their rights including that of confidentiality of personal and demographic data, potential risks and benefits of participation, and expected time duration of study. I prepared a written consent form to be read and signed before the interview was conducted in order to ensure them about their autonomy and willingness.

3.6.2 Confidentiality

Confidentiality is the management of private information provided by subject to the researcher so that the subject's identity is protected. Levine (1976) states that confidentiality denotes that study participants are allowed to provide as well as withhold as much information according to their choice and comfort. Qualitative researchers are presented with unique challenge in preserving participant confidentiality and imparting rich, comprehensive interpretations of respondents' social life at the same time (Kaiser, 2009). Maintaining confidentiality is a researcher's responsibility. I ensured the respondents that their provided information will solely be used for research purpose and no piece of information will be disclosed to anyone otherwise. Besides, the personal information of the respondents is kept confidential and their names are replaced with pseudo names.

Chapter 4

Study Findings and Data Analysis

In this chapter I have presented study findings and data analysis based on collected data. The chapter of study findings and data analysis is divided in to two sections. Each section distinctly presents study findings of qualitative and quantitative data.

4.1 Qualitative Findings

This section presents the findings of qualitative data along with the interpretation. The data presented in this chapter depicts the views of both of breast cancer patients and their husbands in order to present a clear picture of how they both are living with and coping with the effects of breast cancer, how their lives and relationship with each other has changed. Each theme has been analyzed keeping in view the perspectives of all male and female participants, which enhanced the understanding of the phenomenon and how it is differently seen and observed by respondents of both genders in a couple.

4.1.1 Theme 1: Despair and Chaos: Reaction on Breast Cancer Diagnosis

Breast cancer victims faced extreme shock and stress following breast cancer diagnosis as most women thought breast cancer as a terrifying and deadly disease; they assumed that it will only cause death or reduce their life span (Lopez-Class et al., 2011).

A female respondent shared her earlier reaction to the diagnosis of breast cancer as follow;

"I was really afraid when I came to know that I have got cancer. It was shocking and scary. I never imagined anything like this. I was healthy and normal and suddenly from nowhere this disease got me. I cannot express my feelings I was scared really scared; how this could have happened to me, what was my fault, what did I do wrong. I was unable to understand the situation and didn't know what to do. Cancer is such a terrified word to hear. All I did was cry. I cried a lot for so many days. Doctors told me that my disease is not on a critical stage and I would recover soon but I know once cancer develops in your body it never leaves you. I was not thinking about death but I

was not ready to accept the fact of being a cancer patient. I complained to God that how can He do this to me?"

Cancer is very terrifying term/ word as most of the people still believe that it is incurable and the patient will die ultimately. This fear is one of the prominent causes of anxiety and depression among cancer patients as described by the interviewee reflected in above verbatim. The respondent who gave above statement was stressed out and anxious because she wasn't fully aware of her disease and possible treatment but once her treatment started and she started feeling better her fear became lessen.

The respondents who had seen any cancer patient in their family or friends reported to had severe reaction to the diagnosis of breast cancer, as stated by a female participant,

"I had seen my nephew dying of blood cancer, he had gone through long treatment yet he died thus when doctor told me that I had cancer I became so anxious and worried I started crying in the clinic of doctor. The doctor consoled me and said that my cancer can be cured but I was so scared to understand anything."

The cancer patients who had seen any other patient in their family or social circle felt more frightened and anxious because of their experience. In this case the patient's nephew had died of cancer and she had the feelings that she could also die without realizing that her health condition and cancer type and stage was different of her nephew. She insisted that she could die like him no matter what doctors told her she believed that they were saying it just to relax her. Understanding of a disease plays very important role how a patient reacts to her disease and the level of anxiety and depression one feels.

Few female respondents (5 out of 12) who didn't have any knowledge of cancer and its treatment also reported extreme reactions as for them the cancer only meant fatal and life threatening disease.

As indicated by a female respondent,

"My first reaction after knowing that I had breast cancer was very extreme, I only thought of dying. I thought every cancer patient dies with this disease in a short time. I was concerned about my children, they were so young and one of them is mentally handicapped. No one except me can look after him as he doesn't let anyone come near him and requires my attention all time. I was more concerned about him that if I will die who will take care of him."

Child care is a complex issue for breast cancer mothers especially for those having young children. Cancer treatments like chemotherapy and radiation involve episodes where patients are immune-compromised and are advised to avoid exposure to potential threats of infection. Females with young children were observed to have more stress as they didn't only fear death but also how their death will affect their children and their households. On contrary, in some cases having children played an important role for women to get composed and fight with their disease bravely for the sake of their children.

The female patients also experienced anxiety that exhibited itself in a wide-ranging symptoms containing agitation, fear of death, guilt, appetite changes, insomnia, and anxiety among many others. Usually this state doesn't last longer for few weeks once the patient gradually adjusts to the diagnosis. Nevertheless, depending on certain variable in women with breast cancer anxiety and depression may last longer. Bulotiene et al. (2008) mentioned that certain social factors may play a vital role in lasting depression and anxiety longer for some women compared to others. Breast cancer diagnosis affects the mind, body besides spirit of a female as she gets worried about her ability to continue to be the same woman afore to diagnosis and it was also established by majority of my study respondents.

However the experiences of the participants were different and clearly their cancer didn't affect them all similarly. For instance a female respondent expressed feelings contradictory to other respondents and told that she wasn't worried or frightened because she had strong belief, she said,

"I was anxious but was not afraid of death. I believe that our age is written and we will not live one day less or more than our written age. I truly believe that the night which

is written in grave will come there I cannot live an extra day so there is no use of getting frightened. My children are grownup they can take care of themselves but two children are so young. My youngest child is two and half year old I was worried about them but you know when I was one and half years old my father died and my brother was born after my father's death; he survived and passed through all hardships of life so would do my children."

The above statement was given by a female patient who had seen many hardships and ups and down in her life which made her a strong believer of fate and she had understood that her reaction would never change anything so she kept herself composed and unafraid without any denying of breast cancer experience being upsetting; Bury (1991) referred it as "style". A strategy used by patients to adapt to their diagnosis. This approach helped her in fighting against anxiety and fear of death and saved her from many emotional and psychological complications. The excerpt also demonstrates that women relate their suffering with their religious beliefs. The fact that this woman's complaining to God shows her connection to God and her religiosity.

A female respondent shared,

"Whenever I feel anxious and frightened I recite verses from Qur'an and pray. I feel relieved then."

Another female respondent also shared similar experience,

"In the beginning I used to go on roof and cry to hide my emotions from my children then I started to pray, my interest in religion and worship grew maybe due to fear of death or else I felt much lonely but every time I prayed I felt relaxed and strong."

The above excerpts show that female cancer patients seek help from religion and adopted religious practices as measures of self-therapy to overcome the fear and depression associated with their disease. According to them religious practices of recitation and pray provided them the strength and patience which they couldn't get through any other source i.e. family or friends. The more they practiced the stronger their belief got which helped them in fighting with their disease and to accept and overcome the difficulties resulted from cancer.

I observed in field that people who had strong belief in God seemed comparatively more content and satisfied. Their religious beliefs helped them accepting their disease and provided them with moral and emotional strength.

In my research I observed that breast cancer didn't only affect the physical health of females but also their social status in their families and their relationship with their husbands. Many respondents shared that they were afraid to tell their husbands about their disease because of their possible reaction.

A respondent expressed,

"I didn't know how to tell my husband about my disease I was so afraid of his reaction because I knew he will not tolerate or adjust with my situation. He treats me like a slave who is there for his household chores and to please him."

Another female respondent stated,

"When I was diagnosed with cancer I was not only afraid of death but my fear was about the reaction of my husband, I thought he will leave me because we were never so close to each other and now he had an excuse to get rid of me but it didn't happen, he wasn't changed in his actions but he never said anything about my disease."

The above two statements from two different respondents show that female patients whose husbands were not supportive and didn't treat them well even prior to their disease were anxious and worried of their husbands' reaction and the effect of the disease on their relationship with their husbands. They even thought their husbands might leave them because of this disease. Many people due to unawareness consider cancer a transmissible disease and avoid interacting with cancer patients i.e. having food with them or sexual relationship which affect their mental health, social status and make them feel inferior.

However, the data shows that not all husbands were critical or unsupportive instead many husbands cared for their wives and tried to console and comfort their wives by giving them emotional and social support. Husbands of breast cancer patients also narrated varied reaction to their wives' disease. A patients' husband shared that he

hid his wife's reports to avoid further problems and to protect her from mental stress and suffering, he told,

"When doctor informed me that my wife has cancer I told no one; neither her nor other people because people talk and behave strangely around a sick person which would have created more problems for us. People make things from their imagination, stay over to show their sympathy but mock. We had already wasted enough time because we listened to people... our system is like this."

The feeling of uncertainty and disbelief was mentioned by many respondents as the symptoms of breast cancer are usually not as severe and dreadful as the name of disease is. A male respondent told that his wife's disease was "unbelievable" for him because he never imagined that she could be that ill. He explained,

"I couldn't believe her reports, she never fell ill and she didn't seem that ill even the time of diagnosis."

Husbands of female patients were not only worried about their wives' health and well-being but also with the perceived outcomes of their disease for their family i.e. financial burden, household routine and childcare. The following statements show different approaches of two husbands how they both looked at their relationship and the importance of their wife's well-being.

"I didn't think anything else but about her life and health and I did everything that was possible for me to support her through her disease."

While the above respondents were more concerned about his wife's health the statement given by other respondent expressed that he was more bothered about the financial burden and childcare.

"I was worried about our children and financial problems that could be result of her disease."

The husbands of cancer patients were reported to play a critical role in their adjustment to breast cancer diagnosis by majority of respondents. Breast cancer patients

who had caring and supportive husbands were likely to face less anxiety and fear as compared to those who didn't have sympathetic life partners.

4.1.2 Theme 2: Communication and Interaction; Effective & Ineffective Communication Patterns

The study participants were asked how they communicated with their spouses, what the causes of conflict between them were, how they resolved their conflicts and how effectively they communicated their feelings and emotions with each other. These questions helped to provide an understanding of how well the spouses were bonded and committed to their relationship after breast cancer affected the female spouse.

i. Effective Communication

Communication skills are essential for effective communication which results in healthy and happy married life. Self-disclosure, active listening and conflict resolution are main factors of effective communication and couples who have these skills tend to have more stable and happy relationship. Couples who express their inner feelings and share personal emotions with each other tend to have strong bonding and greater satisfaction. Active listening not only entails the process of hearing and understanding but also expressing to the others that they are being heard and understood. It builds strong and respected relationship. Last but not the least conflict resolution is also associated with positive communication. How well a couple can manage to resolve conflict is associated with marital satisfaction of that couple.

Studies on marital satisfaction or marital adjustment and communication suggest that poor communication is among the key reasons of unhappy and dissatisfied married life.

A male participant from my study expressed the need to communication between couples for a successful marriage. He explained,

".. To talk with your partner is the key to successful marriage, I never tolerate when my wife discusses our issues and problem with anyone else, I have given her freedom to talk and express but not to any other person… you know people only create problems and misunderstanding because they don't have to deal with the consequences."

The way married couples discuss over their matters and issues is important to a fulfilling and sustained marriage as it builds emotional connection between spouses. Sharing small instances and openness brings couples close and give them the feeling of oneness. When one knows what is going on his/her life partner's mind and heart the issues can be resolved expeditiously and effectively. Talking to each other doesn't only solve several problems but it also strengthens the relationship by leaving a little or no space for anyone else to create misunderstandings between couple. Preponderance of female respondents and their husbands stated that having a strong and effective communication is a key to successful marriage as it enables them to share their feelings and expectation to their partners.

The other male interviewee stated,

"We always share our issues and problems with each other and in my experience talking is important and helpful in problem solving and prevents from conflict. We know each other so well that there is no space for misunderstanding between us and this strong and happy relationship is built on effective communication."

I observed during data collection that male respondents always discouraged the involvement of a third person in their spousal matters. Likewise, this respondent stressed on open and contented communication because he thought that no other person can be as sincere enough with a couple as the husband and wife with each other. Similar thoughts were shared by many male respondents in one way or another.

ii. **Expressiveness:**

Sharing feelings and expressing affection and love verbally is an important element in marital relationship. It gives strength to relationship and develops a feeling of belonging and mutual trust. It is generally observed, majority of people find it difficult to express themselves in front of others. For female respondents verbal communication stood an important factor to show that their husbands are concerned and worried about them. It is important to know that one is being loved and cared for especially in time of emotional instability and insecurity.

As mentioned by a female respondent,

"My husband never expresses his feelings and to be honest before cancer I didn't care about this much but now I want his attention; he should express his love and care for me in words because it gives me relief and trust."

Another female respondent said,

"I cannot tell you how my husband feels about my disease because he never discuss on this matter. He doesn't sympathize with me. Whenever I get worried he only says that everything will be fine or I shouldn't get worried. It is not sufficient for me."

The above two excerpts clearly show how women felt about their husbands' emotional support and how much it was important for them to know their importance and status in their husbands' lives. When their emotional needs were not fulfilled and their partners failed to fulfill their expectations; they felt insecure and confused which affect their mental wellbeing and ultimately their physical health as the collected data revealed. Majority of female respondents shared that they wanted their husbands to express their affection and care for them and to sympathize with them. As cancer didn't merely affect physical health but they also suffered from psychological as well as emotional problems. A caring and affectionate life partner, as stated by majority of female respondents, plays a vital role in comforting and soothing breast cancer patients. A concerning and caring life partner not only gives strength to women but also encourage them to fight with hard times. While rough times demand closeness and intimacy between spouses, couples may develop changed destructive communication patterns or fail to fulfill their partner's expectations thus resulting in conflict or dissatisfied relationship.

Another important element beside expression of one's feelings is tolerance and patience. A person should try to understand the standpoint and situation of his/her life partner before giving any extreme reaction as this prevents couples from conflicts. Female patients go through many complications and their behaviors may alter, in such situation their husbands need to tolerate their wives' emotional complications, mood swings and harsh behavior.

One respondent shared his strategy by saying,

"Patience is essential for stability of marriage. I bear everything she says and does because I know she is depressed and afraid and most of the time she doesn't mean when she says or does any wrong. She doesn't know how to control her emotions but I understand and remain calm which reduces the chance of fight."

The person who gave this statement was aware of his wife's condition so he endured her moods and behavior in order to comfort her and this strategy was hardly mentioned by any other male respondents. On contrary, many male respondents proved to be harsh with their wives thus creating many issues.

Besides verbal communication, non-verbal communication if understood by both parties is also effective component of marital satisfaction. If a spouse doesn't express his/her feelings verbally but through his/her actions shows respect and care other partner regards and honor these feelings.

"My husband doesn't talk about how he feels about my disease; he doesn't even tell me if my disease scares him but by the things he does I know he loves me. He is not much affectionate but he takes care of me so it would be selfish of me complaining about him."

In order to sustain a relationship it is important for both parties to understand each other completely and avoid putting each other in stress by forcing them to do what one doesn't feel comfortable doing. I observed during data collection that women hardly appreciated their husbands' efforts.

iii. Ineffective Communication

Communication problems occur when a person fails to express his or her feelings. In several situations spouses may become incapable or frightened in expressing their feelings of anger, helplessness or deep melancholy and their relationship is adversely affected. The quality of communication among couples coping with breast cancer is predictive of their marital adjustment (Hodgson, Shields, & Rousseau, 2003). Couples where wives were dealing with breast cancer testified ineffectual or poor intercommunication their major concern. Ineffective communication mainly included avoidance, blame and verbal aggression.

iv. **Protective Buffering**

Most respondents reported not discussing about cancer with their partners. Female patients avoided it as they didn't get intended response from their husbands. From the perspective of female respondents, their husbands didn't listen to them carefully or didn't understand them and worse they made fun of their insecurities and fears. The feeling of not getting heard irritated them and they believed they were worthless in the eyes of their spouse which generated tension and problems.

Effective and positive communication was the key to a healthy relationship in the perspective of respondents as most study participants expected their spouses to understand them and felt frustrated and angry when their life partners failed to do so without realizing that they rarely talked about their problems to them and directed their frustration and aggression towards their spouses.

As a female interviewee stated,

"I do not share my feelings with my husband as he will not understand, in beginning I tried to tell him that how much I was afraid of death but he didn't listen to me and he even made fun of me. So now I keep my feelings to myself but sometimes it annoys me. What is the point of having a partner who is not ready to listen to you?"

Another respondent shared same experience,

"He makes fun of me when I tell him that when I get afraid of my future and share with him. I always think what will happen to my children if I will die but he never takes me serious."

The above statements by two different female respondents show that women felt isolated and neglected when their husbands didn't listen to them or didn't give them attention they needed. They felt unwanted and insignificant; this created frustration and increased psychological complications. Patients suffering from a serious disease like cancer shared their suffering and fear for their catharsis and when other people didn't show their interest and sympathies patients got hurt and suffered psychologically. Yet

there were patients who didn’t like to talk about their suffering with anyone for one reason or another.

Husband of a survivor told,

“She doesn’t express her fears because she tries to be strong for our children and for me. She doesn’t even appear to be concerned but she is.”

A supportive and caring life partner plays a vital role in fighting with difficult times in life. Many male respondents during interviews claimed to be considerate and sympathetic who could understand their wives’ frame of mind yet their wives’ statements were different. In order to get clear and true picture I probed and cross questioned them. In my opinion the expectations of female patients raise and they had become sensitive so they thought that their husbands’ efforts were not enough to meet their emotional needs.

Another female respondent shared,

“He listens but doesn’t understand me. He says I overthink otherwise when doctors have said that I will get cured then I shouldn’t get worried about it. He says to me, “why do you think of the things which are not going to happen”. He doesn’t understand that these thoughts cross my mind unintentionally and make me anxious.”

Many participants admitted that they found difficulties in communicating with their partners effectively. They revealed that expressing their thoughts and feelings was uncomfortable. For females it was uncomfortable because they didn’t know what will be the reaction or response of their husbands on the other hand husbands kept their feelings to themselves to sustain their sense of responsibility and strength as males are perceived stronger and less emotional.

A female respondent put her hesitation in words as,

“I am unaware of how to voice my feelings. I want to tell him that death doesn’t scare me but leaving him and children on their own does. I never have told him how much I love him and appreciate his efforts and now if I will tell him what would be his reaction.”

According to majority of the respondents difficulties in expressing their feelings well is due to the hesitation and shame resulted from our society's manners and teachings. As women in our society are trained to be quiet and unexpressive and males are taught to be tough and emotionally strong which includes keeping distance from their wives to establish their superiority. In such situation husband and wife fail to communicate and interact easily and keep their feelings to themselves as evident from my data that most respondents encountered with same issue while communicating with their partner.

As explained by a respondent,

"We hardly talk with each other except the necessary talks like of children or of family I do not remember ever talking with him about my desires and dreams and now I cannot talk with him about my fears and anxiety."

According to many male respondents they suppressed their feelings of fear, disbelief and isolation because they saw themselves protectors of their wives' well-being and disclosing their "weakness" could affect their wives emotionally which they believed can affect her physically too.

A male respondent said he didn't talk to his wife about her disease because,

"She is already distressed and frightened, sharing my fear and insecurities will only intensify her emotional problems so I better avoid this discussion. I keep my anxieties to myself and pretend as I am not emotionally impacted by her disease."

A male respondent expressed his fear and anxiety,

"When she was diagnosed with cancer it was like a nightmare, I knew nothing, I was terrified however I didn't share my fear with her because it was unfair as I had to take care of her but I felt so overwhelmed and helpless that I couldn't understand what could I do to comfort her."

This led to avoidance and disengagement open communication. This situation might intensify the distress in couples' relationship. Because women having cancer

need emotional support and empathy of their husbands and when they don't get desired response they become suspicious of their husband's loyalty and love.

A female respondent shared her experience in these words,

"I was left alone to deal with this situation, I was terrified and scared and had no one to share my fears, and my husband never told me what he felt. I thought he didn't care for me and my disease didn't matter to him but later when he talked about this and shared his feelings I came to know he was also scared for me and our children. I was much relaxed after discussing everything with him and I knew he was never going to leave me because of cancer.

As evident from above excerpt open communication is very important and influence marital relationship positively. It is not only sharing ones feelings rather it means comforting each other emotionally and being there in difficult times.

However, most breast cancer patients complained about the reaction and attitude of their husbands who according to them didn't discuss their disease and suffering with them.

A respondent stated how she feels irritated by his husband's attitude,

"We talk with each other on every topic in the world except my disease; whenever I try to talk about my condition my husband changes the topic. I don't know why he avoids this topic. Sometimes I get annoyed by thinking that he might not care about my suffering and pain"

Another respondent shared same experience,

"It is not easy for me to talk about my disease with my husband although he is very supportive but he doesn't show any interest in this topic like if I tell him about what I feel and how much it hurts he listens to me but never shares his opinion I want him to relieve me but he changes the topic every time."

A female respondent expressed her grief and agony as,

"I often feel that I am not important for him and he doesn't care how much I am suffering because every time I try to tell him he asks me to change the topic he can at least show some sympathy but no he avoids this topic as if discussion about my disease is forbidden or a sin."

As for male respondents, the disease of their wives was important but not "the only topic" to be discussed between them. Many male respondents reported that their interaction with their wives is confined to discussion about cancer and its impact on their family and children.

A male respondent angrily stated,

"I'm tired of listening to her complaints as if there is no other topic left in the world, all she wants to talk is about her disease and how well she manages everything despite being ill. I want a break."

The above statement clearly shows that how difficult and hectic it became for a patient's husband when his wife continuously made him listen to her complaints related to the disease. It doesn't mean that husbands don't care about or sympathize with their wives they just need a break as they also suffer from mental pressure and stress because of their wives' disease.

Another male respondent shared his experience as,

"She definitely talked a lot about her disease but it was when she was getting her treatment, she only talked about her disease, fears and insecurities. But now she is changed, she talks to me about other family issues and my work routine and problems at workplace. It is a healthy attitude and I like it."

Many male respondents mentioned that they did not discuss the disease with their wives' because their wives didn't like them discussing it. For female patients discussing their disease again and again made them feel bad about themselves and lessen their self-esteem. They considered it as their husbands are trying to boast the favors conferred. Whether or not the husbands intended to do so females made this up and discussion turned into a fight or conflict.

As stated by a male respondent,

"I do not talk to my wife about her disease because she may get depressed and uncomfortable because each time I tried she took it so wrong and we almost had a quarrel so now I do not discuss anything related to her disease except her visit to hospital and her medicines."

On the other hand women sometimes feel disgusted and valueless because of their husbands' attitude so they didn't let them discuss their disease to avoid any bad comments and taunts from their husbands. Explaining this phenomenon a woman stated,

"I am his responsibility but he talks as if he is doing some favor to me by taking care of my needs followed by breast cancer. A woman only gets married to have a protector and care taker who can fully take her responsibility not a man who thinks his duties as if he is doing something special. When he talks about my disease he always finishes his conversation on how much he has spent on my disease and how my disease has negatively affected our family."

Avoidance is a strategy many couples apply to evade fights and disagreements but it does create many problems in couples because women consider their husbands being tired of their disease and not caring for them while husbands do it in order to avoid arguments as evident from several statements given by different respondents. For a healthy and satisfactory relationship a couple must know how to discuss their issues without getting into arguments.

v. Blame & Verbal Aggression

Where most male respondents claimed to be supportive and caring towards their wives, there were female respondents who shared contrary behaviors of their husbands. These females experienced mental torture and abusive behavior of their spouses.

An interviewee shared her experience,

"..He even says that my cancer is a punishment of my disobedience and insolent as if he is a saint himself. I wish I had never married or at least not to him... He doesn't bother to take my opinion in any affair I think he has already considered me dead."

Another female respondent articulated,

"My husband criticizes me in insulting manner and doesn't care about my feelings I feel assaulted and sometimes I want to leave him and go back to my parents' home but it is not possible because in our society there is no respect of a woman who leaves her husband."

Female respondents shared that their husbands in many situations insulted them because they couldn't adjust with the changes their wives' disease had brought in their lives. As a male dominant society this behavior is not much criticized or opposed by other family members rather when a female loses the respect of her husband other family and community members might also treat her unsympathetically and insensitively.

A male interviewee added,

" I never blame her for her disease it is a trial from God but she takes way-out advantage of her disease for example she doesn't do any household chores even though doctors say that she is physically able enough and she fights with my mother and sisters because they regard her disease. She also fights with me when I try to make her understand anything."

Although evident from data that husbands sometimes become insensitive and heartless under the pressure of situation most husbands were caring and sympathetic to their wives and whenever a problem raised both partners in couple were to be blamed.

A female respondent agreed as she told during the interview,

"I may also be responsible for our quarrels because whenever he says something I never keep quiet and always answer him turning it into a heated argument but I cannot control my anger anymore."

Another female respondent shared,

"People advise me to be silent when he is in anger but no one says to him that he should be thoughtful and supportive to me in this critical time. Sometimes he behaves so aggressively that my children become afraid too."

As said by respondents arguments and quarrels happen when both sides try to prove them right without respecting other person's sentiments and feelings. Female respondents claimed to be tolerant of their husbands' transgression for long that it became unbearable for them while husbands were not habitual of listening to their wives. Breast cancer brings many psychological and behavioral complications with it and females suffering from it experience many changes including being sensitive, fretful, bad tempered, lament and aggressive on the word of respondents. These changes were reported to affect the behavior of female patients which their husbands found very difficult to adjust with.

A male respondent explained,

"I have done everything possible for her but she never regards of my efforts. I can tolerate a lot except impudence and she doesn't understand it or at least doesn't seem to care about it."

A female respondent angrily said,

"A man can hit his wife, abuse her in front of whole family and no one blames him on the contrary everyone advises the woman. But a wife cannot say harsh words to her husband even when they are alone. I have always kept quiet but now I cannot control my anger which creates more teething troubles for us.

Females with breast cancer might or might not face much verbal aggression from their husbands as it all depends on the nature and strength of their marital relationships but when any among the spouses go through this situation their satisfaction level significantly decreases; they become less satisfied in their married life and the marital relationship fails to fulfill their needs and expectations. Even though

this situation if tackled sensibly doesn't lasts long but sometimes it gets worse and end into fights and temporary separation.

vi. **Conflict Resolution**

In addition to open and positive communication conflict resolution is considered an important factor for stabilizing a joyful and happy marital relation. Psychological distress and anxiety caused by cancer can influence spousal relationship by crafting arguments and conflicts for couples. The conflict resolution style is important variable of marital satisfaction. The cancer experience can lead some couples to major relationship difficulties and adjustment problems that result in feelings of less intimacy and greater conflict.

A respondent stated,

"At times arguments seem to come out of nowhere we often have serious disputes over insignificant matters and before we realize it we are in a fight. All I know is each time I get blamed for problems."

Regardless of how well a couple manages their relationship, at time they get annoyed at each other for doing something they dislike or disagree on important decisions or they fight because of some other reasons like bad mood or tiredness.

A male respondent told,

"Arguments and fights happen always as they happen in any married couple and we resolve such issues by understanding and listening to each other but now she has changed if I try to make her understand something she gets angry and starts crying which really annoys me."

Since every couple experienced disagreement and conflict in their lives the nature and underlying factors were different. Breast cancer didn't seem to raise conflicts between couple but it heightened existed conflicts.

A female respondent shared her anger as,

"We do not fight over any other thing except finances and economic problems. My husband has never fulfilled his responsibilities of earning and providing for his family I always worked to fulfill my children's' needs but now I am not able of doing so but my husband is still the same he doesn't care about me or my children.. I come to hospital with my son who is very young but I don't ask him to come with me. He hardly provides for our food I have taken loan and other expenses are fulfilled by Bait-ul-Mal. My every demand of money turns into a fight because he is irresponsible and doesn't work hard. If he tries he can make good money but he is lazy and careless."

Breast cancer doesn't only effect working subjects negatively but also affect the economic activities of the entire family. In our society, fulfillment of family's economic needs is a male's responsibility and their failure in doing so doubles the burden of females. As the respondent explained that she was forced to rely on Bait-ul-Mal and emergency help from family and friends; it pushes her to the brink.

A male respondent told about his conflict with his wife by stating,

"We live with my in-laws and my wife always listens to them. I always say to her that we should not involve them in our personal matters but she never listens to me. Her mother and sisters always keep an eye on our relationship and her father and brothers keep discussing with me how I can be more responsible and how to be a good husband and father. They have poisoned my children's brains now they also think that their father is an irresponsible man. This is the only reason of conflict we have and it doesn't has to do anything with her disease except now I cannot say anything to her."

The above two mentioned couples were in conflict majorly due to economic reasons and irresponsibility of husbands. Failure of husbands in performing their duties expectedly created imbalance in married life and family. Breast cancer patients who had neglecting husbands were facing more problems as they had to manage household responsibilities, take care of children, dealing with the social pressure resulting from their husbands' incompetence, earning for their families in addition to fighting with a life threatening disease. They were mentally disturbed and physically vulnerable in comparison of other cancer patients.

Yet there were couples who experienced new sort of conflicts after the breast cancer victimized female spouse among the couples. The conflict seemed majorly resulting from the tension and frustration created by physical deformity of wife, sexual dissatisfaction and incapability of wives in fulfilling their responsibilities.

An interviewee stated,

"I feel disrespected when he complains about my body or my inability to perform household chores, I am going through a hard time and all he cares is about my looks and his clothes and meal. As if I am a servant who only pleases his master and when fails the master insults her in front of everyone."

A female respondent stated,

"He has changed since my mastectomy he doesn't take interest in me, comes home late and gets irritated on little things but when I mention it to him he never accepts and starts argument which goes on and never seem to end."

Breast cancer treatments altered females' physical appearance i.e. losing hair, putting on or losing weight, aging and losing one or both breasts in result of mastectomy. These changes might not be accepted from their husbands immediately and they take time adjusting with these changes. This effect the intimacy and sexual attraction between a couple and conflicts rise. Most of the time men fail to understand the psychological complications females go through thus not taking good care of their wives. The ultimate result of this situation is women feeling dissatisfied in their marital relationship yet there were male respondents who accused their wives for creating problems in their married life.

As shared by a male respondent,

"I am doing everything for her so she can get her health back but my efforts are never appreciated rather she often misunderstands my feelings and intensions. Many issues rise because of her attitude. She often complains by saying "you always care only for yourself or you never do anything for me" I feel insulted and get mean and insulting in response."

Husbands of breast cancer patients go through several difficulties while adjusting with the changes in their lives brought by their wives' disease. So when their efforts were not appreciated they got annoyed and problems are created.

Most female respondents mentioned breast cancer effected their moods and temperament, they claimed to become more sensitive and emotionally weak which created problems in their routine life as little things became irritating and their outlook developed negative resulting in baseless disputes and arguments. As stated by a cancer patient,

"Most of our problems are caused by my temperament, I was not like this before but now I cannot ignore a little thing even if I see him staring at me I start questioning that "why are you looking at me or are you looking how ugly I have become" little things irritate me and I cannot control myself. Although he sooths me most time but gets angry sometimes which results in fight."

The above statement was made by a patient who was well aware of her behavior complications and mood swings but didn't know how to handle these issues. Many women did understand that their husbands were not solely responsible for problems in their couple but they didn't admit it openly.

Many male respondents also stated that their wives' attitude has been modified after their disease. The physical pain and emotional distress affects the overall personality of cancer patients and they experience changes in their moods and behaviors which most husbands find difficult to deal with.

As stated by a male respondent,

"She has grown so sensitive that I cannot even tell her a truth about her because it means an argument, I only point out the flaws she needs and can improve and which are not result of cancer but she doesn't face any issue responsibly or maturely."

Couples tried different strategies for avoiding conflicts and settling their disputes. These strategies vary from couple to couple but most male spouses stated that they give their wives advantage of their disease and try to avoid argument or give up

too quickly to not to hurt their wives as they all thought having stress is not good for their wives. For females tolerating their husbands' bad mood and changed behavior became difficult with their own physical and emotional problems.

A female respondent claimed to give up in order resolving the conflict and stated,

"I often give up too quickly ending an argument because he turns out to be total irrational and I can neither mentally nor physically able to bear the consequences of dispute. Sometimes I feel he is just trying to find an excuse to leave me because I am of no use to him now on the other hand he has to take a lot of social and financial burden imposed by my disease."

Most spouses tended to avoid any situation they think might turn into argument or fight in order to maintain peace and harmony in their relationship as stated by an interviewee,

"In any argument he makes me to feel that every problem or issue is entirely my fault so I try everything to avoid conflict with my husband and make an argument end calmly without considering my inner feelings."

A male respondent shared his interesting strategy of conflict resolution by saying,

"Each time my wife fights with me I keep quiet and listen to her then I go to my in-laws home and tell everything she had said to me, my mother in-law and brother in-law scold her and reconcile her. I can argue with her but I don't like it because I know whatsoever she says she says in stress and her family can make her realize about her being unfair with me."

Another male respondent stated,

"I avoid any argument with her, when things get steamed I walk out of my home and stay away for a while like 3-4 hours spend that time with my friends or relatives. I don't want to hurt her because she is already suffering besides our disputes are momentary and quickly forgotten"

No matter whom started argument or fight women mentioned to give in before men to cool things down and for reconciliation.

A female respondent stated,

"My husband is short tempered and lose control easily, I cannot even think straight when he yells unnecessarily I feel like running away during our fights and give in easily."

Another female respondent shared,

"Our disagreements make me feel distressed every so often that I just clam up myself and become silent. Such the dispute doesn't get severe. My silence cools things down."

As couples fought over different things they also resolved their conflicts and disputes with different strategies. Marital satisfaction and joy was reported to be related to these strategies by many respondents because the more effective a couple resolved their issues left impact on their mutual relationship and bonding. Female stated that they usually withdrew from dispute by keeping quiet or crying, men on other hand left the place for time being. Yet there were couples who resolved their conflicts by mutual understanding and compromising with each other.

An interviewee stated,

"We fight a lot but we never insult each other neither do we fight in front of our children or any other member of our family. We had a vow at our wedding night that we will never involve any third person in our personal relation and we both have kept our promise. When we fight we openly share our feelings and decide how the current issue can be resolved. And once we both express our rancor things get to go normal."

Many husbands stated that their attitude towards their wives had been changed as they gave them the advantage of being diseased and ignore their wives' stubbornness and mischievous.

As a respondent stated,

"My wife is stubborn and emotional and ill too so even when I believe I am right I compromise not to shutter the calm and peace of our home."

Mutual understanding and respect was an important aspect as described by many respondents in conflict resolution among couples. Expressing one's own point of view with respect and giving other person the chance to present his/her opinion developed strong bonding which in turn helped in resolving disputes. Couples who practiced these strategies be likely more happy and satisfied.

A respondent told,

"We are good listeners even when we have some disagreements we can maintain our temper and control at times when things get hard we can resolve our issues because we give importance to our relationship and rationally take decisions. We respect each other's opinions."

Breast cancer in most cases heightened the existed conflicts between couples instead of raising any new clashes. As the nature, causes and severity of conflicts were different for different couples so were their conflict resolution strategies. The life partners who were respected and caring to each other preferred their relationship over individual differences yet experiencing gratification and happiness in their lives. Couples where spouses understood the importance and need of each other seemed to ignore each other's flaws and avoid unnecessary argument thus saving themselves from clashes. On the other hand respondents whom partners were egotistical and self-centered and didn't care about each other's feelings experienced less satisfaction and were not happy with their marriages. Breast cancer didn't seem to play a significant role in nurturing conflicts yet it intensified the situation for couples who were already in disagreements and conflicts of any nature i.e. financial, social or family disputes.

No matter how tough the situation gets couples who stayed committed resolved their conflicts quickly and effectively. Many respondents claimed to choose commitment over argument. Spousal conflicts were very common and may rise without any significant cause; the important thing was how couples acted and resolved their conflicts. Every couple had its own conflict resolution strategies and pattern. Many

respondents shared that they gave in and left argument before it got heated. A number of factors like commitment, loyalty and care for each other played a vital role in conflict resolution. Many female respondents stated that their husbands gave them the advantage of their disease and acted affectionately and differently as they would had done in a normal situation.

vii. Positive Behavioral Changes

A small number of respondents also stated a positive change in their attitude as they had learned communicating their spouses in order to avoid conflict in such times when both partners need each other as stated by a participant "more than ever before."

One husband made a profound statement,

"I learnt the way I should communicate with my wife. I learnt to sit back, calm myself and think before saying anything in response of her statement. I now look at things from all angles and try to understand her mood and intentions."

One female respondent told about the change she brought in her communication;

"He is not a good listener and is never going to change, so I have made adjustment with his attitude. I do not complain about my condition now rather I ask him about his routine at job and the problems he faces and praise him for taking care of me and handling all problems and difficulties with patience and then I slowly change the topic to my issues in this way he doesn't only listens to me but also gives me response in a respecting way by consoling me and assuring me that he will always be there for me. I think the way a husband treats his wife is mainly dependent on his wife."

Personally in this study I observed that besides negatively effecting marital relationships, breast cancer in some cases has done some good for couples as few respondents shared that they have become close to each other. According to them they have changed their behavior with each other especially males show more tolerance and female embrace and appreciate their efforts which make their relationship strong and fulfilling. The couples who experienced such positive changes were more satisfied in

their lives generally and in their marital relationships particularly despite the female spouses being cancer patients.

4.1.3 Theme 3: Deserted Romantic Relationship & Emotional Intimacy

Intimacy in its rawest form is closeness with another person. Intimacy bears out different meanings for men and women. For females, an intimate relationship brings happiness and achieves the greater satisfaction within the relationship. Conversely, men carry the effect of an intimate relationship extend to other areas of functioning. People experience more positive situations in other life contexts i.e. work or social life when they have more satisfied romantic relationship. Intimacy is not only confined to sexual intimacy, even physical intimacy doesn't involve sex. Intimacy has enormous components i.e. loyalty, acceptance, respect, trust, support, understanding, honesty, involvement, mutual friendship and communication. Core components of intimacy are effective communication, solidarity and affectionate feelings between partners (Yoo, 2014).

In addition to sexual intimacy there are different forms of intimacy and all play a significant role in strengthening the bond and relationship between couples. Emotional intimacy is experienced differently by men and women. Generally observed and evident from current data, men increase emotional intimacy through sexual interaction while women require emotional intimacy to be intimated sexually.

A male respondent shared,

"I always express my feelings openly and compliment her which affect her mood even in time of anxiety faced by her disease I didn't change and always tell her something romantic or compliment her when I see her up set and worried, her mood changes and she becomes happy; seeing her happy makes me happy."

Although physical intimacy and sexual relationship is most significant element of marital satisfaction but couples with female breast cancer patients faced problems in this regard. As sexuality after breast cancer is a major concern as sexual interest and frequency of sexual activities remain decreased. Here, husbands play a vital role in order to console and comfort their wives. While most females complained about their

husbands not were being caring of their emotions and physical suffering, there were male respondents who stated that they made efforts to make their wives happy by complimenting them and by little gestures of kindness.

A female respondent shared,

"Whenever I was in pain he would hold my hand and console me, I could feel his care and affection which gave me courage to face all hardships and went through all painful treatments"

Another female respondent shared same experience,

"I feel loved when I see him worried about me and the way he tried to cheer me up and looks after me shows his love and care for me."

The above mentioned statements from two different female respondents are clear evidence of the importance of affection and intimacy among couples. The affection and intimacy given by husbands make wives strong and give them courage to fight cancer.

Intimacy and romance was found in little acts and habits like when wife cooks favorite meal of husband or husband brings some little gifts for their wives, calling each other with affectionate names and neglecting each other's mistakes. Even little acts of kindness and compassion and caring gestures were highly valued from both partners as demonstrated by the following statements given from different respondents of both gender.

A male respondent shared,

"My wife never eats before I get home no matter how hungry she is she always waits for me."

A female respondent stated,

"In our community husbands don't take their wives for outing or for shopping but my husband is exceptional he takes me out even after our children he didn't change."

A female respondent said,

"My husband never calls me with my name in front of others he would rather say "my wife" "begum ji" or any other word. People sometimes make fun of him but I really like when he gives me respect."

While another female stated,

"He never says he loves me but I can feel his love when he tries to help me in household chores he doesn't know to cook but he cuts vegetables, folds laundry, makes tea and most of the time brings bread from market."

The above statements prove that intimacy and affection beyond sexual activities is too important to bring spouses close and strengthen their relationships. Couples who act affectionately with each other are more satisfied in their relationship.

A male respondent told about his relationship with his wife,

"We are so close to each other that we can understand each other's moods and feelings without being said by other person. She doesn't need to tell me about her anxiety and depression as I would already know and she doesn't need me telling her about my problems. If I come home with bad mood and say that I am tired she can understand weather I am tired or I had a bad day."

A male respondent stated,

"I know I can go to my wife for help in any trouble or hard times, she never disappoints me."

Many female respondents shared same experience as expressed by the following respondent,

"I trust my husband completely because he has never lied to me and has been truthful and honest and sincere with me."

A female respondent expressed,

"He solaces me when I get upset and talk to me about different things. He takes me for a walk to a nearby park he doesn't let me worry about my disease by keeping me busy with him and children."

The feelings appeared to be strong when spouses were closed to each other and trusted each other. Many respondents alleged that they respected and trusted their partners which brought them close.

Yet there were people who had problems in intimate and romantic relationship. Breast cancer didn't seem to affect intimacy between couples on a greater scale but if definitely reduced the romantic interaction and effected intimacy between them as the wives were less active sexually and the feelings of fear and anxiety overcame their benign feelings.

As a female stated,

"I often don't feel emotionally close and attached to my husband as our relationship doesn't involve such tenderness and affection. We both perform our duties and responsibilities as expected but nothing more."

Self-exposure leads to intimacy which geneses positive assessment of the relationship and confidence and greater satisfaction in marriage. Women feel more secure and confident when their husbands express love and care in words. Women facing breast cancer needed this security more than ever as many among them were insecure and afraid.

"I know he loves me and will never leave me no matter what because he himself tells me so and his actions as well show his sincerity and concern for me."

Many females acknowledged the efforts their husbands make to keep them happy as said by a respondent;

"I know I can talk to him when I am upset about something and he listens carefully it makes me feel good about myself that despite my disease and the burden he is going through just because of me I am still special and important to him."

She further added,

"I have seen ladies whose husbands totally neglect them and treat them badly because they are supposedly of no use to their husbands after cancer but my husband never treats me this way."

Another respondent said,

"He says nice things to me, tells children that they have a great mom, defends me in front of other people and thanks me for every little thing I do for him and his family. It makes me realize my importance and worth in his life as well as in my children's life."

A male respondent listed few things he does for his wife,

"We hardly have sex as she is not physically strong enough but I show my love to her with little gestures like holding her hand, caressing her, expressing my feelings, praising her efforts for fighting with cancer and bringing little gifts for her like her favorite eatables."

As stated above many respondents described that how they and their spouses found happiness in little things and mutually appreciate each other's efforts. Breast cancer didn't seem to have significant devastating effects on marital satisfaction of couples who were emotionally attached with each other strongly.

Most male respondents accepted that they felt good when their wives appreciated them for taking care of and being nice with their wives.

As approved by a respondent,

"Every time she expresses her gratitude I feel that my sacrifices and efforts are not wasted I am not saying that she should do this often but it feels good to hear that my efforts are being appreciated."

Many respondents experienced hesitation and reluctance when it came to expressing their love verbally to their wives. A respondent expressed his hesitation in following words,

"I do everything possible for her, paying for her treatment, taking care of children, assisting her in household chores even though I believe taking care of home and household is a woman's job but when it comes to express my affection and care in words I cannot do it easily. Neither can I console her nor can I express my own fears and insecurities to her."

A male respondent shared exclusive reason of controlling his emotions not expressed by any other respondent according to him,

"I am often reluctant to show my affection because she habitually misinterpret it as a sexual advance and reacts strangely which destroys my mood. She accuses me of wanting her to be more intimate than she feels comfortable."

Interestingly many female respondents agreed to the above statement indirectly by stating that their husbands' only show affection when they "need" sex, so females on the basis of their previous experiences misunderstand their husbands' intentions and react in annoying ways i.e. neglecting or ignoring their husbands or getting harsh with them.

Yet many female respondents reported that they felt angry and upset when their husbands don't express their feelings verbally or don't show their affection.

A female respondent told,

"He never expresses his emotions and feelings, he thinks that by satisfying our financial needs or paying for my treatment is sufficient for us and we should be grateful of him but I want him to stay with us, spend time with me and children so we can feel our importance in his life"

A female gave words to inner voice of many female respondents when she said,

"I am dissatisfied because he doesn't express affection and doesn't care for me. Every woman wants to be loved and appreciated from her husband but when husbands fail to do we feel frustrated and annoyed."

Most female respondents expressed to have experienced complete support and care of their husbands followed by diagnosis of breast cancer but this was gradually changed as the disease prevailed long enough and husbands got irritated or fed up.

"My husband was very lively and cheerful for first few months he supported me emotionally and physically but then he started getting fed up. I could sense this by his attitude and behavior. Earlier if I told him about my pain or suffering he would calm me down by consoling me and would give me time and involve me in some activity to divert my attention but as time passed he started ignoring me. Now if I tell him something related to my disease he shows as if he has not heard me or replies me in harsh tone."

A female respondent while sharing the changes occurred in her husband's behavior by time stated,

"…he says he will do anything for me but I know he gets irritated now although he hides his feelings but I understand…love and commitment has different meanings for male and female if any woman's husband gets sick she forgets every other thing even her children and spends her all energies for her husband but husbands never do any such thing for their wives."

A female respondent stated,

"Which husband loves a wife who is ill and cannot fulfill her duties of housekeeping, who is not physically attractive and sexually active and because of her the financial burden of family has increases, at least I have never seen such husband so my husband is no different and he is not doing anything wrong if he doesn't give me time. He cannot ruin his social life for me because I don't deserve it."

Living with an ill partner is not an easy task for most husbands as they may experience poor psychological health besides the burden associated with providing physical assistance make them less satisfied in their relationship with their wives.

"I attempt to get closer by expressing my caring feelings and support to her. I want her to trust me when I say to her that she is not alone and I will stand by her side in any

difficulty and troubles. I never realized that how much she is important to me until she had cancer and her life was in danger. I always thought fulfilling my responsibilities were enough to show my affection and love but now I regret the time I could have spent with her without any fear of losing her."

As many female respondents complained about their husbands' behavior, few male respondents expressed their unpretentious feelings of love and affection for their wives. Interestingly expressing one's feelings also gave self-satisfaction and complacency and contributed to the overall satisfaction of relationship. Not every husband took his wife for granted as evident from above statement some were very affectionate and truly loved their wives as well as admitted it openly without any hesitations because for them the most important thing was the happiness and comfort of their diseased wives and they didn't feel hesitant of showing their care to them.

A male respondent claimed to be affectionate with his wife yet having a number of complaints from his wife he said;

"My wife is ill for so long time that I even can't remember her healthy and active. I spend all day working to earn for my family and bear all harsh and difficulties and when I come home I only get to listen her complaints about her life, her health and her issues with children and my family. To say she is ill but she never wastes a chance of fighting with my mother and sister in law. But I cannot even complain because if I will every person will say that I am selfish and do not care about my wife."

Another respondent shared almost same outlook,

"I care for my wife but sometimes it gets so frustrating when I enter my house after a hectic day and I listen to her lamentation, at times I need break from this situation but I can't have any."

Husbands of breast cancer patients faced difficulties in adjusting with their changed life and routine due to the disease of their wives. They tried to manage their extra responsibilities along with traditional roles and duties that become very hectic and difficult for them. The husband who gave the above statement was also occasionally tired and wanted her wife to give him some relaxation which according to him was not

possible because her wife despite of being cured insisted to be taken and treated as a sick person. I observed during data collection that man breast cancer patients who were being treated and were on follow-up wouldn't take part in their routine life normally as they would still consider themselves sick and would take the advantage of their disease.

A male respondent also expressed same experience

"It's not like I don't care about my wife but sometimes I need a break from her disease talk and want to discuss other things which might bring her comfort and a sense of a normal life but my every endeavor fails due to her response."

During data collection I observed that many women took advantage of their disease and teased their husbands unnecessarily as the respondents who gave above statements were annoyed of their wives' attitude but still managed to tolerate and be kind to them. Such circumstances build pressure on husbands and marital relationship becomes less interesting and satisfactory for them.

Majority of respondents expressed grief and sadness over the changed relationship with their wives as for them their wives were their companion and friends and now they miss their closeness with their spouses.

A male respondent who was living in other city due to his job told,

"When she was healthy she expressed excitement and interest on my every visit of home, she would ask me about my activities and events of whole week and would told me about everything happened meanwhile in home. But now she has changed a lot she doesn't speak much and even tries to avoid me and I don't have any idea how to change this situation and attitude."

Another male respondent added,

"She used to be thoughtful about romantic and sentimental things for instance remembering special occasions like birthdays and anniversary. Although we never celebrated these occasions but I liked when she wished me but now she forgets."

Yet another male respondent expressed,

"I have lost a person with whom I could share everything; my problems, my worries and my dreams now I think hard before telling her anything because stress is not good for her. I sometimes need someone to listen to me and console me but I don't have anyone. I at times become so frustrated that I think to have other relationship but then I think of all those years she has spent with me and I feel ashamed."

Marital relationship is not only about household management, child rearing and sexual relationship but also about having a life partner and companion with whom one can share each and everything; his/her worries, achievements and happiness. But breast cancer comes with a lot of complications not only physical rather psychological and emotional too. Females suffering from breast cancer find it difficult to maintain a normal and promising relationship which directly distresses their husbands as above selected quotes clearly depict that the husbands of breast cancer patients also go through many hardships because of their changed relationship patterns.

Where most female patients reported infrequent and less intimacy and romantic interaction among them a female respondent shared her experience different to other study participants. She said,

"Surprisingly I and my husband have come closer to each other since my disease. Since our marriage we had not spent enough time together because of his responsibilities but when we were visiting hospitals and I was admitted at different hospitals he always stayed with me and now when I come for my check-up and follow-up sessions, he comes with me. We talk and share our feelings with each other in a manner we have never done before. I never realized he is so affectionate and cares for me but he does. I was always getting jealous of his family because he never gave me time due to them but now I know I am also dear to him and he will do anything to give me comfort."

The above excerpt illustrated that some couples come closer in time of distress as the female mentioned that in their routine life they weren't close enough due to the responsibilities they were performing for their family. Joint or extended family is most common family type in our society and married couples in this family system are not given enough space or time to spend together in result they feel distant and when hard

times hit they either become more distant and isolated or else become close to each other as revealed by current study's respondents.

Several female respondents stated that they ignore their husbands' attitude and deeds in order to keep their married relationship strong and stable or in order to acknowledge their husbands' efforts. A female respondent stated,

> *"Marriage is not about household chores, rearing children and having sex whenever your husband wants, if my spouse cannot tolerate me in my suffering and support me through hard times then there is no benefit of getting married. My husband is trustworthy and dependable. He is very kind and affectionate and has not left me in need. So if he gets annoyed or irritable sometimes I ignore his bad words and anger because I know he does it under pressure and forgets once his exhaustion is calmed."*

Breast cancer patients and their spouses had different experiences regarding intimacy and romance in their relationship. Some couples faced less intimacy as the wife experiences many psychological and emotional changes. These changes affect their entire spousal relationship. The couples where husbands were supportive and understanding helped their wives to overcome these complications and patiently tolerated their wives' mood swings and behavioral changes; wives in such cases were more satisfied with their partners and found their marriage fulfilling as compared to the couples who didn't have an understanding of these complications and how to deal with these. Intimacy and romance plays a very important relationship element to strengthen it. The husbands of breast cancer patients on the other hand experience less intimacy and romance thus resulting in less satisfaction and fulfilling relationship.

i. Commitment & Loyalty

A happy marriage doesn't solely depend on love and affection it also needs commitment and loyalty as well. Being loyal doesn't only mean physical fidelity and emotional devotion. Loyalty with many manifestations is needed in every aspect of a couple's life. Being loyal means reassuring and following through with the promise of being with one's partner emotionally and physically, at whatever time they need them. A life partner's presence, kind words and helpful actions are vital for trust and security for

his/her mate in the relationship. Many breast cancer patients held resentments about their husbands not being there in the time of crisis in their lives.

As expressed by a female patient,

"He never took care of me even when I was hospitalized he didn't bother to stay with me. If something like this would have happened to him I would have never left him alone but I have seen other women's condition too all husbands are usually selfish and unkind."

These angers would have been avoided with sentient devoted behaviors because loyalty means prioritizing and satisfying one's partner's needs and a commitment to be always there for him/her when they require attention and support. Being loyal also means being respectful to your spouse, keeping his/her honor and not speaking disparagingly about them to others.

As a female respondent angrily expressed,

"I feel so frustrated and embarrassed when he complains to others about me as my disease is my entire fault."

On the other hand, male respondents complained that their wives were demanding and didn't appreciate whatsoever they do for them. According to them they are going through many difficulties yet try to compensate their life partners but they only got grievances in return. A male respondent shared,

"No matter how hard I try to help her and make her comfortable she always has complaints to make and tell people that I don't care for her and that I am selfish."

When partners in a couple do not appreciate each other's efforts they feel unsatisfied and disappointed with each other as evident from the responses of study participants. When a partner was devoted and loyal he/she would never said or did a thing that man shamed his/her partner in public or private and would compensate his/her weaknesses.

A male respondent said,

"When you truly love someone little things don't matter. Spousal fights are very common even though my wife is ill and needs emotional support I sometimes lose my control and explode but later I realize my fault and do not feel ashamed in admitting my bad behavior. When she says or does something she was not supposed to say or do I give her benefit of her disease and ignore to possible extent."

A female respondent expressed same feelings,

"Issues get raise and issues get solved, this is normal routine of our life the only thing we care about is how can we sustain and stabilize our marriage. We can sacrifice our feelings, egos and differences for maintaining our relationship. Sometime I give in before he does at time he does the same."

Loyalty and commitment play a significant role in fulfilling and satisfied marital relationship. Couples who were dependable on one another were happy and contented whatsoever life brought to them. The husbands in such couples were concerned and caring for their wives and their wives appreciated their efforts and actions. While the couples who didn't trust each other completely were less satisfied and were facing more problems i.e. spousal conflicts and quarrels.

4.1.4 Theme 4: Dealing with Physical Deformity & Psychological Issues

Breast cancer patients are given different options regarding their treatment such as surgical treatment; lumpectomy (breast conservation) and mastectomy, radiation therapy, chemotherapy, radiotherapy, and endocrine therapy.

Each treatment procedure has its own cost and complications i.e. nausea and alopecia are common complications after chemotherapy, poor sexual function or sexual dysfunction, weight gain or loss, hair loss, and ovarian damage, skin swelling, inflammation and redness. Mastectomy (the removal of one breast affected by cancer cells or both) can result in deformity, surgical scars besides the sense of losing one's femininity. The breast symbolizes femininity, sexuality, attractiveness, and exemplifies womanhood, nurturance, and motherhood eventually females' views of their bodies and figures are likely altered by the surgical treatment they receive. The study participants

were asked to share their experiences and coping strategies for the stress caused by these physical deformities.

In this study the participants too shared their experiences of dealing with physical deformity and psychological issues in detail. A female respondent shared her reaction to physical changes caused by chemotherapy and her fear of her husband's reaction in these words,

"After chemotherapy I began to lose my hair and became very weak. I was very worried about my physical appearance i.e. looking beautiful and charming. But I was also worried about my husband's reaction. He likes beautiful girls and gets attracted towards them so I became very anxious. I could not let him fall for another girl or could not bear him ignoring me or getting fed up of me. I cried a lot when I first saw myself in mirror. My husband made fun of me he said he was just teasing me."

A male respondent shared his feelings and his wife's reaction to hair loss,

"She didn't go under many changes. When she was having chemotherapy she lost her hair and she started looking very strange but I never said it to her I didn't want her to feel bad about herself. She herself wasn't comfortable with this she started covering her head in home too."

Females, whose husband supported and encouraged them through this hard time and stayed by their side felt more confident and satisfied as compared to those whose husbands were insensitive and less concerned about them.

A female respondent told how her husband consoled her, she stated,

"I didn't experience many physical changes except hair and weight loss. When he (husband) saw me with no hair he smiled and said soon your hair will grow again but you are still looking beautiful although he had never told me before that I am beautiful."

A male respondent stated,

"She (wife) was worried about her hair so I told her that she is beautiful even without any hair. I wanted her to stay positive and strong."

Hair loss and altered weight is reported by every breast cancer patient as a complication resulting from chemotherapy but as the effect was temporary the stress and worry related to this reported to decrease as soon as the hair started to grow so adjusting with these complications was not much difficult as compared to getting adjusted with the complications raised from mastectomy. The women who lost their breast/s stated to have greater stress, less confidence and a permanent feeling of loss.

A female respondent shared,

"I had cancer in my right breast so doctors removed it, I didn't want to get my breast removed but doctors said there was no other option to safe my body from the spread of cancer I felt incomplete and ugly because I lost my body shape."

A female respondent stated,

"I never thought of any such thing ever happening to me, I was told by doctors that they will try to save my breast but they couldn't. They first removed one breast and few months later other breast was also removed. I don't see myself in mirror, I sometimes try to feel my breasts and get frustrated."

Physical deformity and complication leave devastating effects on females' self-esteem and self-confidence.

"… I am not left with a desire to wear new and beautiful clothes. I feel so ugly and unattractive when I see myself in mirror. I hardly go any party or event and cover myself properly but people seem to give me strange and sympathetic looks I want to run from that place."

Male participants of the study reported different views about their wives' changed body and the way they adjusted with these complications. Almost every male respondent agreed that they found it difficult to adjust with their wives' altered bodies and physical changes.

A male respondent stated,

"…it will be a lie if I say that she doesn't look strange to me but I cannot say that she looks ugly she looks different and I still feel difficulty in adjusting with her altered body."

A survivor's husband shared,

"I cannot look at her scars, those are horrible and I feel bad when I see those scars. She feels hurt but I cannot control my expressions."

Husband's support and assurance is among the key factors of marital satisfaction for females but most women with mastectomy stated the negative remarks about their husbands' attitude and behavior. Husbands not only avoided physical relation but also taunted their wives and teased them because of the physical complications and/or changes resulted from breast cancer treatment. Even when they didn't say anything their actions and gestures showed the disguised feelings they had for their wives i.e. avoidance and neglecting, having separate beds, avoiding social activities with their wives, having less or no sexual activities etc. Sometimes the reaction was much severe that female patients were afraid that their husbands might leave them. As explained by a female patient,

"He (husband) makes fun of me not only in words but his eyes and his gestures also speak and taunt me. I feel so depressed and frightened by thought of him leaving because I am not able to fulfill his desires and no longer attractive for him."

A female respondent stated,

"My husband says nothing but his attitude has been changed after my surgery, he avoids spending time with me and when he does, he does it heartlessly."

Another female respondent shared,

"He never turned-off lights when we were in bed I always asked from him but he never listened to me but now he keeps lights off; I feel insulted and hurt."

Females with breast cancer had become more sensitive and felt every change and problem with their husbands' attitude even the slightest. Sometimes their insecurities and complexes made them whimsical and they blamed their husbands for the things which were not even on their husbands' mind. But more often their intuitions were true. According to many respondents their husbands acted differently around them following the diagnosis and treatment of breast cancer and female patients mostly found it uncomfortable and disturbing especially when they found that their husbands were neglecting and avoiding them because of the side effects breast cancer and its treatment left on their physical appearance. Although most husbands were caring and supportive yet it was difficult for them to adjust with altered or deformed body of their wives.

As a male participant expressed,

"Adjusting with her deformed and disfigured body was very difficult for both of us but now things are normal we know that we have no other option rather than accepting the situation and we have to hold each other's back."

In addition to physical deformity females go through many psychological complexities and problems mainly anxiety, mood swings, fear and aggression as mentioned by many breast cancer patients and their husbands. These problems allegedly affected their spousal relationship.

A male respondent told,

"She has become so irritable that I think hundred times before saying anything to her because I'm never sure of her reaction; she either becomes aggressive or starts crying."

Many female respondents reported to experience emotional instability in addition to psychological complexities. In their perspectives these were the result of fear of disease, physical suffering and exhausting treatment. A female respondent described her experience as,

"I was very calm and good-tempered person before the cancer hit me. Now I have become so short-tempered that at times I don't even bear the noise of my own children

and scold or beat them. I also fight with my husband when he doesn't listen to me. People say that cancer medication damages the mental health in my case it is true."

These behavioral issues followed by diagnosis and treatment of breast cancer created difficult situations for couples. Many respondents mentioned that it resulted in spousal and family disputes at times.

A male respondent expressed that dealing with his wife's behavioral problems occurred after breast cancer was more difficult as compared to dealing with her physical illness. He stated,

"My wife was of very polite and unfussy nature. We live in joint family and she had always tolerated my family wholeheartedly but now she is changed. She often fights with my mother and sister in-law despite of the fact that they care and look after our children when my wife is unable to do so. I apologize to them to maintain the peace of house."

A female respondent expressed that she becomes overwhelmed by her emotions and fail to control them; she described her situation as,

"I don't know how to control my emotions; at times I am so angry and the very next moment I am like a child. My husband and family members seem fed up of this situation but I am helpless and can't change it."

Physical deformity and psychological compilations, as discussed by many respondents seemed to affect the spousal as well as family relationships especially with children and in-laws of breast cancer patients. However the spouses seemed to play a significant role in helping women to overcome with these issues and felt confident again.

4.1.5 Theme 5: Derelict Social & Spousal Support

Another theme emerged from data associated with marital satisfaction was social support and shared domestic responsibilities. Women with breast cancer reported to seek both emotional and instrumental social support from their husbands. The emotional support included love and reassurance which is covered under the theme

titled intimacy and romantic relationship the instrumental social support refers to pragmatic help i.e. money and assistance in daily household tasks.

Diagnosis and treatment of breast cancer result in difficulty in returning to usual domestic activities. Yet when questioned about how they manage their household tasks and responsibilities many female respondents reported no or little assistance of their husbands in this regard. They also had to take care of their children.

A female respondent like many others stated,

"I try to do all household chores without any assistance or help. I fulfill all responsibilities of my children including their father's, as well as taking them to school or for shopping and I know no one is going to take care of my children as I do not even their father because he neither ever had nor he will ever do."

Another female shared almost same experience,

"Normally I do perform household chores easily except the days after chemotherapy. But I cannot go out for shopping or for other tasks as I get tired so my husband takes our children to shopping and for other needs. He asks me to do only those tasks which are very important. Otherwise he doesn't let me do any tiring work."

Several females reported they had the assistance of other family members for instance their daughters, sisters or sisters or/and mothers in-law if they lived in joint family.

A female respondent gave detailed description,

"My eldest daughter was of nine years when I got admitted in hospital for treatment and on returning home I wasn't able to do any work she was so young but she tried hard to perform household chores, she was unable to cook but she used to do cleaning and dishwashing and laundry as well. It was so painful for me to see her doing work beyond her age but I was helpless as my husband was not around but even if he was he wouldn't have done anything because he is typical male who thinks household chores are a woman's responsibility besides we are not financially capable of having a maid."

Most of the time females stated that they did not like taking assistance of their relatives when their husbands could do these little tasks but they had to since their husbands didn't bother to share their wives' burden.

"For first few months when I was having chemo and radiation sessions, my sisters used to stay at our home and took care of house. My husband has never thought of doing anything whenever I get sick he asks me to call my sister I argue that we can distribute our tasks but he says he can't do a woman's work."

Hardly any respondent's husband arranged a maid but it was also temporarily. The respondent stated,

"I couldn't afford a maid with increased expenses including my wife's treatment and diet cost yet I arranged a maid for her when she was getting her treatment so that she could take proper rest."

A male respondent said,

"Although I'm not able to afford a maid but I try to help my wife besides our children are young enough to take care of themselves my eldest son is very responsible and takes care of his younger siblings well."

Nevertheless some male respondents claimed to share their wives' burden and household responsibilities whether it be cooking occasionally, doing dishes, ironing their own clothes and taking care of children's responsibilities.

A male participant of study stated,

"I have taken a lot of children responsibilities I look after children so she can have rest; I get tired because despite working full time I am doing more than my fair share in children rearing."

Another study respondent told,

"I often have to bring meal from hotel and often have to iron my own clothes but I don't complain to my wife because I know it is not her fault as she still tries to manage her

household tasks in her bad health…yes it has put an extra burden on my finances and daily routine but I hope it is all temporary."

Another male respondent who lived in joint family system said,

"My niece takes care of my children she gets them ready for school, iron their uniforms and arrange their books, she also cleans our portion, I bring "chapatti" from hotel my wife only cooks curry, I fetch water and even wash clothes. I feel no shame in it."

A patient's husband told the way he takes care of his wife by saying,

"I don't wake her up in the morning for my breakfast, iron my own clothes as well as of my children', if guests come I bring food items from market and prepare tea, and I also help my wife when she does laundry."

As above statements from different male respondents clearly illustrate that they were concerned about their wives' physical health and tried to put them in ease by sharing their burden and by not putting extra and unnecessary burden on them. The husbands who claimed to perform domestic tasks with their wives stated that the most difficult tasks for them is to take care of young children as they are attached to their mothers in comparison of their fathers.

A male respondent shared,

"She cannot perform daily chores properly; she gets tired soon so I try to help her. Children are not close to me they are close to their mother and despite of her disease they remained attached to her so she has to take care of children."

A respondent described same experience,

"The most difficult task is look after children they are so attached to their mother that when she had to stay in hospital I couldn't manage the situation. They cried for her and asked me again and again to bring their mother back. I sometimes cook also, when she doesn't feel good she eats and admires but my children never like my cooking."

In our society child rearing is mainly considered a mother's job while fathers maintain a distance from their children due to different reasons as a result children get

attached to their mothers and look to them for their needs. When mothers don't feel better and fail to take care of their children properly they feel neglected and face several problems i.e. getting late for school, unhygienic and poor food, emotional stress etc.

When asked, female respondents about husbands' assistance had different views sometimes husbands were not supportive and even if they helped their wives they didn't do it happily. So many females prefer to do all chores by themselves.

A female respondent shared,

"Household chores are not difficult to do for me except I cannot stand in heat of kitchen for long time and get tired easily when washing clothes. My husband never helps me himself but if I ask him to take basket of clothes upstairs, he does it without any anger and at times brings dinner from hotel but I try to cook even it is a simple dish because hotel meals are expensive and unhealthy."

Another female interviewee stated,

"I never let him do anything, he never takes a glass of water for himself and my disease has not changed his habits he still expect me to do everything perfectly and when I fail he gets annoyed and angry he uses harsh words in front of my children and other family members."

A female respondent expressed,

"He helps me sometimes in household chores for example he cooks when I don't feel good and have no other option and even cleans the house but he doesn't care about my feelings and taunts me every time he has to do any such task."

In the agreement of former female respondents one added,

"He has always been so cruel and mean to me that I never saw any joy in my married life. My all expenses are taken care by my family yet he complains about me neglecting his chores. My life has no importance for him."

The majority of female respondents decided to perform their household chores without any assistance because of their husbands' taunting and insulting behavior. For

many females doing household chores with poor health was easy in comparison of tolerating their husbands' affronts and insult.

A husband blissfully shared,

"No matter how ill she fell she never left any chore undone whether it is cooking or cleaning or doing dishes. When she had to come for chemo or radiation she would prepare the breakfast and lunch for children and after coming from hospital she would prepare dinner. Our one child is abnormal he doesn't live with anyone except his mother so she never stayed in hospital not for a single night and after getting treatment she never rested or made an excuse of not doing any chore. She never asked for help and if tried she always refused by saying that it's her job not mine. I respect her courageousness no one can have guts of doing so. "

In our society housekeeping is considered a woman's responsibility whether she is working or having any physical disease or emotional deformity she is never freed of her duties and household chores. If a husband is supportive and tries to assist her wife he is mocked by family and friends. Few male respondents who claimed to help their wives in household chores shared their experience that how people make fun of them or taunt them. A male respondent shared his experience,

"..People say different things but I do not care about their opinion any more... If women are solely responsible for household chores then it is the duty of men to earn for their families but she helped me financially when she had the strength to do so. So what difference it makes if I will help her in house after all it is about me and my children."

Another male study participant described,

"I don't understand that how housekeeping is a woman's job and how doing few household chores affect my masculinity? It is absurd to sit and look your sick wife hardly performing her tasks when she is unable to do so but people won't stop saying if you help your wife you are an uxorious and if you don't take care of her then you are mean and selfish."

In our society, gender roles are highly specified and people can hardly go beyond their designated roles especially when it comes to a man doing household chores. Our society hardly acknowledges that if a female can earn so does a man can lend his hand in household chores. Although a male never takes full responsibility of domestic chores still society doesn't except him even partially taking part in domestic tasks and mock and taunt them without realizing the intensity of situation. That is one of the main reasons of males providing less or no help to their wives in domestic chores.

Yet another male respondent expressed,

"A man is responsible for earning for his family and a female need to take care of household and children but for last few years I had to take responsibilities of my wife too as she is not capable enough, my life has become so difficult in trying to keep balance between work and home and I feel so helpless at times."

On the other hand many male participants expressed their anger and irritation on their wives' inability to perform household routine tasks. According to them domestic tasks are sole responsibility of females and they should never neglect their duties. But none of them accepted that they mistreat their wives or force them to do work difficult for them.

A male respondent expressed,

"I sometime get irritated when she is not able to perform household chores and her relatives come and stay with us. I don't like people around me and our routine is specifically set."

Another male respondent explained,

"How can I do cooking or laundry it is a female's job I earn for her and her children I spend all day in listening to people's harsh words and bear all difficulties so I can earn enough to feed my family and then I am supposed to do tasks which are my wife's responsibility."

Yet another study respondent described,

"I don't get angry or irritable but I feel tired and sometimes upset too. I mean as a male I was never trained for housekeeping and I never thought I will need to do such tasks, washing my own cup of tea is such a big task for me and I cannot manage household responsibilities."

Another male expressed that it is unfair to expect from men that they would perform household chores,

"I am doing two jobs so that I can pay for my wife's treatment and medicine it is unfair to expect from me that I will come home tired and will do dishes or laundry. She has to do this by herself and her doctors never said that she cannot do such tasks."

A male respondent complained as he said,

"Her disease has badly affected our life and routine she cannot efficiently perform her duties and my home gets disturbed, my children are suffering and I don't know how to help her like I cannot cook or wash clothes and dishes I have never done it."

A male respondent angrily stated,

"I can have other wife but I didn't go for this option she should be grateful and shouldn't expect more than this she has ruined my peace and life but I still tolerate her with her disease and problems she has created for me."

In our society men are brought-up with a mentality that they are not at all responsible for domestic tasks and they should not take part in household chores. This mentality leads to aggression and irritation when females become unable to perform their customary role.

A male respondent also shared that he felt ashamed as his wife didn't perform household tasks even she is not that ill. He said,

"I feel ashamed when her mother or sisters come to clean our house or to cook food but I cannot do anything she is recovering now and can do little tasks like cooking and cleaning but she is lazy."

The satisfaction is reliably associated with degree of social support and every spouse who provided virtuous social support to his/her partner contributed spouse's marital satisfaction. In our society role and responsibilities are distributed on the basis of gender. A male is supposed to earn for his family and woman is responsible for domestic work and taking care of children. Household chores are usually considered a woman's job and responsibility. Even a woman working outside or ill is not free from these responsibilities. Breast cancer patients were no exceptional only that their husbands were somehow concerned about their health and tried to help them partially otherwise still women were responsible for household maintenance and domestic chores.

4.1.6 Theme 6: Sexual Frustration and Dissatisfied Couple Relationship

Sexual satisfaction has proved to be a major contributor in marital satisfaction and breast cancer affects the sexual performance of females. Pakistan is an Islamic Republic and based on Islamic laws marriage is the only institute for the fulfillment of sexual needs. Sex is only legal and allowed in formally married couples. The satisfaction and quality in a sexual relationship in addition to its frequency appears to be a vital factor in maintaining a happy and satisfying marriage. But as the interviewed couples shared with the wife suffering from a deadly disease the sexual satisfaction merely becomes a dream as it affects the patient not only physically but mentally and emotionally as well.

Sexual dissatisfaction among couples with breast cancer patients was mostly result of the sexual dysfunction of patients. A large number of respondents reported decline in the frequency of sexual intercourse after their wives were diagnosed with breast cancer. Nearly every patient and her husband abstained from intercourse immediately or barely engaged in sexual activities.

A female breast cancer shared her experience as,

''Following diagnosis of breast cancer, we never have sex. As I don't have desire and due to vaginal dryness intercourse has become so painful that I cannot bear it.''

Majority of male respondents reported being depressed and affected due the declined sexual activities. Apparently, adjusting with the sexual dysfunction of wife is the most difficult task for husbands.

A male respondent told,

"She has much pain and makes noise that I get irritated, like it's not something new we have been married for so many years and she has suddenly started acting as this is a new thing which she doesn't understand or is unable to perform."

Another respondent expressed his anger and discomfort as,

"We barely have sex following her diagnosis of breast cancer, sex is not a desire or luxury it is a need if not fulfilled badly affects a man. I feel frustrated and annoyed. I can understand that it is difficult for her but she should also understand my situation."

Sometimes when husbands see their wives performing other chores per routine and participating in other activities they refused to believe the pain and suffering sexual intercourse causes to their wives as a respondent told that:

"My wife always refuses to have sex she says that pain is unbearable for me but she has actually lost her interest in me and/or in sex. My sexual needs and desires don't matter to her, I want to live a normal life but it is not possible for me obviously I am stressed and this affects my family and marital life."

The husbands believed that their wives made excuses in order to avoid having sex with them based on their previous experiences

"… She never was interested in sex I could feel her cold behavior every time she was with me in bed and now she has got an excuse of her disease which she uses as a weapon to get sympathy and to avoid sex at the same time"

Breast cancer affects the intimate part of female body and they become very conscious about their appearance and physical changes. Physical changes distress females' confidence and their performance in bed. The supportive role of husband and

confidence given by him are important factors which help women to get back their confidence and self-esteem.

As a respondent told,

"I felt really ashamed after mastectomy; it killed my desire for sex as I thought I was not beautiful or attractive for my husband. My self-esteem was so low, but my husband behaved so normal as if there was nothing changed. His affection and love helped me to gain my confidence back. I still sometimes feel uncomfortable when I am with him but he is so passionate and caring that I forget my disease."

While undergoing through different treatment procedures most women loss their interest in sex and their sexual desire. They feel sex disgusted and embarrassing and forced sex makes them angry.

As a respondent angrily shared,

"..There remains no difference in a man and a beast when it comes to sex, he just wants to fulfill his needs and doesn't care about his wife's feelings and pain. How am I supposed to be happy about this?"

Many female respondents stated their husbands' behavior and attitude had altered; mocking their wives, making comments, insulting, avoiding and getting angry on little things are common practices of men who are not sexually satisfied with their wives. Many times, wives ignore their pain and join their husbands in order to avoid arguments and fights.

As told by a female respondent that how it feels,

"I was not interested in sex anymore it didn't physically hurt much but I lost interest and couldn't find any pleasure or satisfaction. I thought that I am going to die very soon so any other thing is meaningless. He was not afraid of my disease and wanted to have normal relation but I had lost my interest in him. Our sexual interaction was so problematic due to my resistance that we couldn't continue it. Having physical and sexual relationship is very important in any marriage and in such young age it is not possible to avoid or ignore physical needs. My husband is not a saint who will sacrifice

his needs over mine so when I refused sex his attitude got changed. He became irritable and sarcastic. He started making comments which put me down."

Loss of sexual desire and interest is not the only reason of females to avoid sex but the changes occur in their bodies as the result of breast cancer and its treatment also play an important role in changing females' approach towards sex. Vaginal dryness, bone pain, nausea and loss of intimate part of body is common in breast cancer patients and these factors combined or alone affect the sexual performance of patient.

A female respondent said,

"I have faced many changes after breast cancer my vagina has dried and intercourse has become very difficult, I often ask my husband to stop during intercourse because it becomes so painful which makes my husband annoyed and irritable and his mood gets changed. He then treats me badly and makes snide remarks. I want to kill myself sometimes because of his attitude."

One respondent shared her experience,

"I feel very weak after chemotherapy and cannot perform sex properly despite this my husband forces me for having sex with him more than once in a week, he doesn't care about my difficulty. He becomes a beast when he is in need of sexual intercourse and cannot differentiate between right and wrong. If I try to stop him he turns violent."

The above statement shows that sexual dissatisfaction and frustration even led to marital violence in few cases. Describing her experience she further added,

"I tried to discuss this problem with my few close friends but they all said it is his right and I shouldn't deny it rather should bear it and be thankful to him that he has not left me after such a dangerous disease."

In the Muslim society of Pakistan there is no alternate way for males to fulfill their sexual needs except their legal married wives. When due to any reason a female fails to indulge in sexual activity a male neither can accept the fact nor he can adjust with the situation which creates stress and tension between husband and wife. Many husbands reported continuous stress and discontentment due to sexual tensions between

couple. Most men reported to have forced sex in order to protect them from indulging in an inappropriate or forbidden act i.e. illegal sexual relationships.

A respondent stated,

"He, whoever says sex doesn't affect quality of marriage tells lie, sex is important if my sexual needs are not met I feel frustrated and irritable which affects my whole personality, my personal and social life as well. I cannot behave with my wife as I used to be, I do care for her but my feelings are getting changed and from the time doctor has told me that they never advised my wife to avoid sex but my wife told me that her doctor has suggested her not to have sex anymore. Why shouldn't I get angry? I force my wife for sex because I know it doesn't hurt her. I can fulfill my need by some other means but that is not acceptable for me."

Another respondent shared same similar experience,

"Every time I ask my wife for sex she refuses by saying she has pain or it hurts that definitely annoys me. I haven't enjoyed sex for last 3-4 years"

Most of the time expert advice is not available to people which cause misconception about the nature of disease and its effect. Although cancer is not a contagious disease but people often have the perception of it being transmitted through sexual intercourse. A number of respondents shared their experience of avoiding each other on basis of their own poor understanding or on the advice of unaware people.

A respondent told,

"My wife and I didn't know if we can still have sex or not after my wife was diagnosed with breast cancer but no doctor guided us in this matter and we were so ashamed of asking any question then during our hospital visits we exchanged information with other patients and their spouses but they had diverse opinions. I then encouraged my wife to ask from doctor, her doctor told her that you can have sex unless you feel hurt. But I really care for my wife and don't want to tease her so I have reduced our sexual activities to comfort her."

A respondent said,

‘‘My uncle whose wife died with cancer advised me to avoid sexual intercourse with my wife. He said that sex doesn’t only lead to the recurrence of the disease but it might be transmit to me. I became so scared that I didn’t even touch my wife for a long time’’

Most female respondents stated that they didn’t tell their husbands about the pain and discomfort that coitus causes because they were afraid of the reaction of their husbands. They believed that their husbands might get angry or fed up of them so they did not share their suffering with their husbands.

A female respondent told,

“Sexual intercourse feels so terrible sometimes but I hardly refuse my husband because I am concerned about our relationship. I once met a patient in hospital whose husband had divorced her because of her disease I will die if it happens to me so I don’t give him any chance of complaint about me.”

A male respondent explained,

“I don’t know about any sexual problem she faces, she never complains about any such thing so I take it normal as it was before her disease. I have heard from people that women after breast cancer lose interest in sex but our experience is different may be due to the reason that we never cared about whatever people say, it is our relationship and we know how to keep it warm and strong.”

Not every wife interviewed was afraid of her husband rather there were females who had caring and supportive husbands who took good care of them and they appreciated their efforts. Mostly females didn’t share their feelings and fears to their husbands as they were terrified of their actions yet there were females who hid their pain because they didn’t want to disturb their husbands as they were kind and affectionate and didn’t force them for sex.

A respondent told,

“I no longer have desire for sex or for romance even but I don’t refuse my husband’s demand for coitus as he has always been so affectionate and caring towards me. He

went through many hardships after my disease but he never changed. My act is an acknowledgment of his loyalty and love."

Another respondent stated,

"I never told my husband about my pain and suffering but he himself is very supportive and caring, he never forced me into sex. For first few months I was really unable to satisfy him in bed but he never complained on contrary he consoled me and behaved as if everything was normal and per routine."

In a male dominated society where women and men have their conventional roles, females find it pleasantly strange to have supportive and caring husbands who not only take care of them in time of need but also take consideration of their emotional needs so they hide their pain from their husbands and try to make them happy bearing the pain. Many respondents mentioned that although they didn't enjoy sex anymore but for their husbands, they actively participated in intimate activities as they believed this is one of the best ways to show their gratitude.

A respondent expressed,

"Although I no longer desire for sex but I don't refuse my husband's demand because he is very nice and cares for me so every time he asks for it I try to fulfill his needs."

Having extra marital affair or looking for an alternate way to fulfill one's sexual needs is also controlled by religious teachings as people are afraid of the punishment they might get in result of their immorality. Besides, a number of respondents expressed that their wife's health and feelings are more important to them in comparison of their own desires and needs.

A male respondent shared his thoughts,

"I didn't have sex with my wife after breast cancer. Her health is more important to me than my sexual desires. I feel the desire of sex but I control it. Sometimes it becomes very difficult but I know I have to answer my ALLAH one day so I cannot dare to fulfill my need in any other way which is not legal or is a sin."

Another male respondent stated,

"Sex is important but not more than her health, I know her pain and troubles and how hard she is struggling for her life and only a selfish man would think of having sexual pleasure from a woman in such times. I do not have complaint rather I appreciate her efforts."

Sexual satisfaction is an important element in marital satisfaction and stability. A number of factors were stated by the respondents to influence their sexual relationship including sexual dysfunction of wife subsequent to physical and emotional effects of breast cancer resulting in decreased frequency of sexual activities and intercourse, lack of sexual interest among wives, maladaptation to the body changes and quality of sexual intercourse/ dissatisfied sex. In addition, the misconception about the disease' nature and its impact on sexual functioning of patients plays a significant role in the problematic sexual relation.

4.1.7 Theme 7: Leisure, Spousal Shared Time and Breast Cancer

Leisure activities and shared leisure participation between couple plays a significant role in maintaining a marital relationship. Marital satisfaction increases with the increased leisure time spent with a spouse, reported by several study respondents of both genders.

A female respondent claimed that time spent and shared leisure with her husband made their relationship stronger,

"When we spend time with each other it brings us close in a positive manner, we feel the warmth and affection of our relationship and realize the importance of each other's in our life."

According to her, leisure activities brought couples close and built a strong bond of affection and companionship. The time a couple spends together makes them realize each other's importance in one another's life.

The other female interviewee stated,

"My husband never spends time with me, my in-laws are very strict and rigid in these matters so we don't get to spend time together and our routine didn't change even in my disease. He never sat with me and consoled me."

In our society joint family system sometimes creates problems for couples as they are not given sufficient time and space to share with each other. This practice might affect the intimacy and association of couples as they don't get to know or understand each other completely and do not feel related. This situation may ascend dissatisfaction from one another in couples.

During data collection, I observed that most couples did not share their social and leisure activities and did not spend enough time together yet there were couples who claimed to have leisure time spent together but it was mainly confined to watching T.V or having little personal conversations.

A female respondent shared,

"We get our time when everyone is asleep; we watch movies or T.V programs then tell each other what we have did in that day." Her husband in separate interview added, *"We don't discuss any problems or issues in that time rather we only talk about pleasant and good things. It gives us both the energy for next day."*

Another male interviewee said,

"We look forward to spend time together, even the smallest routine things whether it is grocery shopping, preparing meal or folding laundry and watching TV becomes enjoyable for us when we do it together."

He wasn't ashamed of participating in household chores with his wife as for him he was not only able to give a relief to his wife but they enjoyed it which brought them close and gave their relationship warmth and strength.

A female study participant told,

"We go for a walk in a nearby park twice or thrice a week. We have befriended with more couples there. We sometimes sit together and talk. Most of the time our conversations are confined to our children yet we feel relaxed and fresh."

Another male respondent stated,

"We don't have much options of recreation because we don't have T.V or computer and there are no parks in our areas so I take my wife to her sisters' home or to different relatives' homes. She feels good there."

Spending time together and having shared leisure activities appeared to play a vital role in a couple's marital satisfaction. The more time a couple spends together the more intimated and affectionate the partners become for each other contributing for the more satisfying and promising relationship. The couples who neglected this important element were reportedly more stressed and dissatisfied in their relationships.

A female respondent shared,

"He never has time for me if I gripe about his busy routine he yells at me and gets me critically agitated and jittery according to him his busy routine is due to my disease as he tries to earn more because of the financial problems I have put him into. He says that "I am doing a lot for you beyond me responsibilities and duties so I have no time to cocker you."

Sometimes husbands don't consider the importance and need of recreation among their marital life and this practice negatively affect their relationship. As the above excerpts show when husbands harshly refuse to spend time with their wife or children they feel distant and ignored resulting in dissatisfactory marital as well as family relationships.

Couples with children had more recreational activities yet instead of having some alone time their children remain the center of their activities.

A female respondent shared,

"After children, we never get to spend time with each other as a couple. Our every activity and discussion revolves around our children."

Another female interviewee stated,

"We used to go out in early days of our marriage but after children our routine has hanged we mostly spend time with our children and take care of them."

As majority of the respondents of this study belonged to middle or upper middle class, the meanings and resources of recreation were limited and confined to them watching TV together or going for necessary shopping. Most of them didn't have any time together or enough resources to plan a recreational trip as a couple.

A male respondent shared,

"We barely get any time together because we do not even share same bedroom as our children are young and we feel ashamed to live in a separate room."

The majority of couples with adult children shared same experience as mentioned by the respondent in above excerpts. In our society parents in middle class keep a distance between them in front of their children otherwise it is considered a disgraceful act.

Marital satisfaction depends on a number of elements and shared time between spouses and leisure activities are among those factors. But in our society couples usually don't consider it important as evident from current data. The couples who used to share their leisure activities were relatively close to each other and shared a stronger bond in comparison of those who didn't have mutual interests.

4.1.8 Theme 8: Breast Cancer and Marital Turmoil

Breast cancer according to the study participants changed the couple's relationship. Some couples claimed being close and intimated following breast cancer. For other couples, breast cancer created friction between couples and challenged their relationship in new ways or enhanced the existed problems and conflicts. Being with a patient of life threatened disease tests the relationship.

As expressed by a female respondents,

"My life was not like movies or dramas before I was diagnosed with cancer however it wasn't either so challenging. I get tired in maintaining my duties and responsibilities and nothing turns out as I wish or everyone around me expects. My husband often gets annoyed or irritated which makes me feel inferior and insecure."

A male respondent shared that he and his wife suffered following her diagnosis and treatment of cancer, he said,

"I don't know how and why we became so detached. We both started making fuss of little and insignificant things. May be it was her disease and the stress of that situation but it was really a hard time for us and for our children."

A female respondent stated,

"Yes, in the beginning we faced many problems because of me. My disease had put us in many emotional and financial problems and we both didn't know how to handle the situation. The situation became so worse that I left my home to live with my brother's family but no one cared for me and my husband also realized his mistakes so I came back and now whatever happens we never think of leaving each other."

The husband of the respondent who gave above statement, in his interview uttered,

"I admit that sometimes I mistreat my wife under the pressure of circumstances and made her leave our home in anger but I always apologize to her and couldn't imagine to divorce her and remarry as no other woman can take care of me, my children or my household in the way she does."

In our society, married females are considered honored and respectable only if they are living happily with their husbands otherwise their own families do not accept them. Many females bear every cruelty of their spouses because they know that no one will take their side not even their parents or siblings this is one of the main reasons why women don't leave their husbands even when they are insensitive and cruel to them. Others give priority to their children's comfort and peace of mind. As spoken by a female respondent,

"Sometimes I think it's better to end a relationship instead of keeping it alive with force, I know there have been so many problems that we cannot get back normal in our relationship but we cannot take this step in order to save our children from any sufferings and worries."

As evident from data, children play an important role in fabricating the relationship between couples even in hardest times. As many respondents mentioned that they tolerated each other and fought with the situation for the sake of their children as they couldn't let them suffer because of their conflicts and problems.

There was no case of husbands leaving their wives because of their disease. Although every couple interviewed agreed that their relationship was altered following breast cancer diagnosis and treatment of wife but no one talked about leaving their spouse whether it was a husband or a wife.

A male respondent told,

"The thought of leaving her has never crossed my mind not even once. She is my wife and mother of my children I cannot leave her just because she is ill and cannot perform her duties well."

Another male respondent shared almost same sentiments,

"We are facing many issues but I will never leave her alone to face this all because I know if I was the one going through all this she would never leave me alone."

The majority of husbands regarded their wives and acknowledged their prominence in their lives. They agreed that as a couple they had and were facing different problems but it didn't bring them to a limit where they would think to leave their wives. In Pakistan, joint and extended family play an important role in keeping couples allied as described by the respondents living in joint family, husbands don't need to take the burden of most of the things as the relatives and other family members share their responsibilities. Along with this in our society separation and divorce is regarded as disrespectful and dishonored act and people are not encouraged to do so.

This family and social pressure makes couples to live together even if they are going through problems in their marital relationships.

A female respondent shared,

"We have gone through very difficult situations in last 3-4 years but we never thought of leaving each other as it is not the solution. We cannot ruin our children's life besides we love and care for each other yet there are times when holding up to things becomes very tough."

As mentioned by different respondents in above excerpts, despite of many problems and spousal conflicts divorce or separation was never an option crossed their minds. The couples who shared strong bond and intimacy were concerned about each other and husbands played a significant role in keeping their relationship fulfilling and promising. The more caring and concerned husband was the more satisfied was wife with their relationship.

As a female interviewee stated,

"When I was diagnosed with breast cancer I thought my husband will leave me because many people told me so and in hospital I listened to women who shared their experiences of being ill-treated by their husbands; I was really frightened but my husband never showed any sign of leaving me."

Yet the couples who were emotionally detached and didn't share a strong bond were sincere to each other because of their children as for them their children were significant in maintaining their spousal relationship. Only one male respondent had second marriage after his wife's disease. According to both of them this decision was taken after the wife refused to take any responsibility of children and of house.

The female stated,

"My husband patiently waited for me to get normal and accept the reality but I didn't give the response he deserved so he went for another wife. You know I don't blame him as I know it was my entire fault. The cancer was from God but I made our life

miserable with my reaction to the disease although he didn't divorce me but now I have to share him with another woman which is very difficult for me."

The particular respondent shared that she was so obsessed with the thought of dying that she made her family members' life miserable with her reaction. Although doctors told her that she will be recovered and cured but she wasn't able to take the pressure emotionally and gave her children and husband a tough time. Their daughters were very young and needed full time attention but she couldn't take care of them and refused to fulfill their or her husband's every sorts of needs.

The husband on the other hand shared his perception as,

"I never thought of marrying second time but I wasn't left with any other option. All she did was crying, not taking care of our daughters and she became so stubborn that she didn't care about our unborn child. My home and family was shattered and I was going to be crazy so I decided to have another wife it was not easy decision but I needed to make it and I don't regret it." He further added, *"My daughters are well taken care now, my needs are fulfilled in time and I have a companion to share my worries and happiness with."*

The respondent told that taking the decision of having second wife was not easy because he loved his wife besides his own family and his wife's family was against his decision but he knew it was *"only solution"*.

Based on the experiences of study respondents one can easily conclude that breast can and does alter the spousal relationship in one way or another. It puts marital relationship in test. The couples who genuinely love and care for each other and respect their relationship handle these difficulties well and with mutual understanding while the couples who were already in conflicts and disagreements may feel weary and displeased.

4.2 Part II: Quantitative Analysis

In this section statistical analysis of the data along with the interpretation of the results is presented. After the completion of data collection it was processed using SPSS 16.0, the same software was used for conducting statistical analyses. Aim of the quantitative investigation was to confirm the occurrence of variables derived from the qualitative analysis in a larger population of breast cancer patients and their husbands. This was done after converting variables into response items and organizing them in 5 point Likert scale, in order to obtain the perception of couples confronting breast cancer. The reliability analysis of research scale was also measured. Demographic profile of study respondents is also given.

The section is further divided into following two sections:

1. Demographic Profile of Study Participants
2. Descriptive statistics (frequency, means, standard deviation and percentages)

4.2.1 Demographic Profile of Study Participants

The sample of study participants was drawn from Nuclear Medicine, Oncology and Radiotherapy Institute (NORI) hospital, Islamabad. The couples were selected in order to assure the equal representation of both gender and spouses in the study.

Table 4.2.1 Distribution of Respondents according to their Age

	Responses	Frequency (Male)	%	Frequency (Female)	%	Total (Couple)
Age of Respondents	34-39 years	1	0.4%	12	4.3%	13 (2.3%)
	40-45 years	38	13.6%	122	43.7%	160(28.7)
	46-51 years	118	42.3%	120	43.0%	238(42.7)
	52-57 years	101	36.2%	25	9.0%	126(22.6)
	Above 57	21	7.5%	0	.0%	21 (3.8%)
	Total	**279**	**100%**	**279**	**100%**	**558(100%)**

This table presents the age distribution of study respondents respective to their gender. For male respondents, the majority (118) was in the age group of 46-51 years besides a large number of male respondents 36.2% belonged to age category of 52-57 years. Where no female respondent was reported above 57 years, 21 male respondents (7.5%) were of above 57 years of age however only one male respondent (.4%) belonged to the age group of 34-39 years. Among 279 female respondents confronting breast cancer majority respondents 122 (43.7) were in the age limit of 40-45. Although 4.3 % female respondents reported their ages between 34-39 years a large number of respondents belonged to the age category of 46-51 years while 25 female respondents (9.0%) were in the age of 52-57 years.

The above data shows that in contrast to common perception, breast cancer is not greatly uncommon to younger women. As 4.3% female respondents of present study were between the age of 34-39 ears and 43.7 women were in the age group of 40-45 indicating the occurrence of breast cancer in young age. Partridge (2018) stated that women who develop breast cancer at a relatively young age i.e. under age 45, confront with diverse problems unique to their life stage including how the effect of disease on their careers, sexual functioning, personal and social relationships, as well as ability to have and raise children.

Table 4.2.2 Distribution of Respondents According to their Education

	Responses	Frequency (Male)	Percentage	Frequency (Female)	Percentage	Total (Couple)
Educational Attainment of Respondents	Illiterate –Primary	66	24%	86	30%	152 (27)
	Middle – Metric	76	27%	82	29%	158 (28)
	Intermediate – Bachelors	74	26%	60	22%	134 (24)
	Masters –MS/MPhil	44	16%	37	14%	81 (14)
	Professional Degree/ Diploma	19	7%	14	5.0%	33 (6)
	Total	**279**	**100%**	**279**	**100%**	**558(100)**

The table shows the distribution of respondents in accordance with their gender and educational attainment of both cancer patients and their husbands. The data shows that 86 (31%) females were illiterate while only 14 female respondents (5.0%) had a professional degree or diploma. The majority of male respondents 76 (27%) were in the category of middle to metric and 66 male participants of study were illiterate or had primary level education. The table also illustrates that among 558 respondents 158 (28%) respondents had only middle to metric level education irrespective of their gender. While the percentage of professional degree and diploma holders was 6% (33 respondents). The least study gap was also found in this category.

Table 4.2.3 Distribution of Respondents According to their Employment Status

	Responses	Frequency (Male)	%	Frequency (Female)	%	Total (Couple)
Employment Status of Respondents	Employed	264	95%	64	23%	328 (59%)
	Unemployed	15	5.%	215	77%	230 (41%)
	Total	**279**	**100%**	**279**	**100%**	**558(100%)**

The above table describes the employment status of the study participants. The table shows that among 279 female respondents of study, majority 215 participants were unemployed which made them (77%) of the sample while only 23% (64 females) were employed however only 15 male respondents (5%) were unemployed and 95% (264 males) were employed. The table indicates that in the studied population of breast cancer majority of respondents didn't have any job or employment thus constraining them from contributing in their families' income.

Table 4.2.4 Distribution of Respondents According to their Marriage Year

Group	Responses	Frequency (Couple)	Percentage
Marriage Period	5-9 years	126	22.6%
	10-15 years	347	62.0%
	16-21 years	68	12.2%
	Above 21 years	18	3.2%
	Total	**558**	**100%**

The above table portrays the years of marriage of study respondents. As the data was collected from the couples the responses are not divided in gender categories. Majority respondents 347 (62%) were married for 10-15 years while a large number of couples (63 couples) were married for 5-9 years. Only 9 couples were married for more than 21 years whereas 34 couples were married for 16-21 years.

Table 4.2.5 Distribution of Respondents According to Breast Cancer Stage

Responses	Frequency (Female)	Percentage
Stage I	22	7.8%
Stage II	45	16.1%
Stage III	84	30.1%
Stage IV	58	20.7%
Follow-up	70	25.0%
Total	**279**	**100%**

The above table shows the distribution of female respondents according to the stage of their cancer. There are 5 stages of caner categorized on the basis of locality, size and spread in body: stage 0 (zero), which is noninvasive (confined to the milk duct), and stages 1 through 4 of invasive breast cancer (cancer spreads into the normal tissue of the breast). The information about the stage of cancer was obtained from female breast cancer patients only. The above data demonstrates that majority women were patients of stage 3 cancer at the time of data collection while no respondent of stage 0 cancer was found. A large number of respondents belonged to the follow-up category; survivors of cancer who had rejoined routine life after completing their treatment and were followed-up out of the risk of recurrence.

4.3. Descriptive Statistics

Descriptive statistics defines the normality distribution of the scores of the sample in inquiry. This section presents the descriptive statistics for the variables surveyed in the present study. The reliability of scale designed for survey was assessed through Cronbach's Alpha Test (Test of internal consistency). The internal reliability of the instrument showed acceptable level .716 for the present sample. The questionnaire is distributed in 5 sub-categories in order to organize and display data simply and presentably. Each category also represents the theme emerged from qualitative data which were used in devising the instrument. Each table displays the responses of both genders separately thus giving a clear representation of their thoughts and views about the studied variables of marital satisfaction and their differences regarding the subject. This helped me in interpreting and blending the findings of both research methods and deriving conclusions.

Table 4.3.1 The Distribution of Respondents According to Their Communication & Conflict Resolution

Item	Communication & Conflict Resolution	Frequency Distribution & Percentage of Female Respondents					Frequency Distribution & Percentage of Male Respondents				
	Statement	SA	MA	NA/ ND	MD	SD	SA	MA	NA/ ND	MD	SD
1.	My partner doesn't often communicate his/her opinion properly.	78 28.0%	67 24.0%	50 17.9%	45 16.1%	39 14.0%	73 26.2%	72 25.8%	45 16.1%	45 16.1%	44 15.8%
2.	We do not discuss about my/my partner's disease often.	95 34.1%	45 16.1%	51 18.3%	32 11.5%	56 20.1%	72 25.8%	64 22.9%	44 15.8%	46 16.5%	53 19.0%
3.	My spouse and I understand each other's problems.	44 15.8%	40 14.3%	61 21.9%	77 27.6%	57 20.4%	50 17.9%	42 15.1%	53 19.0%	63 22.6%	71 25.4%
4.	I do not share my problems with my spouse because he/she doesn't care.	40 14.3%	56 20.1%	65 23.3%	57 20.4%	61 21.9%	63 22.6%	54 19.4%	62 22.2%	55 19.7%	45 16.1%
5.	Whenever we fight I swiftly relinquish to finish the dispute.	49 17.6%	60 21.5%	73 26.2%	31 11.1%	66 23.7%	50 17.9%	45 16.1%	66 23.7%	60 21.5%	58 20.8%
6.	My spouse and I try to resolve conflicts differently.	62 22.2%	64 22.9%	62 22.2%	66 23.7%	25 9.0%	63 22.6%	72 25.8%	46 16.5%	54 19.4%	44 15.8%
7.	Sometimes we have serious spousal disputes over minor issues.	95 34.1%	59 21.1%	46 16.5%	38 13.6%	41 14.7%	62 22.2%	77 27.6%	76 27.2%	31 11.1%	33 11.8%
8.	My spouse often blames me for strain in our relationship.	62 22.2%	47 16.8%	45 16.1%	58 20.8%	67 24.0%	45 16.1%	53 19.0%	61 21.9%	48 17.2%	72 25.8%

9.	My spouse doesn't usually take our arguments seriously.	67 24.0%	59 21.1%	82 29.4%	40 14.3%	31 11.1%	89 31.9%	74 26.5%	53 19.0%	37 13.3%	26 9.3%
10.	My spouse often behaves aggressively.	78 28.0%	53 19.0%	35 12.5%	52 18.6%	61 21.9%	48 17.2%	36 12.9%	39 14.0%	44 15.8%	112 40.1%

The above table shows the tabulation of study participants' responses related to their mutual understanding, communication and conflict; problems either arising of or getting severe due to wife's breast cancer.

The data shows that majority of both male and female respondents correspondingly 73 (26.2%) and 78 (28%) thought that their spouse couldn't deliver his/her opinion properly while 39 (14.0%) female and 44 (15.8%) male respondents strongly disapproved the statement. The majority of female respondents 95 (34.1%) strongly agreed that their husbands avoid discussing their disease while the majority of husbands 72 (25.8%) accepted that they do not discuss their wife's disease interestingly there was not much gender difference in the number of respondents who disapproved the statement as 56 (20.1%) female respondents and 53 (19.0%) male respondents shared that they discuss their/their wife's disease. Only 44 (15.8%) females and 50 (17.9%) males approved that as a couple they understand each other's problems nonetheless among female respondents, majority of respondents 77 (27.6%) neither agreed nor disagreed to the statement while among male respondents, majority of respondents 71 (25.4%) strongly disapproved that as couple they or their spouse understand one another's problems.

While 40 (14.3%) female respondents and 63 (22.6%) male respondents complained that their spouse doesn't care about their problems so they often do not share their problems with their husband/wife the majority of females 65 (23.3%) didn't completely approved or disapproved the statement however among male respondents only 45 (16.1%) respondents strongly disapproved the statement and stated that their wives do not seem to care about their problems so they do not discuss their problems

with them. The number of respondents who agreed to surrender to their husband/wife in a fight was much close for both genders 49 (17.6%) for females and 50 (17.9%) for men. However, the majority of respondents irrespective of their gender 73 (26.2%) female and 66 (23.7%) male respondents didn't visibly approve or disapprove the statement.

Among females, majority of respondents 66 (23.7%) moderately disagreed that their husbands tend to solve spousal conflicts differently while 62 (22.2%) respondents strongly and 64 (22.9%) moderately believed that their husbands' conflict solving strategies do not match with their own while the number of male respondents who had same thoughts was 63 (22.6%) however the number of male respondents who strongly disagreed to the statement 44 (15.8%) was quite high than the number of females 25 (9.0%) who strongly rejected the statement of having different conflict strategies of a couple. When asked about the nature of disputes between a couple, 95 (34.1%) females and 62 (22.2%) males agreed that they often argue and quarrel over negligible matters however 41 (14.7%) female and 33 (11.8%) male respondents strongly rejected the statement.

The above table also illustrates that the husbands of a high number of females 62 (22.2%) held their wives responsible for tension in their relationship or married life nonetheless 45 (16.1%) husbands also experienced their wives accusing them for problems in their married life or their spousal relationship. however irrespective of their gender, majority of study respondents 67 (24.0%) females and 72 (25.8%) male respondents strongly disagreed that their spouse blames them for problems in their relationship.

Among female respondents 82 (29.4%) respondents neither agreed nor disagreed to the statement that their husbands do not take their arguments seriously while 89 (31.9%) male respondents strongly agreed to the statement and approved that their wives do not seriously consider their arguments. Although only 31 (11.1%) women and 26 (9.3%) men rejected the statement completely the highest number of female respondents 82 (29.4%) neither agreed nor disagreed that whether their husbands give importance to their arguments.

The data tabulated above shows that most female respondents 78 (28.0%) agreed that their husbands often show hostile behavior however only 48 (17.2%) male respondents were facing their wives' aggressive behavior whereas 112 (40.1%) male respondents strongly disagreed to the statement while the number of female respondents who disagreed to the statement was 61 (21.9%), nearly half of the male respondents.

Table 4.3.2 The Distribution of Respondents According to Their Spouse's Personality & Behavior

Spouse's Personality & Behavior		Frequency Distribution & Percentage of Female Respondents					Frequency Distribution & Percentage of Male Respondents				
Item No.	**Statement**	**SA**	**MA**	**NA/ ND**	**MD**	**SD**	**SA**	**MA**	**NA/ ND**	**MD**	**SD**
1.	My spouse has become too critical in period following cancer.	105 37.6%	53 19.0%	45 16.1%	35 12.5%	41 14.7%	116 41.6%	51 18.3%	45 16.1%	29 10.4%	38 13.6%
2.	I feel anxious about my spouse's temperament at times.	77 27.6%	74 26.5%	50 17.9%	33 11.8%	45 16.1%	81 29.0%	59 21.1%	56 20.1%	31 11.1%	52 18.6%
3.	Sometimes my spouse seems unhappy and emotionally detached.	92 33.0%	113 40.5%	37 13.3%	25 9.0%	12 4.3%	97 34.8%	96 34.4%	54 19.4%	19 6.8%	13 4.7%
4.	My spouse and I help each other in household responsibilities	56 20.1%	37 13.3%	56 20.1%	55 19.7%	75 26.9%	52 18.6%	68 24.4%	45 16.1%	52 18.6%	62 22.2%
5.	My spouse sometimes displays distressing behavior in front of our family or friends.	77 27.6%	53 19.0%	55 19.7%	54 19.4%	40 14.3%	79 28.3%	76 27.2%	51 18.3%	47 16.8%	26 9.3%

6.	I feel my spouse has become very stubborn in recent time.	72 25.8%	78 28.0%	51 18.3%	45 16.1%	33 11.8%	89 31.9%	55 19.7%	50 17.9%	45 16.1%	40 14.3%
7.	My spouse often delays his/her responsibilities.	83 29.7%	58 20.8%	52 18.6%	50 17.9%	36 12.9%	89 31.9%	71 25.4%	39 14.0%	45 16.1%	35 12.5%
8.	At times, it becomes difficult for me to handle my spouse's mood and irritability.	86 30.8%	85 30.5%	55 19.7%	24 8.6%	29 10.4%	110 39.4%	72 25.8%	47 16.8%	30 10.8%	20 7.1%
9.	My spouse behaves very intimidating sometimes.	60 21.5%	61 21.9%	42 15.1%	68 24.4%	48 17.2%	54 19.4%	33 11.8%	50 17.9%	67 24.0%	75 26.9%
10	Role and responsibilities are fairly distributed in our marriage.	75 26.9%	66 23.7%	47 16.8%	54 19.4%	37 13.3%	70 25.1%	72 25.8%	40 14.3%	53 19.0%	44 15.8%

The above table shows the tabulation of study participants' responses in accordance with their Spouse's Personality & Behavior issues. The data shows that not only breast cancer patients, but their husbands also thought that their spouse become too critical in period following cancer 105 (37.6%) and 116 (41.6%) respectively while only 38 (13.6%) male and 41 (14.7%) female respondents strongly disapproved the statement. Interestingly the number of respondents who neither approved nor disapproved the statement of experiencing critical behavior of their husband/wife was equal 45 (16.1%) irrespective of their gender.

Most female respondents 77 (27.6%) strongly agreed that they feel anxious about their husband's temperament now and again while the majority of husbands 81 (29.0%) also agreed to experience this difficulty moreover their number was greater of female respondents who felt anxious about their husband's temperament.

The above data shows that the responses of study participants' about their unhappy and emotionally detached life partners were close as 92 (33.0%) females strongly and 113 (40.5%) female respondents moderately agreed that at times their husbands do not seem or emotionally attached to them while 97 (34.8%) male respondents strongly and 96 (34.4%) moderately agreed to the statement interestingly there was not much gender difference in the number of respondents who disapproved the statement as only 12 (4.3%) female respondents and 13 (4.7%) male respondents.

Only 56 (20.1%) females and 52 (18.6%) males agreed to the statement of sharing domestic duties and helping each other in household chores nonetheless among female respondents, majority of respondents 75 (26.9%) rejected the statement and established that they do not get any help from their husbands while among male respondents, majority of respondents 68 (24.4%) neither approved nor disapproved the statement.

While 77 (27.6%) female respondents accepted that their husband behave inappropriately in front of other people 79 (28.3%) male respondents also had the same complaint to their wives. Only 40 (14.3%) females and 26 (9.3%) male respondents completely rejected the statement indicating that male respondents were facing this problem more frequent as compared to their female partners.

About the changes in their husband/wife's attitude the majority of females 78 (28.0%) moderately agreed the statement that their husbands were now more stubborn however among male respondents 89 (31.1%) respondents strongly approved the statement and stated that their wives have become more stubborn however the number of respondents who disagreed to the statement was close for both genders 33 (11.8%) for females and 40 (14.3%) for men.

The above data also shows that most respondents irrespective of their gender 83 (29.7%) female and 89 (31.9%) male respondents strongly approved that their husband/wife doesn't show punctuality while performing his/her duties or fulfilling his/her responsibilities while among females, only 36 (12.9%) strongly disagreed that

their husbands delay their responsibilities whereas the number of male respondents who had same thoughts was 35 (12.5%).

The number of male respondents who strongly agreed to face difficulties in dealing with their wives' glumness and irritability 110 (39.4%) was fairly high than the number of females 86 (30.8%) who strongly agreed that their husbands had mood issues and often exhibited irritability. Yet 29 (10.4%) females and 20 (7.1%) males strongly disagreed to the statement. When asked 60 (21.5 %) females and 54 (19.4%) males agreed that their life partner often behaves intimidating however 48 (17.2%) female and 75 (26.9%) male respondents strongly rejected the statement.

The above table also illustrates that there wasn't much difference among the responses of both gender groups on their idea of fairly distributed roles and responsibilities irrespective of their gender, majority of study respondents 75 (26.9%) females and 70 (25.1%) male respondents strongly agreed that they were satisfied how their couple managed roles and responsibilities. Only 37 (13.3%) females and 44 (15.8%) males showed their concerns in this regard.

Table 4.3.3 The Distribution of Respondents According to Their Emotional Bonding & Intimacy

	Emotional Bonding & Intimacy	**Frequency Distribution & Percentage of Female Respondents**					**Frequency Distribution & Percentage of Male Respondents**				
Item No.	**Statement**	**SA**	**MA**	**NA/ ND**	**MD**	**SD**	**SA**	**MA**	**NA/ ND**	**MD**	**SD**
1.	My partner fails to completely satisfy my emotional needs.	72 25.8%	105 37.6%	38 13.6%	41 14.7%	23 8.2%	96 34.4%	79 28.3%	32 11.5%	39 14.0%	33 11.8%
2.	My partner and I share a strong emotional bond.	55 19.7%	37 13.3%	50 17.9%	65 23.3%	72 25.8%	57 20.4%	49 17.6%	56 20.1%	63 22.6%	54 19.4%

3.	Our relationship lacks spousal affection and tenderness.	60 21.5%	72 25.8%	52 18.6%	33 11.8%	62 22.2%	52 18.6%	62 22.2%	67 24.0%	47 16.8%	51 18.3%
4.	I have never had compunctions about marrying with my spouse.	56 20.1%	42 15.1%	61 21.9%	75 26.9%	45 16.1%	74 26.5%	62 22.2%	45 16.1%	45 16.1%	53 19.0%
5.	My spouse and I emotionally support each other.	83 29.7%	63 22.6%	51 18.3%	62 22.2%	20 7.1%	76 27.2%	67 24.0%	45 16.1%	56 20.1%	35 12.5%
6.	I can truly express all my feelings to my spouse.	73 26.2%	55 19.7%	32 11.5%	53 19.0%	66 23.7%	50 17.9%	35 12.5%	37 13.3%	43 15.4%	114 40.9%
7.	My spouse doesn't express his/her feelings openly.	76 27.2%	95 34.1%	42 15.1%	26 9.3%	40 14.3%	85 30.5%	60 21.5%	54 19.4%	35 12.5%	45 16.1%
8.	At times, my spouse shows irritability and weariness.	89 31.9%	42 15.1%	55 19.7%	44 15.8%	49 17.6%	57 20.4%	50 17.9%	60 21.5%	60 21.5%	52 18.6%
9.	My spouse often understands my unspoken feelings	62 22.2%	59 21.1%	64 22.9%	44 15.8%	50 17.9%	69 24.7%	49 17.6%	54 19.4%	57 20.4%	50 17.9%
10.	At times, I have negative feelings about my spouse and our relationship.	80 28.7%	56 20.1%	57 20.4%	37 13.3%	41 14.7%	77 27.6%	62 22.2%	39 14.0%	52 18.6%	49 17.6%

The above table shows the tabulation of study participants' responses according to their emotional bonding and intimacy among couples confronting breast cancer. The above data displays that emotional needs of both breast cancer patients and of their husbands' also left unsatisfied as 72 (25.8%) female strongly and 105 (37.6%) female moderately agreed while 96 (34.4%) males strongly and 79 (28.3%) males moderately agreed that their husband/wife were unable to satisfy their emotional needs. only 23 (8.2%) female

and 33 (11.8%) male respondents approved satisfaction with their spouse respectively while 55 (19.7%) female and 57 (20.4%) male respondents strongly approved sharing a strong emotional bond between them and their life partner 72 (25.8%) female and 54 (19.4%) male respondents by disagreeing to the statement established that their emotional bonding with their spouse is not strong enough. The above data shows that most female respondents 72 (25.8%) moderately agreed that their marital relationship lacked spousal affection and tenderness while the majority of husbands 67 (24.0%) neither agreed nor disagreed to the dearth of relationship warmth and spousal tenderness in their couple. However, 51 (18.3%) male respondents and 62 (22.2%) female respondents agreed that they give and receive fair amount of affection as a part of a couple.

The tabulated data illustrates that among 279 female respondents 56 (20.1%) females strongly and 42 (15.1%) female respondents moderately agreed that they never regretted on marring with their husband while 74 (26.5%) male respondents strongly and 62 (22.2%) moderately agreed to the statement while the number of respondents who disapproved the statement was 45 (16.1%) female respondents and 53 (19.0%) male respondents. When asked about supporting each other emotionally most females 83 (29.7%) and most males 76 (27.2%) established that their life partner and they emotionally support each other in hard times however 20 (7.1%) females and 35 (12.5%) respondents approved insufficient emotional backing from/for their husband/wife. The above data displays that 73 (26.2%) female and 50 (17.9%) male respondents agreed to the statement that they can justly express their feelings to their life partner while 66 (23.7%) female and 114 (40.9%) male respondents strongly disagreed to the statement indicating that for studied population in comparison of female study respondents their male partners felt more hesitant in sharing their feelings with their intimate partner.

The table also represents the data of respondents according to their spouses' expressiveness as displayed above 76 (27.2%) female strongly and 95 (34.1%) moderately approved that their husbands do not demonstrate their feelings overtly while for male respondents 85 (30.5%) strongly and 60 (21.5%) moderately agreed to the statement however 40 (14.3%) female and 45 (16.1%) male respondents didn't agree to the statement indicative of their spouses' expressiveness.

The above data also reveals that among females a high number of respondents 89 (31.9%) had to deal with their husbands' weariness and irritability however this number was 57 (20.4%). However, the number of respondents who didn't approve the statement was partially different for both genders; 49 (17.6%) and 52 (18.6%) for men and women respectively. The data about couple's understanding of unspoken feelings exposed that among 279 respondents of each gender only 62 (22.2%) females and 69 (24.7%) males were certain that their husband/wife understands their unexpressed emotions and sentiments however the number of respondents who strongly disagreed to the statement was interestingly same for both male and female respondents.

The above data also illustrate that 80 (28.7%) females and 77 (27.6%) male respondents confirmed having negative thought about their life partner and their marital relationship while 41 (14.7%) females and 49 (17.6%) male respondents never experienced any such feelings.

Table 4.3.4 The Distribution of Respondents According to Their Social Life & Recreational Activities

Social Life & Recreational Activities		Frequency Distribution & Percentage of Female Respondents					Frequency Distribution & Percentage of Male Respondents				
Item No.	Statement	SA	MA	NA/ND	MD	SD	SA	MA	NA/ND	MD	SD
1.	My spouse does not seem to enjoy time with me.	81 29.0%	58 20.8%	43 15.4%	63 22.6%	34 12.2%	84 30.1%	59 21.1%	49 17.6%	51 18.3%	36 12.9%
2.	I am concerned about our confined social life.	56 20.1%	56 20.1%	44 15.8%	54 19.4%	69 24.7%	48 17.2%	56 20.1%	48 17.2%	69 24.7%	58 20.8%
3.	I comfortably attend family gathering and functions alone.	110 39.4%	59 21.1%	45 16.1%	28 10.0%	37 13.3%	103 36.9%	48 17.2%	45 16.1%	49 17.6%	34 12.2%
4.	I am satisfied with my spouse's participation in our family gatherings.	61 21.9%	47 16.8%	48 17.2%	54 19.4%	69 24.7%	63 22.6%	58 20.8%	37 13.3%	55 19.7%	66 23.7%
5.	I feel contented about the amount of time we give to our children and family.	76 27.2%	48 17.2%	43 15.4%	62 22.2%	50 17.9%	77 27.6%	52 18.6%	54 19.4%	50 17.9%	46 16.5%
6.	My partner and I do not spend enough lone time together.	103 36.9%	71 25.4%	58 20.8%	26 9.3%	21 7.5%	112 40.1%	63 22.6%	51 18.3%	34 12.2%	19 6.8%
7.	We seldom find chances for recreation.	60 21.5%	45 16.1%	67 24.0%	56 20.1%	51 18.3%	48 17.2%	51 18.3%	51 18.3%	72 25.8%	57 20.4%

The above table shows the tabulation of study participants' responses according to the social life and recreational activities of couples confronting breast cancer. The above data displays that majority of both breast cancer patients and their husbands felt that their spouse does not enjoy time with them as 81 (29.0%) females while 84 (30.1%) males strongly moderately agreed that their husband/wife doesn't enjoy time with them. Only 34 (12.2%) female and 36 (12.9%) male respondents rejected the statement strongly and believed that both partners spend enjoyable time together.

The above data also illustrates that 69 (24.7%) female and 58 (20.8%) male respondents approved not worrying about their confined social life however 56 (20.1%) female and 48 (17.2%) male respondents agreed that they had breast cancer confined their social life that concerned them. The above data shows that most female respondents 110 (39.4%) strongly agreed that they attend family functions and gatherings without their husbands while the majority of husbands 103 (36.9%) also gave same answer. However, 34 (12.2%) male and 37 (13.3%) female respondents rejected and established that they feel uncomfortable in the absence of their wife/husband in a social gathering. Nonetheless the number of respondents who didn't approve or disapprove the statement completely was same for both breast cancer patients and their husbands; 45 (16.1%).

The tabulated data illustrates that among female respondents 61 (21.9%) and among male respondents 63 (22.6%) males agreed that their wife/husband participated in their family gatherings satisfactorily while the number of respondents who disapproved the statement was 69 (24.7%) females and 66 (23.7%) males.

When asked about time spend with children and family most females 76 (27.2%) and most males 77 (27.6%) established that their life partner and they spend a good amount of time with their family however 50 (17.9%) females and 46 (16.5%) male respondents approved that their time spend with family is insufficient. The above data displays that most females 103 (36.9%) and most males 112 (40.1%) agreed to the statement that they cannot spend lone time with their life partner while only 21 (7.5%) female and 19 (6.8%) male respondents strongly disagreed to the statement establishing that they spend enough lone time as a couple. The table also displayed above also reveals that most respondents 60 (21.5%) female strongly approved that they rarely find any chances of recreation with their husbands while for male respondents 48 (17.2%)

strongly agreed to the statement however 51 (18.3%) female and 57 (20.4%) male respondents didn't agree to the statement.

Table 4.3.5 The Distribution of Respondents According to Their Sexual Relationship

	Sexual Relationship	Frequency Distribution & Percentage of Female Respondents					Frequency Distribution & Percentage of Male Respondents				
Item No.	**Statement**	**SA**	**MA**	**NA/ ND**	**MD**	**SD**	**SA**	**MA**	**NA/ ND**	**MD**	**SD**
1.	My spouse and I have satisfactory sexual relationship.	51 18.3%	40 14.3%	42 15.1%	51 18.3%	95 34.1%	50 17.9%	37 13.3%	34 12.2%	59 21.1%	99 35.5%
2.	After cancer my spouse doesn't enjoy sex.	93 33.3%	52 18.6%	48 17.2%	42 15.1%	44 15.8%	72 25.8%	60 21.5%	49 17.6%	48 17.2%	50 17.9%
3.	My spouse sexually frustrates me.	40 14.3%	35 12.5%	44 15.8%	41 14.7%	119 42.7%	95 34.1%	55 19.7%	33 11.8%	57 20.4%	39 14.0%
4.	My spouse often misinterprets affection with sexual advance and acts accordingly	81 29.0%	52 18.6%	45 16.1%	44 15.8%	57 20.4%	65 23.3%	52 18.6%	63 22.6%	47 16.8%	52 18.6%
5.	After cancer my spouse's and my interest in sex is not same.	61 21.9%	66 23.7%	59 21.1%	44 15.8%	49 17.6%	80 28.7%	64 22.9%	60 21.5%	29 10.4%	46 16.5%
6.	I feel annoyed when my spouse unfairly uses or refuses sex.	70 25.1%	30 10.8%	44 15.8%	64 22.9%	71 25.4%	53 19.0%	59 21.1%	54 19.4%	53 19.0%	60 21.5%

7.	My spouse & I can comfortably discuss our sexual issues	41 14.7%	47 16.8%	42 15.1%	98 32.9%	51 18.3%	37 13.3%	48 17.2%	39 14.0%	99 35.5%	56 20.1%
8.	I never discuss our sexual issues with a third person.	103 36.9%	69 24.7%	16 5.7%	32 11.5%	59 21.1%	107 38.3%	52 18.6%	26 9.3%	31 11.1%	63 22.6%
9.	At times my spouse treats me inappropriately.	32 11.5%	39 14.0%	38 13.6%	62 22.2%	108 38.7%	31 11.1%	37 13.3%	58 20.8%	55 19.7%	98 32.9%

The above table tabulated the responses of study participants according to the sexual relationship of couples confronting breast cancer. The data displays that majority of both breast cancer patients and their husbands were not sexually satisfied in their marital relationship as 95 (34.1%) females while 99 (35.5%) males strongly disagreed to having contented sexual relationship with their spouse. Nonetheless the number of male and female respondents who experienced satisfactory sexual relationship was fairly close, 51 (18.3%) female and 50 (17.9%) male respondents rejected the statement strongly and believed that breast cancer didn't affect their sexual relationship. The above data also illustrates that 93 (33.3%) female and 72 (25.8%) male respondents implicated that after breast cancer their husband/wife didn't enjoy sex however 44 (15.8%) females and 50 (17.9%) males rejected the statement.

The above data shows that among 279 female respondents only 40 (14.3%) believed that their husbands sexually mistreat and frustrates them however most female respondents 119 (42.7%) rejected the statement while the number of male respondents who felt sexually frustrated because of their wives' attitude was quite high compared to female respondents; 95 (34.1%); however, 39 (14.0%) male respondents rejected the statement.

The tabulated data illustrates that 81 (29.0%) female and 65 (23.3%) male respondents agreed that their wife/husband mistakes affection with sexual advance and behave accordingly while the number of respondents who disapproved the statement was 57 (20.4%) females and 52 (18.6%) males.

When asked about sexual interest most females 66 (23.7%) moderately and most males 80 (28.7%) approved that their spouse's interest in sex doesn't equate with them however 49 (17.6%) females and 46 (16.5%) male respondents didn't face such problem.

The above data displays that 70 (25.1%) females strongly and 59 (21.1%) males moderately believed that their spouses used or refused sex deceitfully which annoyed them while most females 71 (25.4%) refused the statement moreover the number of females who strongly agreed to the statement was almost equal to the number of women who strongly disagreed to the statement. However, most male respondents also 60 (21.5%) rejected the statement. The tabulated data above also reveals that irrespective of their gender very few respondents 41 (14.7%) females and 37 (13.3%) male respondents who actually felt comfortable while discussing sex related matters with their spouse. The number of male and female respondents who moderately disagreed was 99 (35.5%) and 98 (32.9) respectively.

The above data shows that most respondents kept their sexual issues and problems to themselves as 103 (36.9%) female respondents and 107 (38.3%) male respondents strongly approved that they do not discuss their sexual issues with a third person however 59 (21.1%%) females and 63 (22.6%) males didn't agree to the statement. The above data represents that among females a high number of respondents 108 (38.7%) was satisfied with the way their husbands treated them overall; most men 98 (32.9%) also responded similarly although their number was less compared to female study participants. Nonetheless 32 (11.5%) female and 31 (11.1%) male respondents had this complaint to their spouses that they didn't treat them well or appropriately.

Table 4.3.6 Indicating Mean and Standard Deviation for Couples Communication & Conflict Resolution

Item No.	Communication & Conflict Resolution	Female			Male		
	Statement	Mean	N	St. Dev.	Mean	N	St. Dev.
1.	My partner doesn't often communicate his/her opinion properly.	2.64	279	1.399	2.75	279	1.423
2.	We do not discuss about my/my partner's disease often.	2.67	279	1.531	2.52	279	1.404
3.	My spouse and I understand each other's problems.	3.23	279	1.350	2.12	279	1.106
4.	I do not share my problems with my partner because he/she doesn't care.	3.15	279	1.355	2.52	279	1.404
5.	Whenever we fight I swiftly relinquish to finish the dispute.	3.02	279	1.408	2.36	279	1.447
6.	My spouse and I try to resolve conflicts differently.	2.74	279	1.286	2.69	279	1.464
7.	Sometimes we have serious spousal disputes over minor issues.	2.54	279	1.446	3.01	279	1.439
8.	My spouse often blames me for strain in our relationship.	3.08	279	1.493	2.52	279	1.311
9.	My spouse doesn't usually take our arguments seriously.	2.67	279	1.288	2.20	279	1.266
10	My spouse often behaves aggressively.	2.87	279	1.537	3.49	279	1.533

In above table all items related to communication and conflict resolution from the whole scale are sorted and presented to give readers a clear presentation of respondent's views about their spousal communication. The responses are divided on the basis of gender

for the equal representation of both genders. Among female respondents, the understanding of couple and careless spouse were found to have the highest mean ratings (above 3) on a 5 point Likert scale while for male respondents highest means were scored for aggressive spouse and spousal disputes (above 3). Female respondents' mean score for ineffective communication, avoidance of disease discussion, couple's understanding, unshared problems, withdraw from dispute, dissimilar conflict resolution approaches, serious spousal disputes over minor issues, spouse blaming, unserious spouse and aggressive spouse scored (2.64, 2.67, 3.23, 3.15, 3.02, 2.74, 2.54, 3.08, 2.67, 2.87) with lowest mean scored for spousal disputes (2.54) with a standard deviation of 1.446 and highest mean scored for couple's understanding (3.23) with a standard deviation of 1.350.

Among male respondents' mean score for ineffective communication, avoidance of disease discussion, couple's understanding, unshared problems, withdraw from dispute, dissimilar conflict resolution approaches, serious spousal disputes over minor issues, spouse blaming, unserious spouse and aggressive spouse scored (2.75, 2.52, 2.12, 2.52, 2.36, 2.69, 3.01, 2.52, 2.20, 3.49) with lowest mean scored for couple's understanding (2.12) with a standard deviation of 1.106 and highest mean scored for (3.49) with a standard deviation of 1.533. Both male and female respondents exhibited dissimilar views regarding their communication and conflict resolution approaches and surprisingly male respondents scored lowest on variable of couple's' understanding which was measured highest for female respondents.

Table 4.3.7 Indicating Mean and Standard Deviation for Spouse's Personality & Behavior of the Study Respondents

	Spouse's Personality & Behavior	**Female**			**Male**		
Item No.	**Statement**	**Mean**	**N**	**St. Dev.**	**Mean**	**N**	**St. Dev.**
1.	My spouse has become too critical in period following cancer.	2.48	279	1.464	2.36	279	1.447
2.	I feel anxious about my spouse's temperament at times.	2.62	279	1.414	2.69	279	1.464
3.	Sometimes my spouse seems unhappy and emotionally detached.	2.11	279	1.095	2.12	279	1.106
4.	My spouse and I help each other in household responsibilities.	3.20	279	1.475	3.01	279	1.439
5.	My spouse sometimes displays distressing behavior in front of our family or friends.	2.74	279	1.414	2.52	279	1.311
6.	I feel my spouse has become very stubborn in recent time.	2.60	279	1.340	2.52	279	1.404
7.	My spouse often delays his/her responsibilities.	2.63	279	1.402	2.52	279	1.404
8.	At times, it becomes difficult for me to handle my spouse's mood and irritability.	2.37	279	1.285	2.20	279	1.266
9.	My spouse behaves very intimidating sometimes.	2.94	279	1.419	3.27	279	1.463
10	Role and responsibilities are fairly distributed in our marriage.	2.68	279	1.394	2.75	279	1.423

In above table all scale items related to spouse's personality & behavior of the study respondents from the whole scale are assembled and tabulated to give readers a clear

presentation of respondent's views about their spouse's personality & behavior. Interestingly both male and female respondents correspondingly scored lowest mean (low than 2.5) unhappy and emotionally detached spouse 2.12 and 2.11 respectively. Among female respondents the mean calculated for above ten items were as, critical spouse (2.48), spouse's temperament issues (2.62), unhappy and emotionally detached spouse (2.11), sharing household responsibilities (3.20), spouse's distressing behavior (2.74), stubborn life partner (2.60), spouse's delayed responsibilities (2.63), spouse's mood and irritability (2.37), intimidating spouse (2.94) and fairly distributed role and responsibilities (2.68) with lowest mean scored for unhappy and emotionally detached spouse (2.11) with a standard deviation of 1.092 and highest mean scored (3.20) with a standard deviation of 1.475 for couple's shared household responsibilities.

Among male respondents' mean score for above 10 items was measures as critical spouse (2.36), spouse's temperament issues (2.69), unhappy and emotionally detached spouse (2.12), sharing household responsibilities (3.01), spouse's distressing behavior (2.52), stubborn life partner (2.52), spouse's delayed responsibilities (2.52), spouse's mood and irritability (2.20), intimidating spouse (3.27) and fairly distributed role and responsibilities (2.75) with lowest mean scored for unhappy and emotionally detached spouse (2.12) with a standard deviation of 1.106 and highest mean scored for intimidating spouse (3.27) with a standard deviation of 1.463.

Table 4.3.8 Indicating Mean and Standard Deviation for Emotional Bonding & Intimacy

	Emotional Bonding & Intimacy	**Female**			**Male**		
Item No.	**Statement**	**Mean**	**N**	**St. Dev.**	**Mean**	**N**	**St. Dev.**
1.	My partner fails to completely satisfy my emotional needs.	2.42	279	1.246	2.41	279	1.388
2.	My partner and I share a strong emotional bond.	3.22	279	1.464	3.03	279	1.414
3.	Our relationship lacks spousal affection and tenderness.	2.87	279	1.455	2.94	279	1.368
4.	I have never had compunctions about marrying with my spouse.	3.04	279	1.368	2.79	279	1.472
5.	My spouse and I emotionally support each other.	2.54	279	1.313	2.67	279	1.389
6.	I can truly express all my feelings to my spouse.	2.94	279	1.544	3.49	279	1.550
7.	My spouse doesn't express his/her feelings openly.	2.49	279	1.359	2.62	279	1.439
8.	At times, my spouse shows irritability and weariness.	2.72	279	1.489	3.00	279	1.401
9.	My spouse often understands my unspoken feelings	2.86	279	1.401	2.89	279	1.443
10	At times, I have negative feelings about my spouse and our relationship.	2.59	279	1.423	2.76	279	1.472

The above items show the perception of study participants about their emotional bonding and intimacy shared with their husband/wife. The mean score of female study

respondents was satisfaction of emotional needs (2.42), emotional bonding (3.22), lack of spousal affection and tenderness (2.87), compunctions about marrying (3.04), emotionally support (2.54), expression of personal feelings (2.94), inexpressive spouse (2.49), irritable spouse (2.72), spousal non-verbal understanding (2.86), negative feelings about spouse and relationship (2.59). The mean score of male study respondents was satisfaction of emotional needs (2.41), emotional bonding (3.03), lack of spousal affection and tenderness (2.94), compunctions about marrying (2.79), emotionally support (2.67), expression of personal feelings (3.49), inexpressive spouse (2.62), irritable spouse (3.00), spousal non-verbal understanding (2.89), negative feelings about spouse and relationship (2.76).

The highest mean scored from female respondents (3.22) with a standard deviation of 1.464 was for their emotional bond with their husbands while men scored highest on openly expressing their feelings to their life partners with a mean of 3.49 and standard deviation of 1.550.

Table 4.3.9 Indicating Mean and Standard Deviation for Social Life & Recreational Activities

	Social & Recreational Activities	**Female**			**Male**		
Item No.	**Statement**	**Mean**	**N**	**St. Dev.**	**Mean**	**N**	**St. Dev.**
1.	My spouse does not seem to enjoy time with me.	2.68	279	1.410	2.63	279	1.408
2.	I am concerned about our confined social life.	3.09	279	1.479	3.15	279	1.387
3.	I comfortably attend family gathering and functions alone.	2.37	279	1.423	2.51	279	1.442
4.	I am satisfied with my spouse’s participation in our family gatherings.	3.08	279	1.492	3.02	279	1.515

5.	I feel contented about the amount of time we give to our children and family.	2.86	279	1.480	2.77	279	1.444
6.	My partner and I do not spend enough lone time together.	2.25	279	1.253	2.23	279	1.280
7.	We seldom find chances for recreation.	2.97	279	1.400	3.14	279	1.391

The above table shows the responses of study participants about their social life and couple's shared leisure/recreational activities. The measured score for female respondents are for uninterested spouse (2.68), confined social life (3.09), attending functions alone (2.37), spouse's participation in family gatherings (3.08), amount of time given children/family (2.86), couple's lone time (2.25), and for chances for recreation (2.97). The mean score of male respondents are calculated as uninterested spouse (2.63), confined social life (3.15), attending functions alone (2.51), spouse's participation in family gatherings (3.02), amount of time given children/family (2.77), couple's lone time (2.23), chances for recreation (3.14). The highest mean score among above items (above 3) was for both gender categories was measured of confined social life (3.09 for females with a standard deviation of 1.479 and 3.15 for male respondents with a standard deviation of 1.387). Correspondingly, the lowest mean score recorded for both gender categories was of couple's lone time (2.25 for females with a standard deviation of 1.253 and 2.23 for male respondents with a standard deviation of 1.280).

Table 4.3.10 Indicating Mean and Standard Deviation for Sexual Relationship & Issues

	Sexual Relationship & Issues	**Female**			**Male**		
Item No.	**Statement**	**Mean**	**N**	**St. Dev.**	**Mean**	**N**	**St. Dev.**
1.	My spouse and I have satisfactory sexual relationship.	3.35	279	1.517	3.43	279	1.518
2.	After cancer my spouse doesn't enjoy sex.	2.61	279	1.469	2.80	279	1.450

3. My spouse sexually frustrates me.	3.59	279	1.488	2.61	279	1.475
4. My spouse often misinterprets affection with sexual advance and acts accordingly	2.80	279	1.513	2.89	279	1.424
5. After cancer my spouse's and my interest in sex is not same.	2.84	279	1.397	2.63	279	1.418
6. I feel annoyed when my spouse unfairly uses or refuses sex.	3.13	279	1.533	3.03	279	1.424
7. My spouse & I can comfortably discuss our sexual issues	3.25	279	1.334	3.32	279	1.328
8. I never discuss our sexual issues with a third person.	2.55	279	1.579	2.61	279	1.610
9. At times my spouse treats me inappropriately.	3.63	279	1.408	3.54	279	1.374

The 9 items presented above are sorted from the complete scale on the basis of their relatedness to sexual issues and relationship. The mean scores of female respondents were found for satisfactory sexual relationship (3.35), spouse doesn't enjoy sex (2.61), sexual frustration (3.59), misinterpreted affection (2.80), unequal sexual interest (2.84), unfair use of sex (3.13), discussion of sexual issues (3.25), sexual discussion with third person (2.55), and inappropriate treatment (3.63). However, male respondents showed mean score as satisfactory sexual relationship (3.43), spouse doesn't enjoy sex (2.80), sexual frustration (2.61), misinterpreted affection (2.89), unequal sexual interest (2.63), unfair use of sex (3.03), discussion of sexual issues (3.32), sexual discussion with third person (2.61), and inappropriate treatment (3.54). High similarity was found in the responses of both male and female respondents as both scored highest for inappropriate treatment from spouse (3.63 for female respondents with a standard deviation of 1.408) and (3.54 for male respondents with a standard deviation of 1.374).

Chapter 5

Discussion, Conclusion and Recommendations

In this chapter I will discuss my findings and conclusions derived from the data.

5.1. Discussion

This Exploratory Sequential Mixed Methods Design study aimed at exploring and understanding the experiences of female breast cancer patients and their spouses by delving into their narration of marital satisfaction. While the effects of breast cancer on marital satisfaction of breast cancer patients are well studied gap was identified in understanding the husbands' perspective and their experience of marital satisfaction followed by their wives' disease in addition to how they deal with these situations. Understanding the male participants' experiences, perceptions and/or strife of marital satisfaction along with the cancer patients may offer a comprehensive understanding of the phenomenon and facilitate health practitioners to improve their counseling strategies for the betterment of the breast cancer patients not only on an individual level but may also help them in developing better marital relationship with their life partners.

The study adopted mix method approach throughout the study i.e. from sampling to data analysis. Results obtained from both methods strengthened and validated the overall findings of the study.

The first phase of this study was a qualitative exploration of marital satisfaction of breast cancer confronted couples for which 12 married couples identified using the purposive sampling technique were interviewed. The in-depth individual interviews were conducted to explore the experiences of these 24 participants. Each in-depth interview was recorded and transcribed verbatim and analyzed thematically. The themes that developed from qualitative data analysis embodied the study participants 'experiences besides their alleged feelings of marital satisfaction either being a breast cancer patient or her husband. Based on the findings produced by qualitative study a survey questionnaire was designed to gather data from a larger population of breast cancer patient and their husbands. In the second phase of the present study a quantitative

description of the perceptions and problems of participants. The quantitative data was collected using a 47 items 5 point Likert scale prepared after analyzing the findings of qualitative data. The data was analyzed through different statistical tests and findings were used to validate the conclusions derived from qualitative data analysis. In the final analysis, data collected in both phases were mixed in order to offer a comprehensive narrative of the marital satisfaction of couples confronted with breast cancer.

Before discussing the conclusions, it is important to highlight basic findings from the present study. The findings of qualitative data analysis enhanced the understanding of the experiences of breast cancer confronting couples in regard to marital satisfaction. The findings showed that both partners confronted with breast cancer experienced several issues individually or collectively in general and in marital relationships specifically as indicated by the emerged themes from data analysis. The themes that emerged for qualitative study included: fear, shock and denial as a reaction to breast cancer diagnosis, communication and interaction including conflict resolution and self-exposure, changes in intimate and romantic relationship, dealing with physical deformity & psychological issues faced by both partners, social support from/to spouse and assistance in household chores, sexual dissatisfaction, leisure activities influenced, and turmoil in marriage due to breast cancer. The quantitative data analysis validated the findings of qualitative analysis and confirmed the marital satisfaction's concerns and changes in their spousal relationships.

The female participants reported to experience sudden changes in their lives following the breast cancer diagnosis denoted to the fear, anxiety and emotional distress as a result of diagnosis. The findings are consistent with the results of Boehmke and Dickerson (2006) study of breast cancer women designed to explore their shared experiences and breast cancer patients reported their lives changing overnight. Similar results have been affirmed by Kralik, Brown, and Koch (2001) and Longman, Braden and Mishel (1999) in their studies. Most females exhibited extreme emotional reactions on breast cancer diagnosis because it was unexpected and shocking for them, previous studies also administered that cancer was sudden and unexpected even for females having cancer history in their families (Al-Azri, Al-Awisi, & Al-Moundhri., 2009; Drageset et al., 2011; Montazeri 2008; Shaha et al., 2008). Contrary to the findings of

Liamputtong and Suwankhong (2015) and akin to the findings made by Holmberg (2014) biographical disruption of female patients was accredited to the clinical confirmation of the disease as soon as they heard the term "breast cancer" it horrified women and majority of them thought their days were counted; they wouldn't live much longer and their routine lives were disrupted suddenly; their hopes and future dreams were shattered. The diagnosis of cancer highlighted the existential fear that life couldn't be taken for granted also revealed by (Curtis et al., 2014; Drageset et al., 2011). While every study participant narrated varied reactions, the fear of death was experienced by many female respondents; the diagnosis was seen as a chaotic experience that led to losing hope about future; "despair" as mentioned by Bury (1982, 1991) and Frank (2013). Bury (1991) suggested that people use some means to lessen their illnesses' influence that he termed as 'style', 'strategy' or 'strategic management'. Most patients accepted their fate as well as their partners and acceptance of disease was the most common coping strategy adopted by patients also mentioned by (Jensen et al., 2014; Kvillemo & Branstrom, 2014). In my study I found that women used religious practices and spousal support to emotionally cope with their disease similar to the findings of Ursaru, Crumpei, and Crumpei (2014) that showed breast cancer patients experiencing religious coping significantly. Thuné-Boyle et al. (2011) also found that patients' religious beliefs in addition to personal spiritual or/and religious practices were considerably improved following breast cancer diagnosis. My study participants also established that husband's support was a major contributor in reducing emotional vulnerability of female cancer patients. Spousal support and female's emotional coping and adjustment with breast cancer is also discussed and approved by previous studies (Ben-Zur et al., 2001; Li, & Loke, 2014; Merluzzi, & Sanchez, 2018; Schulz, & Schwarzer, 2004). In this study I found that partners' emotional involvement and patient' adjustment to breast cancer was significantly related. Other important aspect narrated by female respondents was a willingness to fight the disease for the sake of their children; every woman who was a mother shared her experience of finding emotional strength and managing their pessimist thoughts to save their children from stress, to take care of them and a hope to live long for them. The love of children proved an important coping strategy for women with breast cancer. The way females manage diagnosis and treatment influence their instantaneous emotional misery besides well-

being together in addition to their enduring adjustment to disease (Astin, Shapiro, & Shapiro, 2013; Heppner, Armer, & Mallinckrod, 2009; Watson, Homewood, & Haviland, 2012). The participants of present study reported optimism, enthusiasm and hope as significant coping strategies consistent with the findings of previous studies (Alcalar et al., 2012; Rotegard et al., 2012; Wang et al., 2013). This study extends that biographical disruption of an intimate partner also affects the psychological and emotional wellbeing of other partner as male respondents mentioned undergoing great stress and emotional distress. The strategy adopted by female cancer patients was also somewhat dependent on their husbands as most females were dependent on their husbands economically and socially.

Breast cancer diagnosis then treatment was narrated to be very traumatic by both cancer patients and their husbands; Bisson (2007) stated that trauma includes a feeling of extreme dread, hopelessness and desolation. Both partners faced several emotional challenges i.e. anxiety, distress and anguish; these findings were consistent with the findings of Williams and Jeanetta (2016) who mentioned that female cancer survivors experienced it as 'a very stressful journey'. The stress was credited to the lack of necessary information about the nature and probable effect of disease; most couples described that they weren't given proper information on who to handle with the disease and other life aspects influenced through it. Many women distanced themselves from their husbands and children due to the fear of transmitting their disease to them. Previous studies also mentioned the requirement for more cancer-specific information as an important yet often unmet need (Alananzeh et al., 2016; Butow et al., 2013; Goldstein et al., 2014; Mitchison et al., 2012). The participants also reported that they were not professionally informed about available treatment options and their side effects similar findings were made by former researchers (Halbach et al., 2016; Ladd, 2016; Lim et al., 2016). Previous studies have also stressed the importance of healthcare providers' improved understanding of emotional experiences of and provision of psychosocial counseling to breast cancer patients in addition to assisting them in dealing with negative effects of diagnosis and treatment (Drageset et al., 2011; Elmir et al., 2010; Liamputtong, & Suwankhong, 2015; Mehnert, & Koch, 2007). Not only breast cancer patients but their husbands also needed professional help to cope with

their stress as revealed by early studies (Hilton & Koop, 1994; Lewis et al., 2008; Zahlis & Lewis, 2010) as well as to better assist their wives in whole process of diagnosis, treatment and post-treatment period (Kroenke et al., 2006).

Breast cancer patients and their spouses reported numerous side effects of these treatments including nausea, hair loss, weight alterations, sexual dysfunction and breast removal (mastectomy in severe cases); each treatment procedure of breast cancer has its own cost and complications. A number of previous studies have also mentioned several of these compilations and side effects of cancer treatments consistent with the present study. Moreira et al. (2010); Pinto, Moreira and Simões (2011) mentioned nausea and alopecia common complications after chemotherapy, weight gain or loss was mentioned by Parizadeh et al. (2012) whereas Bakht and Najafi (2010) point out hair loss, no patient reported ovarian damage inconstant with Petrucelli, Daly, and Pal (2016) who included ovarian damage in the list. In addition they also found that radiation therapy causes skin swelling, inflammation and redness which were also mentioned by present study respondents as being temporary conditions. Mastectomy (the removal of one breast affected by cancer cells or both) can result in deformity, surgical scars revealed by Trindade et al. (2018) besides the sense of losing one's femininity is mentioned by Özalp et al. (2015). Breast cancer treatments including radiation, surgery and chemotherapy along with the adjuvant therapy (hormone) are observed to hypothetically impart the bodily besides emotional consequences to breast cancer patients and can suggest certain explanation to the multifaceted relationship complications experienced by them (Braithwaite et al., 2010; Holmberg et al., 2001; Schmid-Buchi et al., 2011). The study respondents irrespective of their gender claimed to bear difficulties while dealing with these complications. The most common and highly impacted effect of breast cancer treatment found was sexual complications. Similar to the current findings Alicikus et al. (2009) suggested poor sexual functioning while sexual dysfunction was stated by Fobair et al. (2006).

The findings of the present research show increased responsibilities of husbands as majority of them revealed performing and managing extra domestic duties and social onuses in response of their wives' disease albeit male respondents seek help and assistance from other family members. Similar results were found when Silver (2004)

testified that healthy partner is precipitously confronted with much more responsibility when one partner gets a prolonged disease. The healthy spouse faced more workload, increased domestic responsibilities, increased medical expenditures in addition to the potential loss of an affectionate and sexually satisfying relationship.

Lewis et al. (2008) while analyzing other authors' studies concluded that distress experienced by spouses of cancer patients has been established in literature by both cross-sectional as well as longitudinal researches. Besides, considerably higher levels of psycho-social indisposition ensue up to 3 years post diagnosis. Spouses' agony extent or surpass their wives' suffering then continue to advance than standard intensities. The female respondents reported their husbands' distress and particularly his disconsolate mood and anxiety to have imperative significances for the diseased wife as most of the time husbands fail to express their emotions rather in trying to hide their suffering they turn out to be helpless in stress management; they become annoyed and vent their spleen on their diseased wives effecting their wives' physical and emotional welfare deleteriously thus husband's distressed mood is significantly correlated with higher distress in patients diagnosed with cancer. The findings were comparable with the findings presented by Fang, Manne, and Pape (2001) that the greater distress in cancer patients was found to be considerably associated with their spouses' mood disturbance, similar findings were made by Baider and Kaplan (1988). Numerous factors played their role in husband's disturbed mood including delayed or deferred everyday domestic chores, reduced/infrequent and dissatisfied sexual activities, revocation or adjournment of social events besides greater levels of responsibility together with taking care of sick life partner and children suffering emotionally and getting neglected due to their mother's disease.

Roy (2006) in his study found that chronic pain or illness in a spouse made other spouse feel excluded, annoyed, exhausted, distrustful, mortified and even atrocious of hurting their spouse because the physical and emotional condition of one partner forces other partner in taking greater responsibility, dealing with unpredictability, besides decreased level of sexual involvement with their partner. The couples who had poor stress management strategies tend to be more dissatisfied and met with more spousal conflicts. Many respondents consisted of both genders expressed the feelings of

pessimism, exhaustion, hopelessness and distress. Alcalar et al. (2012) and Schou, Ekeberg, and Ruland (2005) also found feelings of pessimism, lost liveliness and enthusiasm, in addition to inclinations to give up and concluded that hopelessness/helplessness increase the severity of situation and results in reduced quality of life. The present study also established that depression among breast cancer patients also causes depression among their partners. Couples who were optimistic about their situation were relatively less depressed and had better quality of life compared to couples where one partner or both were highly distressed and exhausted. Lewis et al. (2008) in their studies found only three predictors of spouse's depressed mood of breast cancer women; age, education, and length of marriage as the risk for depression was considerably high in older and less educated spouses because their understanding to conceive the breast cancer in non-threatening terms seemed to be inadequate. However in my study I found education and the nature of relationship between spouses prior to diagnosis of breast cancer associated with husband's depression. Husbands who were relatively close and emotionally attached to their wives experienced high depression when they failed to comfort their wives to their expectations. Similar findings were reported by Zimmermann and Heinrichs (2006) that husbands mentioned feeling helpless and frequently unaware of providing an adequate support when dealing with their wives' distress.

Spouses of breast cancer patients revealed that their wives' disease has put them through challenging circumstances and burdened them both physically and emotionally by increasing their responsibilities and stress. A husband's personal, social and psychological life was directly affected by his wife's disease in accordance with the results of Zimmermann (2015) suggesting that partners deal with difficult situation while managing a "double role" where they stand supportive to their spouse and deal with their own stress simultaneously. The norms of distributed fairness, or justice, norms of equity and of reciprocity are among prominent cognitive orientations debated in the literature of exchange theory (Blau 1964; Homans 1961; Walster, Walster, & Berscheid, 1978). Every single of these orientations has to do with the expectation that in an intimate, close relationship, the rewards gained by partners must be equitably distributed. The violation of these norms, as when housework is not distributed fairly

in a marriage, results in people complaining more about the relationship and stress their spouses (Berardo, Shehan, & Leslie, 1987). In Pakistani society male respondents are neither trained nor expected to lend their hand in domestic chores that's why male respondents reported to be stressed and overburdened.

While the focus of every treatment is to cure the patient physically, their emotional and psychological complications are neglected as no patient received any formal treatment or professional help to deal with social and psychological difficulties. The neglecting of these complications severely affects breast cancer patients. Patients suffering from severe anxiety and high level of depression were additional distressed and experienced gradual recovery when compared to emotionally stable and psychologically healthy patients. No patient or spouse mentioned receiving formal treatment for severe depression and anxiety. Several studies share same findings Lueboonthavatchai (2007) found that even though females diagnosed with breast cancer commonly experience anxiety and depression often worsening the outcome of treatment when left untreated. Elmir et al. (2010) added that breast cancer patients become 'emotionally vulnerable' due to the several emotional responses following breast cancer diagnosis for instance gloominess, chaos, hopelessness, fear, anxiety too (France et al., 2013).

While females reported feelings of shock, disbelief, denial, fear of death and concerned about their family and children, men stated the feelings of shock, helplessness, fear and sadness following their wife's diagnosis of breast cancer. Somewhat identical feelings were reported by Zahlis and Lewis (2010) stating that husbands regarded the breast cancer diagnosis as sudden, unpredicted, then emotionally overwhelming impacting each aspect of their daily life together with job performance then shared time with friends.

The male respondents reported worrying about their wife, the severity of her disease, their wives' survival, treatment cost and financial expenses, cancer recurrence, and about their future, findings alike, were given in several studies (Lethborg, Kissane, & Burns, 2003; Northouse, 1989; Zahlis & Shands, 1991). However dissimilar to the findings of Zahlis and Shands (1991) no spouses reported feeling guilty or being self-

critical for not being able to sufficiently help their wives or incapability to support her rather talked more about what they had done and were doing to support their wives including bearing treatment cost, emotional support, extra childcare responsibilities, household management and adjusting with altered social and family life despite of insufficient support and without their wives admiring their efforts. This resulted in increased stress and depression ultimately affecting their relationship as a couple.

Many couples reported that the breast cancer transformed their relationship. Although some couples also mentioned improved relationships and positive effects of this experience on their marital life referable as posttraumatic growth as also revealed by previous studies (Koutrouli, Anagnostopoulos, & Potamianos, 2012; Salander et al., 2011; Silva, Crespo, & Canavarro, 2012; Wang et al., 2014). Female patients were more appreciative for their lives, relationships and families, Turner (1967) stated that this appreciation is a feature of the liminal period. Balmer, Griffiths, and Dunn (2015); Blows et al. (2012) found that some survivors experienced positive changes and a better gratitude towards life following cancer diagnosis, in my study I observed that not only for few cancer patients but also for their husbands post-diagnosis and post-treatment period brought positive changes i.e. they became more appreciative and concerned about each other. The fear of potential loss of a life partner brought spouses closer besides men became more expressive and caring towards their wives. Breast cancer allegedly helped them to discover each other's importance in their lives and reshaped their relationship in a positive direction and strengthened it. Nevertheless few couples experienced these positive changes most respondents reported otherwise.

But for majority respondents this relationship alteration was generally negative and confronted couples with bitterness in their spousal relations. These findings are consistent with the findings of Zahlis and Lewis (2010) who also found in their study that the relationship of couples confronted with breast cancer was altered in both positive and negative way. The experience either brought some spouses closer as they dealt with breast cancer as a team or it tested the couple and their relationship in novel means and caused conflict and disagreement between them.

The most important challenge faced by couples confronting with breast cancer was communication; their communication patterns were modified. A vast research has established that marital satisfaction and communication are dependable. As Litzinger and Gordon (2005) highlighted in their study that communication was consistently besides significantly related to marital satisfaction as couples who lacked in communication skills or unable to communicate effectively were unhappy resulting in marital dissatisfaction. In the present study the couples who claimed to be expressive and openly shared their feelings between spouses, self-disclosure and responsive to each other were more content with their life despite of breast cancer affecting their life in several ways. Alternatively, couples who lacked in communication skills were distressed and their situation worsened consistent with cross-sectional studies constantly shown that the difference between distressed and satisfied couples also depends on their communication behaviors as the unsatisfied couples exhibited more negative communication patterns during their conflict resolution while the satisfied couples displayed comparatively positive communication behaviors (Bradbury & Karney, 2013). Pierce (2016) stated that social exchange theory addresses the significance of effective communication, productive divulgence, conflict resolution, as well as realistic expectations in a relationship with the goal of helping individuals in effectively communicating his/her expectations and needs from a relationship thus describing moreover sustaining relationship satisfaction. In present study, couples who were honest and open in expressing their needs and feelings were more satisfied and emotionally attached with each other which helped them in maintaining a strong bond in the time of hardship.

Protective buffering on the other hand was also found to be an important but negative phenomenon related to marital satisfaction for both patients and their husbands. Men mentioned to involve in protective buffering in order to protect their wives from anxiety and emotional stress while females highlighted the neglect and avoidance of their spouses. The females described to experience abridged satisfaction when their husbands exercised fairly high levels of protective buffering as it was regarded husbands being insensitive and careless to their wives; while husbands stated being compassionate and protective but the communication gap thwarted them to win

their life partner’s trust the study of Hagedoorn et al. (2011) is congruent with the findings of present study. Their findings suggested that the communication lapse characterized through augmented protective buffering cause enduring effects on patients’ interpretations of their spousal relationship. People revealed different strategies like averting disease related discussions and distancing to protect their spouse from emotional stress but the unfortunate consequence of this was increased spouse’s tension and spousal conflict between partners, these findings were consistent with those of Coyne and Smith (1991). They found that protective buffering coping strategies may lessen constructive communication otherwise increase conflicts within couples subsequently intensifying partners' stress which may impact the conjugal relationship undesirably.

Traa et al. (2015); Wootten et al. (2014) stressed on interventions possible to facilitate partners in expressing their physical and mental suffering and stress communication in order to enhance the well-being of couples. The findings of the present investigation suggest that marital relationship thus satisfaction in couples confronted with breast cancer is influenced by patient-partner interaction patterns. Conflict resolution strategies proved important in maintaining healthy and fulfilling relationship, husbands played very important role in this regard by forgoing their negative feelings and compromising more often. Women approved that their spouses give them the advantage of their disease and listen besides tolerate their bad moods if they didn’t do it prior to their disease. Inconsistent with findings of previous study conducted by Hagedoorn et al. (2000) that reported no differences regarding patient–partner differences and consistent with Manne et al. (2007) present study suggests that partners in this case husbands hid negative feelings besides sidestepped arguments and conflict more often than breast cancer patients.

Although in general, breast cancer patients narrated support from their spouses besides family, few women shared extremely upsetting experiences of blame, aggression and isolation. Stephens et al. (2006) suggested that a patients’ an ongoing illness as a disastrous consequence may erode his/her partner’s ability to be sympathetic over time and may intensify their critical and controlling behaviors. The findings and observations are made across conditions affecting adults including chronic pain,

diabetes, rheumatic disease, heart disease and cancer (Fisher et al., 2002; Schmaling & Sher, 2000). These observations are approved by the present study' participants; men and women revealed the behavioral changes occurred in them besides their spouse. As the time passed and disease prolonged male spouses experienced exhaustion and frustration. They stated their life partners' physical plus emotional distress tested them to their limits. They argued with them over insignificant issues, made excuses for performing household chores even when they were able to do, sexual dissatisfaction and lessened intimacy. Additional domestic, childcare and social responsibilities reduced personal time and emotional stress and financial burden was not easy to deal with. Moreover the depreciating attitude of their wife stirred up the situation. These findings were relatively consistent with Baider and Sarell (1984) who presented in their study results that instead of cancer patients their spouses stated less emotional exchange, decreased domestic support, increased marital conflicts and increased problematic spousal relationships in comparison of cancer patients. Fergus and Gray (2009) explored in a qualitative study the relationship challenges besides vulnerabilities of couples coping with breast cancer and summarized that appropriate interaction amid couples stood interrelated to reduced distress in addition to improved marital adjustment nonetheless they also stated that open communication between couples confronted with breast cancer couldn't occur attributed to spouse/partners' individualities and their shared patterns of communication that was also confirmed through the present study.

Breast cancer didn't only impact couples' interaction patterns but also their intimate and physical relationship negatively. Patrick et al. (2007) found that support from the life partner and intimacy as compelling predictors of marital satisfaction in wedded couples. Lack of effective communication influenced couples' expressiveness and intimating relation resulting in emotional distress for both partners. As explained by Laurenceau et al. (2004), the failure of one partner in revealing indispensable emotions and apprehensions about a nerve-wracking life experience results in compromised intimacy maintaining process since there exists a disregarded chance for the second partner to respond then, eventually, for intimacy to be established and/or sustained. The emotionally distressed patients and their husbands' experiences were

regarded by them as one of the most problematic features of life subsequent to breast cancer but patients reported the feelings of greater intimacy when their husbands expressed and disclosed their feelings; patients mentioned feeling being loved, protected and cared of despite of their disease which gave them strength to fight with their disease relatively. Similar findings were stated by Manne et al. (2004) that partner's disclosure was related to unabridged acceptance, empathetic, besides caring towards patient thus anticipating patients' sentimentalities of intimacy. Some couples also described breast cancer strengthening their emotional intimacy by bringing spouses close to each other and by casting the fear of potential loss of an intimate relation, somewhat similar evidence was provided by Graziottin (2008) couples' shared solidarity by following breast cancer diagnosis and treatment may reinforce their emotional intimacy. Villa and Del (2013) revealed that among a number of behaviors considered fundamental for marital satisfaction empathy/expressiveness is the only component of marital satisfaction simultaneously important for both spouses regardless of their gender. The present study approved their proclamation to the extent that female spouses regarded intimacy and empathy more important than sexual satisfaction while male respondent mentioned sexual dissatisfaction as a drawback of breast cancer influencing their overall relationship with their life partner.

Keesing, Rosenwax, and McNamara (2016) explored that both breast cancer patients and their partners encountered with numerous amendments in their routine roles and responsibilities moreover complications in communication, intimacy, and sexual problems. Similar findings were assessed in present study as respondents shared all aforementioned issues in addition to problems faced in parenting. The sexual dysfunction and complications were testified by both breast cancer patients and their husbands. Basson (2005) stated sex then sexuality as imperative measures and crucial to marriage. Breast cancer patients shared varied experiences how diagnosis and treatment affected their sexuality, sexual functioning and sexual relationship with their husband. Sexual functioning and physical satisfaction was unquestionably declined either by psychological effects of breast cancer for instance mood swings, depression, loss of sexual desirability, resentfulness, or by physical effects i.e. fatigue, pain, nausea, difficulties in getting mentally and physically aroused, altered body in result of

mastectomy, difficulties in achieving orgasm, or dyspareunia because of the vaginal dryness (in case of menopause). Graziottin (2008) stated that these biological factors are frequently ignored in the clinical management thus dramatically affecting physical intimacy and satisfaction of breast cancer patients. In the present investigation, breast cancer patients complained about painful sexual intercourse while describing the reasons of avoiding coitus with their husband with this loss of sexual interest was also mentioned by respondents.

Almost every female patient experienced some physical changes and confronted with a number of side effects of treatment; tiredness, body ache, hair loss and weight alteration were commonly experienced as a result of radiation and chemotherapy. Breast cancer treatments have several well-documented physical side effects including fatigue, hot flushes, pain and sleep disturbance (Janz et al., 2007), vaginal dryness (Ganz et al.,1999), agonizing coitus (Speer et al., 2005), reduced libido (Avis et al., 2004) besides dearth of sexual desire (Foster et al., 2009). Ganz et al. (1999) identified these symptoms as the predictors of reduced sexual healthiness amongst women diagnosed with and treated for breast cancer. These symptoms also found to be additionally prevailing in females treated with chemotherapy (Emilee, Ussher & Perz, 2010). Moreover, upsetting to a number of females, chemotherapy may result in temporary hair loss. The physical suffering was augmented when husbands were insensitive and ridiculed their wives. Female respondents shared that their individual body image and satisfaction with their relationship was directly affected with their husband's perception of their body image similar findings were found by Dye (2008) that how a husband felt about her wife's altered body and how his wife perceives his feelings affected women's personal body image and marital satisfaction.

Furthermore, women whom breast was removed (mastectomy) contrasting women who had breast-conserving surgery (lumpectomy) or any other treatment were further prospective to feel differently towards their bodies because the side effects of other treatment are in general temporary besides breast is the symbol of sexuality. The results of present study in this particular regard were corresponding to the findings of Piot-Ziegler et al. (2010) who found mastectomy emotionally distressing notwithstanding whichever reconstruction that possibly will be done. Pelusi (2006)

also confirmed that mastectomy remained a significant cause of negative effects on a female's body image similar views were shared by the respondents of present study endorsing the conclusions derived from previous studies on same topic but relatively contrary to the findings of Figueiredo, Fries and Ingram (2004) younger women following mastectomy were to a greater extent concerned towards their body image as compared to older women. The participants of study furthermore approved the finding of cancer treatment and therapies likely to disturb sexuality directly through hormonal and gonadal effects then indirectly through instigating apathy, fatigue, vomiting, nausea, and malaise as well as sleeplessness besides disturbed appetite reported interfering with sex drive also mentioned by (Ganz et al., 1987; Ganz et al., 1998; Reaby & Hort, 1995; Wilmoth, 2001; Yurek, Farrar & Andersen, 2000). Dealing and adjusting with altered body was not patients' sole issue rather for their husbands also. As mentioned by male respondents they faced difficulties while adjusting with physical complications and altered body of their wife especially during sexual intercourse.

The findings also suggested that body image of female patients was highly influenced and disturbed by objectified body consciousness they were particularly concerned about their appearance and narrated disturbing experiences regarding people's reactions but the distress was high when their husbands "partner-objectified" them. This is notable that few husbands talked about their wife's altered bodies unless asked. It was women's internalization of sexual objectification that led them body related concerns and depression and effected their sexual functioning. Moradi and Huang (2008) suggested that women internalize sexual objectification via self-objectification. The internalization of cultural standards of beauty and physical attraction was interrelated to poor body image and dissatisfaction and low self-esteem in women treated for breast cancer; the findings were consistent with previous research on body image in the general womenfolk and eating disorders (Bessenoff & Snow, 2006; Calogero, Davis, & Thompson, 2005; Greenleaf, McGreer, 2006; Mensinger, Bonifazi, & LaRosa, 2007; Murnen, & Smolak, 1997). Women with high internalization of objectified self and body reported more vulnerability similar to these findings were similar with of Boquiren et al. (2013).

The current study added that sexuality and sexual functioning of females was affected following breast cancer thus causing sexual dissatisfaction among their life partners. Lack of libido was attributed to side effects of treatment for instance weight gain/loss or sleeplessness, incessant nausea, an altered body image and pain. Few females also reported the issues of vaginal dryness and painful coitus. Yet other women hinted lost interest in sex attributing to the spiritual experience and fear of a life threatening disease which made them weary and tedium of worldly affairs compatible findings were presented by Foster et al. (2009) and mentioned that their systematic review established that considerably high number of females living beyond breast cancer diagnosis testified loss of sexual desire, enjoyment dearth besides lack of arousal in comparison of healthy women. Nonetheless some women declared their husband's unattractiveness towards them after breast cancer as the major cause of glitches in their sexual relationship although husbands didn't mention losing interest in their wife. Brandberg et al. (2008) while conducting a research with females who undertook prophylactic bilateral mastectomy, suggested a negative impact of this treatment on sexuality and body image however refused the assumption that surgical removal of women's breasts was correlated with anxiety, depression, or their quality of life on contrary my data suggest a high level of anxiety among women who underwent mastectomy even their life partners faced difficulties in adjusting with their wife's "deformed" body, body shame and sexual anxiety which was attributed to the self-objectification of women patients. Zurbriggen et al. (2011) predicted that appearance related concerns and other person's outlook of one's own body leads to anxiety and body shame. As constructed by self-objectification theory; female study participants' internalization of their partners' objectification heightened their anxiety and body shame and effected their sexual functioning resulting in decreased relationship satisfaction. The female more concerned about their appearance and modified body devoted less attention to their husband's needs and instigated their husbands' feelings of sexual frustration. Female respondents in general had internalized the concept of sexual-objectification and viewed their husbands' actions through the lens of sexual-objectification; they attributed their husbands' changed and irritable behavior to their failure of fulfilling their husbands' sexual desire and needs.

Gerrero and Weber (2001) confirmed sexual function as one among the most noteworthy parts related to the cancer patients' quality of life. Sprecher (2002) found correlation between sexual satisfaction and marriage stability and concluded that rise in sexual satisfaction results in enhanced love, commitment thus marital satisfaction. Subsequently higher the sexual satisfaction greater will be the quality of life and marital instability will decrease over time and conversely (Yeh et al., 2006). The findings of present study approved of Sprecher (2002) that men's sexual satisfaction dominates the relationship when compared to females' sexual satisfaction, and of Byers (2005) that in comparison, sexuality is supposed to be more important to men and although respondents shared assorted experiences in present study, the couples where men were sexually satisfied with their wife were more contented. On the other hand females gave more value to emotional intimacy and spousal support and complained their husband's insensitive behavior in this aspect of their relationship while husbands tried to justify them in the name of religious and social values.

Breast cancer patients described greater marital satisfaction associated with increased support from spouses. Richter, Rostami and Ghazinour (2014) found in their study that couples that had enhanced communication and were greatly satisfied with perceived support of their partners didn't require considerable social support from a third party or outside the marriage. Several survey studies on the same subject (Hagedoorn et al., 2000; Hinnen et al., 2008; Kuijer et al., 2000; Langer, Brown, & Syrjala., 2009) have revealed substantial associations amid partners' existing supportive behavior and patients' relationship satisfaction. The participants of current study also ratified the existing data. Women having supportive husband reported less stress and more physical and emotional strength to cope with their disease in addition to less distressed married life and infrequent spousal conflicts. Chi et al. (2011) and Mueller (2006) congruently suggested that social support acts as a buffer averse to deleterious consequences of day-to-day life stressors related to marital disputes then further social conflicts which must influence marital satisfaction. In contrast to the findings of Pasipanodya et al. (2012) that social support both in patients then partners constrains was not considerably related with marital adjustment in couples' well-being coping with early-stage breast cancer the findings of present study suggest that social

support is very important component of marital satisfaction for couples confronting with breast cancer regardless of cancer stage and time post-diagnosis. Kim and Park (2014) in their research on breast cancer patients conducted in Korea established a positive relationship concerning perceived spousal support and interpersonal relations, health responsibility, nutrition, stress management, and spiritual growth, their findings were verified by female respondents of present study. Women who received more spousal support were more stable both physically and emotionally as compared to women with low level of spousal support. Moreover, similar to the findings of Yedirir and Hamarta (2015) the results of my study show that the mutual spousal support received from each other proved an important variable for providing happiness in married couples despite the challenges they faced due to female partners' sickness.

There is a general perception of cancer effecting marital relationship and marriage breakdown. Many women confronting breast cancer may stress due to a common belief that husbands of women with breast cancer desert their wives. However different studies exhibited diverse findings, Odigie et al. (2010) in their study of 81 breast cancer female patients in Nigeria exhibited that married African women found that as high as 38.3% of the 81 women included in their study 3 years after therapy had separated or divorced attributed to their physical, emotional besides social problems. The findings of their research were comparatively different from present study as no study participant mentioned considering separation or divorce in present study; neither the patient nor husband. This difference can be attributed to the cultural diversity and family structure for instance, a study in Saudi Arabia found the divorce rate among cancer patients admitted/treated in Princess Noura Oncology Center remained considerably lower when compared to the divorce rate of the general Saudi population (Alzahrani et al., 2018). Culture, societal values and family are important factors in strengthening the relationships.

In Pakistani society, family and children traditionally play a significant role in keeping couples tied. Social and emotional support, financial aid in time of need, assistance in household chores from family members and social pressure exercised by this primary social institution manages and supports a couple in their hard times; thus leaving little or no space for temporary or permanent separation. Kirchhoff et al. (2012)

in their study of investigating young adult cancer survivors established that respondents' risk of divorce or separation was higher attributable to the emotional besides financial burdens resulting of their condition furthermore a study by Glantz et al. (2009) suggested that after cancer, marital dissolution can be more prevalent if the victimized partner is a woman. Many women narrated utmost fear in early days following breast cancer diagnosis as they heard people and fellow patients about the deleterious reaction of spouses of cancer patients nevertheless the findings of the contemporary investigation suggest that for husbands, in general, their fear of potential loss of their wife to the cancer took antecedence above everything. Although most couples reported that problems beset them during the following diagnosis and early days of treatment as they needed to make countless adjustments together with social, economic, family and sexual. As the time passed and wife started getting recovered from early trauma and physical compilations things started getting normal for couples and their satisfaction increased. Ming (2002) found that spouses' deficient social support besides disturbance in sexual relationship resulting from treatment of breast cancer was elements prominent to intensification in marital complications similar narrations were made by the respondents of present study thus approving the findings of Ming (2002).

My findings of the present study further stress the importance of individual and collective leisure activities in couples' satisfaction adding to the existing literature showing that leisure is related to marital satisfaction (Crawford et al., 2002; Johnson et al., 2006) marital adaptability and cohesion, other than family functioning (Zabriskie & McCormick, 2001). Leisure and pleasurable activities are indispensable to healthy and successful spousal relationship yet this is most neglected in Pakistani society. Couples even prior to disease didn't give much importance to leisure and the role it might play in strengthening their spousal relationship. Johnson, Zabriskie and Hill (2006) suggested that spending time together improves communication and strengthen their bond besides they learn to adapt to traumatic circumstances these findings were approved by present study as the couples who claimed to spend more time together and involved in collective leisure and social activities were relatively more satisfied and

hopeful about their relationship as compared to people who didn’t give due attention to this factor.

The study found that the husbands of females with breast cancer were disheartened attributed to the depreciation of their endeavors made to support their wives similar to the findings of Keesing et al. (2016) respondents mentioned that their significant role played in supporting their partner throughout this period was not well-recognized. Most of the respondents believed that they had made maximum efforts to help their wives in fighting with their disease and bore financial and emotional burden so they deserved acknowledgment of their efforts. Husbands who were appreciated by their wives and family members tent to be more supportive and caring towards their life partners thus strengthening their relationship and ultimately enhancing their marital satisfaction.

The present study advances understanding of the association between couples’ experience of breast cancer and marital satisfaction. My findings were largely consistent with my predictions, suggesting that breast cancer patients and their spouses experienced an array of physical, social, psychological, economical and marital problems but rejecting the notion of people weighing their relationship with perceived cost and benefits as described by social exchange theory. Pinderhughes (2002) suggested that the social exchange theory proposed that males perform the role of prime breadwinner in a marital relationship in exchange for sex, domestic tasks, besides child rearing and caregiving. My study findings showed that people did believe their marriage to be an "exchange relationship” but also a "communal relationship," as termed by Clark and Mills (1979). A partner in a communal relationship is under no obligation to reinstate an equivalent benefit after receiving aid from other partner; instead it establishes norms of mutual responsiveness. The findings of my study also supported the notion derived from social exchange theory which is that people decide to participate in a relationship based on the perceived rewards that relationship might offer. The fact that not all people look at their marriage as an exchange relationship is may be somewhat denoted to cultural background may be the reason behind this finding. In Pakistani society mutual interests in personal and social relationships are emphasized over individual interests thus relationships are not seen and measured in

terms of cost and outcomes. Likewise, many study respondents irrespective of their gender and health condition didn't attribute their dissatisfaction to the failure of their spouses in offering professed equal benefits/outcomes/rewards. On contrary their dissatisfaction was more of a collective experience and a result of the issues breast cancer created for them. Although, most male respondents mentioned declined sexual satisfaction, decreased emotional support and intimacy and in general they undertook extra responsibilities, few believed that they deserved any benefit of it. They also believed not being appreciated enough for their support but their general concern was their spouses' survival and well-being and none of them wanted to end the relationship merely based on the fact that their female partners were not able to return their favors and were economical and emotional burden.

My observations advocate the similar conclusion derived by Manne et al. (2014) that marital relationship laid foundations of emotional then social support together for the patients and their companions during cancer, therefore protecting the relationship quality was crucial in addition to the findings of Srivastava et al. (2006) that marital satisfaction or dissatisfaction had foremost impact on the physical health of patients confronting with breast cancer, my observations correspondingly suggest that patients in couples with strong bond and stable marital relationship were in general in better physical and emotional state while females who were facing problems in their married life were more stressed and in poor physical and emotional condition. Similar to my observations, Gray et al. (2017) concluded in their research that distressed relationships intensify people's poor health and physical conditions and they may experience their chronic and existing illness worsen due to negative impact of their relationship. Thus the important role of patient's partner/spouse in disease management is very important. Weihs, Enright and Simmens (2008) revealed the interrelatedness of relationship quality with positive health outcomes and proved this to be positively affecting to those with breast cancer by improving the survival rates.

Few respondents also described the negative role of their spouses' family in their spousal relationship as for them impolitic involvement brought undesirable and negative consequences for couples. Females faced this problem more than male

respondents as their disease made them vulnerable to their in-laws' inappropriate behavior and reactions; this situation triggered conflict between couples.

Breast cancer is found to intensify spousal strain in couples studied. The diagnosis and related treatments of breast cancer changed females' customary roles, Kinsinger et al. (2011) established that in such situation husbands replace some roles also exhibited by current study respondents i.e. assisting wives in household chores or taking care of children. Consistent with previous studies' findings husbands of female breast cancer patients reported stress when trying to perform their traditional domestic and professional roles (Northouse et al., 2012). These negatively modified roles placed stress on respondents' spousal relationships successively resulted in marital strain.

5.2 Conclusion

The results of the present investigation as discussed above, in general, suggest an association between breast cancer and couples' marital satisfaction. On the basis of study findings breast cancer can be regarded as a "couple's disease" as it increases strain in married life of couples confronting it. The qualitative findings of present study revealed that marital satisfaction is effected by wives' breast cancer. The qualitative findings strongly complemented the quantitative findings, with female cancer patients and their husbands reporting several aspects of their marital life being affected by breast cancer. Despite the subjective nature of marital satisfaction's phenomenon and its discrete interpretation, both the patient and their spouse mentioned to experience altered spousal relationship once the female partner was victimized by cancer. Breast cancer impacted their relationship either through creating new difficulties or by magnifying already existing problems, nonetheless, few shared positive influence specially on communication pattern and conflict resolution strategies.

Male partners in couples mentioned making several adjustments for instance financial, social and job related adjustments, while wives were fighting their disease physically and emotionally, husbands also went through emotional distress and burden. Their responsibilities were increased; their traditional role of provider and breadwinner was compromised as wives were unable to perform their domestic and childcare duties.

Sexual dissatisfaction along with enhanced household responsibilities, lack of intimacy and problematic communication patterns were narrated by husbands of breast cancer patients while these all are important components of marital satisfaction, thus male respondents were less satisfied in their marital relationships. Nonetheless, notwithstanding the customary expectations from marriage, the spousal relationship of husbands of women with breast cancer confronted with many challenges, despite of this fact women felt supported because men generally wanted their wives only to survive and feel strong. In general, few women experienced seclusion, rejection, withdrawal, or blame for the disease, however such experiences appeared both physically and emotionally deleterious and women who described these responses were in poor mental and physical condition compared to females who had supportive and caring spouses. Mutual spousal support is indispensable both for breast cancer patients and their spouses in order to have stable and satisfied marital life and to cope with stressful life events. Breast cancer elicits marital dissatisfaction but couples who understand and support each other completely and prefer collective interest over individual recovers from the damage swiftly as compared to couples who were already in some distress or conflict prior to breast cancer diagnosis or who didn't have strong spousal relationship. It was also observed that couples who mutually supported each other were comparatively happy and satisfied as compared to couples who focused on individual interests. Breast cancer doesn't always negatively influence marital relationship rather sometimes it gives new strength and positivity to couple with a sense of oneness. Couples didn't assume their relationship as an exchange and didn't weigh their relationship on the basis of perceived benefits and cost or rewards as suggested by social exchange theory.

5.3 Study Implications and Directions for Further Study

The verdicts of the contemporary study have several clinical implications. The findings of current study are of high importance for clinicians who work with breast cancer women and their partners. These findings suggest that patients and their partners experience declined marital satisfaction and henceforth might benefit from psychosocial support post-diagnosis and during treatment to prevent marital distress.

The findings suggest that patients and their husbands couldn't get necessary information related to disease therefore professional information providers must be engaged in hospitals and clinics to guide patients about available treatment options and their impact and side effects. The ineffective communication was mentioned by several respondents suggesting that psychologists and counselors should work with couples and promote the development of effective communication patterns. Sexual dysfunction was mentioned by many patients and their husbands and also that patient's sexual concerns are unaddressed thus confirming the significance of acknowledging sexual modifications as well as to develop supportive interventions both for patients and spouses. Future research can focus on role of extended family and provided social support in strengthening or weakening the spousal relationship between couples confronted with breast cancer. There is also a need to find out the relationship between financial problems/issues and its impact on spousal relationship or marital satisfaction especially with a focus on financial impact of breast cancer for couples.

5.4 Suggestions

The findings and analysis of both qualitative and quantitative data suggested that breast cancer patients, their families and care providers face an array of problems during the course of treatment and follow up. Following suggestions are made on the basis of results of the current study.

Short Term Recommendations	Long Term Recommendations
• Distinctive programs in hospitals for spouses and caregivers of cancer patients should be initiated with focus on better caregiving strategies and emotional needs of cancer patients. • Healthcare providers must be aware of the effects of breast cancer for patients' spouses and	• Health care professionals particularly in the field of oncology may improve their skills in addressing the basic biological issues of breast cancer patients especially concerning sexual complications. • Future research should focus on intervention strategies for

include them in the treatment process. • Couples may be guided to cope effectively with emotional and psychological distress caused by breast cancer through professional couple counseling. • Psychoeducational support could be provided to breast cancer patients and their spouses	husbands of breast cancer patients. • Further research is required to develop couple-based interventions conceptually and methodologically in addition of defining ways of incorporating these interventions into cancer hospitals and clinics. • Print and electronic media might be used to educate people about the diagnosis, treatment and effects of breast cancer for patents, their spouses and their families. • Cultural diversity must be considered as it may provide new dimensions for understanding social exchange theory.

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International Islamic University Islamabad

Consent form

Participate in research study Questionnaire

I, the undersigned, volunteer to participate in this research project titled **"Effect of Breast Cancer on Couples' Marital Satisfaction in Pakistan"** conducted by **Ms. Nudrat Mushtaq**, I confirm that I have read and understood the information about the project, as provided to me by the researcher and I understand that my confidentiality as a participant in this study will remain secure and that the researcher will not identify me by name in any reports using information obtained from this interview and the use of data in research, publications, sharing and archiving has been explained to me.

______________________ ______________________

Name of Participant Signature of Participant

i. Gender _______
ii. Age:______
iii. Education _______
iv. Employment Status __________
v. Married for (years) __________
vi. Cancer Stage ___________

Below is a list of statements dealing with your general feeling about yourself. Please indicate how strongly you agree or disagree with each statement.

1 = Strongly agree (SA)

2 = Moderately agree (MA)

3 = Neither agree nor disagree (NA/ND)

4 = Moderately disagree (MD)

5 = Strongly disagree (SD)

Item no	Statement	Responses				
		SA	MA	NA/ ND	MD	SD

1.	My partner doesn’t often communicate his/her opinion properly.					
2.	We do not discuss about my/my partner’s disease often.					
3.	My spouse and I understand each other’s problems.					
4.	I do not share my problems with my spouse because he/she doesn’t care.					
5.	Whenever we fight I swiftly relinquish to finish the dispute.					
6.	My spouse and I try to resolve conflicts differently.					
7.	Sometimes we have serious spousal disputes over minor issues.					
8.	My spouse often blames me for strain in our relationship.					
9.	My spouse doesn’t usually take our arguments seriously.					
10.	My spouse often behaves aggressively.					
11.	My spouse has become too critical in period following cancer.					
12.	I feel anxious about my spouse’s temperament at times.					
13.	Sometimes my spouse seems unhappy and emotionally detached.					

14.	My spouse and I help each other in household responsibilities					
15.	My spouse sometimes displays distressing behavior in front of our family or friends.					
16.	I feel my spouse has become very stubborn in recent time.					
17.	My spouse often delays his/her responsibilities.					
18.	At times, it becomes difficult for me to handle my spouse's mood and irritability.					
19.	My spouse behaves very intimidating sometimes.					
20.	Role and responsibilities are fairly distributed in our marriage.					
21.	My spouse does not seem to enjoy time with me.					
22.	I am concerned about our confined social life.					
23.	I comfortably attend family gathering and functions alone.					
24.	I am satisfied with my spouse's participation in our family gatherings.					
25.	I feel contented about the amount of time we give to our children and family.					
26.	My partner and I do not spend enough lone time together.					

27.	We seldom find chances for recreation.					
28.	My partner fails to completely satisfy my emotional needs.					
29.	My partner and I share a strong emotional bond.					
30.	Our relationship lacks spousal affection and tenderness.					
31.	I have never had compunctions about marrying with my spouse.					
32.	My spouse and I emotionally support each other.					
33.	I can truly express all my feelings to my spouse.					
34.	My spouse doesn't express his/her feelings openly.					
35.	At times, my spouse shows irritability and weariness.					
36.	My spouse often understands my unspoken feelings					
37.	At times, I have negative feelings about my spouse and our relationship.					
38.	My partner fails to completely satisfy my emotional needs.					
39.	My spouse and I have satisfactory sexual relationship.					
40.	After cancer my spouse doesn't enjoy sex.					
41.	My spouse sexually frustrates me.					

42.	My spouse often misinterprets affection with sexual advance and acts accordingly					
43.	After cancer my spouse's and my interest in sex is not same.					
44.	I feel annoyed when my spouse unfairly uses or refuses sex.					
45.	My spouse & I can comfortably discuss our sexual issues					
46.	I never discuss our sexual issues with a third person.					
47.	At times my spouse treats me inappropriately.					

………….. Thank you…..

Interview Guide

Marital satisfaction among Breast Cancer Patients & their Husbands

Background information

Name	Age	Qualification	Job status	Family type	Married for	Children

Information about Breast Cancer

Breast Cancer stage	History	treatment type	Economical problem	physical disability	Emotional stability

Experiences of the Disease & Treatment

1. What was your first reaction on the diagnosis of breast cancer? (Depressed, anxious, frightened, fear of death)

2. How did the disease affect your daily life? (Daily routine, household chores, child caring, association with friends & relatives)

3. How did the treatment affect you physically? (Change in Physical Appearance, Lymphedema, Anemia, fertility and sexual side effects)

4. Can you please explain in detail if and how your disease has influenced your relation with your children?

- How your children feel and think about your disease?
- What kind of reaction do they show?

- Has there been any change in how they approach you after you were diagnosed?)

4. Can you please explain if and how your relation and daily interaction with your neighbors/relatives and friends has changed after the diagnosis of the disease?
    - How do these people feel towards you?
    - How they approach you?
    - Do you discuss your marital life issues with your family members & friends?
    - What kinds of comments do they give about your marital wellbeing and relation with husband?
    - Do they give you hope?
    - Do they sympathize with you or with your husband?
    - Do they feel you are an extra burden on your husband?

Marital Experience

5. What kind of relationship did you have with your husband before the disease was diagnosed?
    - were there any conflicts at times

7. What was the reaction of your husband on the diagnosis of breast cancer?

8. Do you think there has been change in your husband's attitude ever since your disease was first diagnosed? Please explain in detail.

9. How did your husband support you through this dilemma?

    - financial support
    - emotional support
    - care
    - assistance in household chores
    - taking care of children

10. Do you feel your relationship with husband has weakened or strengthened due to the disease?

11. How did he deal with physical deformity, mood swings, emotional problems, sexual problems?

12. Did you experience any change in his behavior? (Aggressive, impatient, irritable, contentious)

13. Has your disease affected your *physical* relationship with your husband?

- Has there been decrease in sexual activity?
- Has there been change in sexual performance?

14. Do you believe your *physical* relationship has influenced your relation with your husband in general?

- do you feel that due to decreased sexual activity or sexual performance your husband's attitude towards you has changed)

Questions with Husband:

15. How was your relationship with your wife before she was diagnosed?
- Smooth & normal
- Conflict in relations
- Argued frequently
16. How did you initially feel about your wife when she was diagnosed with breast cancer?
    - Depressed
    - Anxious
    - Frightened worried about finances
17. Were there feelings of fear that the disease could possibly transfer to you through your wife?
18. 18. Do you ever feel aggressive, impatient, irritable, and contentious due to the unexpected changes in your life?
19. Does the thought of your wife dying with cancer make you uncomfortable and frightened?

20. Can you please explain how you gradually got used to the situation over time and your current feelings about the disease of your wife and how it is influencing your daily life?
21. How do you think her disease has affected her performance at home and does this concern you as a husband?
    - Performing daily chores taking care of children etc.
22. What kinds of measures do you take to support her in this regards?
    - Do you assist her in household chores and child rearing?
23. How do you feel about the changes in the physical appearance of your wife after the disease has been diagnosed? Do you still find her beautiful and attractive?
24. Do you think due to her disease there is change in the attitude and behavior of your wife towards you as a husband and towards your children? (Change in affection, love, taking care of personal belonging like clothing, shopping for you and your children)?
25. Do you think there has been change in her sexual performance, sexual needs, the way she approaches you and the way she responds to your sexual needs. Please give detail.
26. How do you deal with your wife's physical, emotional and sexual complications?
    - Have you ever thought of any alternatives to meet your sexual needs e.g. finding a second wife, extra marital relations etc.?
27. How do you deal with the burden imposed by your wife on your personal, family and social life?
28. At this stage do you feel completely hopeless or are there feelings of hope that may be she will recover somehow?

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Glossary

Appraisal support: evaluative feedback

Breast cancer: The term denoted to a malignant tumor grown-up as of cells in the breast.

Emotional support: empathy, trust, caring and love.

Informational support: information, suggestion and advice.

Instrumental support: actual help in time, money, and energy.

Marital dissatisfaction: A calamitous besides unsteady marriage with greater possibilities of experiencing divorce (Sullivan, 2001).

Marital satisfaction: A blissful besides stable marriage with fewer possibilities of experiencing divorce (Sullivan, 2001).

Sexual Satisfaction: An enjoyable and satisfying feeling consequential to individual actions or relational collaborations (Kavyani 1999).

Social exchange theory: A theoretical perspective that explores relational trades in relationships through assessment of perceived rewards and costs (Miller & Bermudez, 2004).

Spousal Protective Buffering: By definition are measures taken to fortify one's spouse/partner from burden and upset by hiding worries, concealing apprehensions, besides to avoid disagreements, acquiescent to the partner Coyne and Smith (1991).