



Working for the well-being of couples and their families

The impact of breast cancer on couple satisfaction and quality of life: a review of the literature

Briefing report

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Outline

While breast cancer is the most common cancer in women, there have been a number of recent improvements in its treatment and high proportions of women survive past five years. This makes it essential that women and their partners are helped to adjust to the psychological, emotional and physical impact of the disease. This literature review on the impact of breast cancer on the couple relationship suggests that there is no major increase in relationship breakdown specifically due to the disease. However, increases in conflict, strain, troubled communication and disagreements are common in many couple relationships as well as variations in outcome. Several factors predict who is most at risk of a decline in relationship quality. These include the quality of the pre-existing relationship, chronic psychological distress, sexual difficulties, and poor communication between partners. The involvement of health professionals and others, enhanced by specific training, may reduce some of the difficulties encountered by couples.

Key findings

- Although evidence is limited, it suggests that breast cancer and its treatment does not present an additional substantial risk of relationship breakdown.
- Nevertheless, there is a considerable variation in outcome between couples. Some may find that surviving the illness enriches their relationship and they grow closer and more intimate. Others find the additional stress drives them apart.
- The majority of couples report more conflict, strain, and troubled communication, and this occurs in even those that are highly satisfied with their relationship with the quality remaining good.
- Several factors predict who is most at risk of relationship decline. The quality of the pre-existing relationship is the most important factor, but chronic psychological distress, sexual difficulties, and poor communication between partners may also be important.
- Many male partners cope by withdrawing from open discussion about the illness, particularly in the long term. Women are more likely to want to talk and may misinterpret their partner's withdrawal / avoidance as a lack of feelings or caring.
- Health professionals and others need to support both patients and their partners and encourage more open communication.

Introduction

The diagnosis of any type of cancer involves a high degree of uncertainty regarding what caused it, how best to treat it, and what will be the long term outcome. But women with breast cancer confront additional stresses and anxieties. The disease and its treatment, including surgery, may change the way a woman thinks and feels about herself including her femininity, sexuality, desirability and attractiveness.

Women may also fear that their partners will leave them or that their emotional and sexual relationship may deteriorate (Taylor-Brown et al, 2000). These beliefs may lead to increased anxiety, fears and distress in the women involved.

The focus of this literature review is the impact of breast cancer on the relationship between the patient and her partner. This includes: the incidence of relationship breakdown; changes in marital quality and satisfaction; predictors of couple adjustment after breast cancer; and the role of the health professional.

Method

In this study, computer searches were made on Medline, CancerLit, PsychLit, BIDs and other appropriate searches. Relevant journals, articles and reviews were read to identify other studies or review papers on related areas including communication issues, psychological adjustment and gender differences in coping.

Marital breakdown

Many relationships will break down over time even in the absence of serious external stresses. The most appropriate way of testing whether breast cancer leads to a greater incidence of relationship breakdown is to compare couples with a diagnosis of breast cancer with similarly matched couples that do not. This was undertaken in one study which compared two cohorts of women with breast cancer with age matched population based control subjects (Dorval et al, 1999). At all time periods assessed, marital breakdown was similar or lower in women with breast cancer than in the control subjects taken from the general population. While this is only one study, it did include a large number of participants, and the results tentatively suggest that breast cancer does not substantially increase the risk of marital breakdown.

Marital satisfaction, conflict and strain

Most studies conducted have suggested that marital satisfaction in couples with breast cancer does not differ significantly from couples from “normal” populations. Levels of marital satisfaction in couples with breast cancer one to two years following the initial diagnosis and treatment are generally equal to or above the levels of marital satisfaction found in the normal

population. Studies using retrospective accounts have also found that satisfaction had either remained the same or improved.

These results, however, hide changes that do occur. First, many studies suggest that couples report more conflict, strain, troubled communication and disagreements. This has been found to occur even in couples who report that they are highly satisfied with their relationship with the quality remaining good.

Secondly, there is considerable evidence of variation between couples. Some couples find that surviving the illness and trauma enriches their relationship and they grow closer and more intimate. This has been termed “posttraumatic growth” (Weiss, 2004). However, there are some couples whose relationships deteriorate and they are become more at risk of breakdown.

Who is at risk of a decline in quality and possible breakdown?

The findings in the literature give tentative suggestions according to the type of couples who might be most at risk. However, only the first risk factor has been consistently identified and is considered to be the most important factor.

1. Quality of the pre-existing relationship

Couples in previously good relationships who communicate and support one other (or who have found an alternative way of coping that suits them) are much less likely to be at risk of relationship deterioration and breakdown. Indeed, there is considerable evidence to suggest that some couples believe that their relationship has become stronger as a result of enduring the crisis together.

Couples with pre-existing problems, however, may find that the experience drives them further apart. Couples with poor quality, unfulfilling relationships may be able to carry on living together as long as they are not presented with additional stresses. When faced with a major stressor, such as breast cancer, they do not have the emotional resources to support each other and survive the trauma, thus leading to dissatisfaction, disappointment and distress on both sides (Carter & Carter, 1994; Taylor-Brown et al, 2000).

Facing breast cancer may also provoke a number of existential concerns. Qualitative research and clinical evidence suggests that many couples or individuals when faced with a cancer diagnosis will start to review their lives and priorities. This may consolidate good or reasonably good relationships, but those in poorer quality relationships may decide that they cannot carry on living together as before. Similarly, a woman may believe that the stress of living in a difficult marriage was a major factor in the development of their cancer and that future stress might also affect its prognosis. Thus the diagnosis stimulates action in a previously unhappy relationship.

2. Degree of psychological distress.

Another possible predictor of couple adjustment after breast cancer may be the degree of psychological distress experienced by the patient as well as whether it becomes chronic. It is possible that the partner can cope with short term distress in the patient but that prolonged emotional distress may be difficult to endure. Preliminary evidence suggests that women who show continued distress elicit less social support from others and continued distress in the male partner may have a deleterious effect on the couple relationship (Bolger et al, 1996). Thus the less distressed spouse may learn to cope with the distress by avoidance, distancing themselves, or directing their attentions elsewhere, all of which could have an impact on the couple relationship.

3. Presence of Sexual difficulties

Body image is very commonly affected and there is evidence of sexual difficulties post diagnosis and treatment, including those relating to desire, arousal and orgasm. However, these problems are not found in all individuals or couples and many problems will decrease over time as the couple learn to adapt and adjust (Schover, 1991).

Few studies have specifically examined the impact of sexual difficulties on the couple relationship with women with breast cancer. However, one would expect that the quality of the pre-existing relationship would be a major factor, not only in determining the quality of the sexual relationship but also the impact of sexual difficulties on the relationship.

4. Adverse reactions in either the patient or her partner

There is little in the current research literature on adverse reactions. This may be due in part to the methodologies employed as studies using questionnaires are unlikely to yield such examples. However, qualitative studies and clinical reports do suggest that adverse reactions such as rejection, withdrawal or blame are infrequent but do sometimes occur (Lichtman et al, 1987). Patients and their partners may feel ambivalent feelings and may withdraw in order to reduce the pain of separation that they fear may occur later. They may find it difficult to live with the uncertainty of the illness, leading them to avoid emotional or physical intimacy with their partner, or an open discussion of feelings.

5. Disclosure, support and open communication

Women and men vary according to their ability to disclose and their need to talk. Generally disclosure is related to better psychological and emotional adjustment. This is possibly due to: the emotional relief found by the ventilation of feelings; being able to conduct more cognitive processing of the experience; undertaking the important task of the search for meaning; enabling feedback and support from others; and engaging in appropriate problem solving.

Nevertheless, women do not always disclose the painful feelings they are experiencing preferring to maintain a strong façade to protect those around them. Other family members may collude in this pretence, thus leading all the individuals involved to bear the distress alone. This can be particularly difficult for the partner who might not be receiving help from others. They may feel reluctant to burden the patient with their own concerns and fears but have no one else that they can turn to for support.

Many male partners cope with illness in their partner by withdrawing from overt discussions about the illness (Badr, 2004). Thus women may want to talk but find that their partners withdraw from all these discussions, preferring to put on a brave face, an optimistic cheerfulness or a total avoidance of the subject. This type of reaction has been found to have an impact on the couple relationship, with avoidance and withdrawal being commonly misinterpreted by the other partner as a lack of feelings or caring.

While patients may see the recovery as a long term process, their partner may prefer to regard the illness as successfully resolved by treatment. This can lead to dissatisfaction in the relationship, especially if woman interprets this as a sign that her partner's concern was short lived.

These results suggest that it is important for most couples to openly express their concerns and fears. Men should try to be empathetic and low in withdrawal. However, open communication is not helpful for all couples, some may cope better by avoidance.

The quality of the pre-existing and continuing relationship may be important here. Couples in more satisfying marriages are less likely to interpret non-communication as a lack of caring, but recognise that it is the way that their partner finds easiest to cope.

Other factors including age and type of treatment

Most studies report a reduction in dysfunction and distress over time. Age is not a major factor nor type of surgery or treatment. However, therapies that bring about a premature menopause and physiological changes can be particularly problematic in terms of sexual problems. Giving women the choice of treatment is usually the most appropriate action as women will vary according to what concerns them most, whether this is appearance or worries over survival.

Discrepancy between research findings and lay beliefs

The limited evidence presented here suggests that there is no strong evidence of an excess of relationship breakdown in couples with breast cancer nor a substantial decrease in marital dissatisfaction. This differs substantially from lay beliefs and anecdotal reports.

One possibility for the discrepancy may be the study methods. Most investigations did not use very sophisticated measures of marital satisfaction and quality. Questionnaires may also lead to

an underestimate of difficulties reported as individuals or couples may find it hard to admit to these problems (Pistrang & Barker, 1995).

It is also possible that there is much more focus on couples who breakup or whose relationships deteriorate significantly than those couples whose relationships stay the same or improve after the diagnosis. Women or their partners do not always divulge their condition to others and others might not always be aware that they have had the illness unless it has some other major impact on the couples' life.

The process of attribution, or looking for causes, may also be important. Many couples may have been on the verge of splitting up prior to the diagnosis or be muddling along in an unhappy relationship. Any subsequent breakup is likely to be attributed to the breast cancer rather than any longer term pre-existing difficulties.

Finally, a diagnosis of cancer may act as catalyst to discontinue living in an unsatisfactory relationship as before. Facing one's own mortality may prompt the individual or couple to review their past lives and priorities. Those living in difficult relationships may decide to part (Taylor-Brown et al, 2000).

How can health professionals help?

Although these findings are tentative, they do reinforce the need for interventions designed to reduce emotional distress in both patient and partner. Help and support should be available at all stages as the findings suggest that recurrence and the later stages of the disease may be a particularly difficult time for the individual and the couple, often having more of a psychological and emotional impact than the original diagnosis.

Supporting patients and partners is not always easy. The needs of patients and their partners may differ from each other and over time. Health professionals need to be sensitive and vary their approach accordingly. Nevertheless, it is important for the health professional to be pro-active rather than wait for the woman (or her partner) to bring up relationship or sexual issues. Talking to individuals or couples gives them the permission to talk about the impact of the illness and a joint session with the woman and her partner may be an important way of facilitating a more open communication between partners. It may also be valuable for the health professional to talk about the different ways that people cope, with some preferring to talk while others put on a brave face and use denial. This can increase understanding between couples according to the different ways that they personally adopt. It may also be important for health professionals to suggest that adjustment may take some time and that support and talking should not be limited to the treatment phase but should occur at later periods as well.

As pre-existing difficulties are the most important predictors of subsequent marital distress, an assessment of the relationship at an early stage can therefore be of value to determine risk. There

may be a number of options available to couples, including referral to a more specialised agency or a support group. Initial research on interventions strongly supports that all types of support and therapy can be helpful (NHMRC,1999).

Future work

There is still much more work that needs to be done. Many studies used rather crude measures and there is concern that the use of questionnaires will lead to an underestimate of difficulties reported. There is a lack of studies that focus on separation and relationship breakdown. Further studies, particularly within the UK, are needed to confirm preliminary findings.

Additional qualitative studies are also necessary to explore the subject in more detail. Valuable information could be obtained by conducting interviews with couples who had found that the experience had enriched their relationship as well as those couples who report a deterioration or who have subsequently separated. These interviews can also be of value in determining how best to support and help couples.

For further information

Contact Roslyn Corney at One Plus One (rc@oneplusone.org.uk) or download the full report or executive summary from www.oneplusone.org.uk

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