

**SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**

**EXPERIENCES OF SPOUSES OF MEN WITH ADVANCED
PROSTATE CANCER IN THE ACCRA METROPOLIS**

BY

MARGARET OFORI

10262735

**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF
GHANA, LEGON IN PARTIAL FULFILMENT FOR THE
AWARD OF MASTER OF PHILOSOPHY IN NURSING**

JULY 2017

DECLARATION

I hereby declare that this thesis was the result of my own research work conducted under supervision. This thesis has not been submitted in any form to another university for any degree or diploma. The references to other works and literature used in this research have been duly acknowledged in the text and list of references.

.....
MARGARET OFORI
(STUDENT)

.....
DATE

.....
DR. LYDIA AZIATO
(SUPERVISOR)

.....
DATE

.....
DR. MATHEW YAMOAH KYEI
(CO-SUPERVISOR)

.....
DATE

ABSTRACT

Spouses play significant roles in the care of their husbands. This comes with a lot of experiences in times of ill-health of the men and may have several effects on the spousal caregiver. It is likely to affect the woman's physical, social, psychological and spiritual wellbeing. This study therefore explored the experiences of spouses of men with advanced prostate cancer in the Accra Metropolis using the Quality of Life Model Applied to Family Caregivers (Ferrell, 2001) as an organising framework to understand their experiences. An exploratory descriptive qualitative research design with purposive and snowball sampling techniques were used to recruit women above 18 years living with and having any intimate relationship with men with advanced prostate cancer within the Accra Metropolis. Data saturation was achieved with sample size of 13 participants. The recruitment outlet was the Korle-Bu Teaching Hospital. A semi-structured interview guide was used for data collection from only participants who signed an informed consent form. The interviews were recorded with participants' permission, and transcribed. Anonymity and confidentiality were ensured during the study. Braun and Clarke's technique of thematic content analysis was adopted for data analysis. Five major themes were derived and described as follows: Physical, social, psychological, spiritual wellbeing and spousal involvement. It was found that spouses of men with advanced prostate cancer experienced fatigue, sleep disruptions, pain, loss of appetite and effects of pre-existing diseases. The spouses experienced isolation, financial burden, had no time for leisure activities. Again, the spouses experienced anxiety, depression, and fear but had hope for their husbands' recovery. It was also revealed that the participants lacked adequate knowledge in prostate cancer and were not involved in the treatment of their husbands. It was recommended that spouses should be included in the choice of treatment and care for men with advanced prostate cancer, and there should be support groups for spouses of men with advanced prostate cancer.

DEDICATION

This work is dedicated to the following motivators in my life and career: my lovely son, Carl David Kwame Edwards, my husband, Mr. Walter David Edwards, my mother, Ms. Bertha Okrofu and my supervisor, Dr. Lydia Aziato.

ACKNOWLEDGEMENT

To God be the glory for the guidance and protection throughout this study.

I wish to express my sincerest gratitude to my supervisor Dr. Lydia Aziato, the Acting Dean for the School of Nursing and Midwifery, for her tireless efforts in ensuring the completion of this research. I am grateful to my co-supervisor Dr. Mathew Yamoah Kyei of the School of Medicine and Dentistry for his support. The mentorship of Ms. Lillian Akorfa Ohene of School of Nursing and Midwifery is highly appreciated. I am thankful to Dr. Patience Aniteye, Dr. Kwadwo Ameyaw Korsah, Mrs. Patricia Avadu and the former Acting Dean for School of Nursing and Midwifery, Professor Ernestina Donkor for their encouragement during difficult moments of the study. A deeper appreciation goes to my husband Mr. Walter David Edwards, Ms. Bertha Okrofu and Ms. Akuorkor Kwamie for managing the home and taking care of our baby which enabled me to concentrate on the study. Another appreciation goes to all the nurses at the surgical O.P.D and genitourinary ward of the KBTH for their support. I extend gratitude to the participants of the study. Lastly, I wish to thank Mr. Edmund Okyerefo for his support.

TABLE OF CONTENTS

CONTENT	PAGE
DECLARATION	i
ABSTRACT	ii
DEDICATION	iii
ACKNOWLEDGEMENT	iv
TABLE OF CONTENTS	v
LIST OF TABLES	viii
LIST OF FIGURES	ix
LIST OF ABBREVIATIONS	x
CHAPTER ONE	1
1.1 Introduction/Rationale	1
1.2 Problem Statement	4
1.3 Purpose of the study	5
1.4 Objectives of study	6
1.5 Research Questions	6
1.6 Significance of the study	6
1.7 Operational definitions	7
CHAPTER TWO	8
LITERATURE REVIEW	8
2.1 Models used for the Study	8
2.2 Model used for the Study	10
2.3 The Physical Wellbeing of Spouses Caring for Men with Advanced Prostate Cancer	14
2.4 The Impact of caring for partner with Advanced Prostate Cancer on the Social Wellbeing of Spouses	16
2.5 Psychological Consequences of Advanced Prostate Cancer on Spouses	23
2.6 The Spiritual impact of having a Partner with Advanced Prostate Cancer	24
2.7 Spousal Involvement in the care of a partner	26
2.8 Summary of the Literature Review	27
CHAPTER THREE.....	28
METHODOLOGY	28
3.1 Research Design	28
3.2 Research Setting	28
3.3 Target Population	29
3.4 Inclusion Criteria	29
3.5 Exclusion Criteria.....	29
3.6 Sample Size and Sampling Technique	29
3.7 Data Collection Tool	30

3.8 Data Collection Procedure.....	31
3.9 Piloting of Instrument.....	31
3.10 Methodological Rigour.....	32
3.11 Data Analysis	33
3.12 Data Management.....	34
3.13 Ethical Considerations.....	35
CHAPTER FOUR.....	36
FINDINGS	36
4.1 Description of Study Population	36
4.2 Physical Wellbeing.....	37
4.2.1. Fatigue	37
4.2.2. Sleep Disruption	38
4.2.3. Pain/Aches	39
4.2.4. Appetite.....	41
4.2.5. Effects of pre-existing diseases.....	42
4.3. Social Wellbeing	43
4.3.1. Isolation	43
4.3.2. Roles /Role Adjustment	44
4.3.3. Affection/Sexual function.....	47
4.3.4. Leisure Activities	50
4.3.5. Financial Burden.....	51
4.3.6. Employment.....	53
4.3.7. Fidelity/Honesty.....	54
4.3.8. Thoughts of divorce	55
4.3.9. Perceived relationship with husband	55
4.3.10. Perception on roles.....	56
4.4. Psychological wellbeing.....	56
4.4.1. Anxiety.....	57
4.4.2. Depression	58
4.4.3. Fear	59
4.4.4. Distress.....	60
4.4.5. Difficulty Coping	60
4.4.6. Concentration.....	61
4.4.7. Empathy	62
4.4.8. Secrecy.....	63
4.5. Spiritual Wellbeing.....	64
4.5.1. Meaning	64
4.5.2. Hope.....	66
4.5.3. Religiosity.....	67
4.6. Spousal involvement in the care of a partner	68
4.6.1. Knowledge on disease condition of a partner	68
4.6.2. Consent to treatment	69
4.7. Summary	69

CHAPTER FIVE.....	72
DISCUSSIONS	72
5.1. Characteristics of Participants of the Study	72
5.2 Physical Wellbeing	73
5.3 Social Wellbeing	75
5.4 Psychological Wellbeing	77
5.5 Spiritual Wellbeing.....	80
5.6 Spousal involvement in the care of a partner	82
5.7 Evaluation of the model used	84
CHAPTER SIX	86
SUMMARY, IMPLICATION, LIMITATION, CONCLUSION AND RECOMMENDATION	86
6.1 Summary	86
6.2 Implications	87
6.2.1 Nursing Education	87
6.2.2 Nursing Practice.....	87
6.2.3 Nursing Research.....	88
6.2.4 Nursing Administration	88
6.3 Limitation	88
6.4 Recommendation.....	88
6.5 Conclusion.....	92
REFERENCES.....	93
APPENDICES	114
Appendix A: Background Information of Participants	114
Appendix B: Interview Guide	115
Appendix C: Consent Form from NMIMR.....	118
Appendix D: Ethical Clearance	120
Appendix E: Introductory Letter	121
Appendix F: Correspondent from Professor Betty Ferrell	122

LIST OF TABLES

Table 4.1: Summary of Themes 71

LIST OF FIGURES

Figure 1: Quality of Life Model Applied to Family Caregivers (Ferrell, 2001)..... 12

LIST OF ABBREVIATIONS

ADL	Activities of Daily Living
ENT	Ear, Nose and Throat
GU	Genitourinary
IRB	Institutional Review Board
KBTH	Korle-Bu Teaching Hospital
OPD	Out-Patient Department
PCa	Prostate cancer
PCASG	Prostate Cancer Support Groups
QoL	Quality of Life

CHAPTER ONE

1.1 Introduction/Rationale

Prostate cancer begins when the cells in the prostate gland grow out of control. The prostate gland is found only in males. It is a walnut-sized gland which lies in the pelvic cavity in front of the rectum and behind the symphysis pubis, surrounding the first part of the urethra. The gland contains an outer fibrous covering, a layer of smooth muscles and glandular substance contained of columnar epithelium. The prostate gland secretes a thin, milky fluid that makes up about 30% of semen, and gives it its milky appearance. The alkalinity of the fluid provides a protective local environment for sperm arriving in the acidic vagina (Waugh & Grant, 2001). The actual cause of prostate cancer is unknown however there are certain risk factors associated with the disease. These are: age, race/ethnicity, geography, family history, gene changes, diet, obesity, smoking, workplace exposure, inflammation of the prostate, sexually transmitted infections and vasectomy (American Cancer Society, 2011; Jemal, 2011).

Cancers are diseases of increasing significance worldwide. In 2008, there were about 12.7 million cancer cases and 7.6 million cancer deaths estimated to have occurred (Jemal et al., 2011). Prostate cancer (PCa) is one of the most common cancers and among the leading causes of cancer deaths in men (Haas, Delongchamps, Brawley, Wang, & de la Roza, 2008). It accounts for 903,500 estimated new cases and 258,400 estimated deaths worldwide. Comparatively, there were 648,400 estimated new cases and 136,500 estimated deaths in the high income countries whereas in the low income countries, it accounts for 255,000 estimated new cases and 121,900 estimated deaths (Ferlay, Shin, Bray, Forman, & Mathers, 2008). Prostate cancer has no boundaries and therefore found in all continents.

In Africa, although reports on the incidence rate among African men are limited due to few population based cancer registries in the continent (Parkin & Chirenje, 2008),

observations show that the rate of prostate cancer is on the increase in Africa (Chu, Ritchey, Devesa, & et. al., 2011; Rebbeck, Devesa, Chang, & et. al., 2013). Among the high-income countries like America, records have shown that it is more prevalent among African American men (Odedina et al., 2009). The prevalence of prostate cancer is relatively high in West African men as compared to black American men, and for that matter, Ghana (Chung et al., 2014; Hsing et al., 2014). In Ghana, prostate cancer comprises of 64% of all genitourinary cancers referred to the Korle Bu Teaching Hospital within 1980 to 1990 (Klufio, 2004). Again, cancer mortality in Ghana based on a 10 year review of autopsies and hospital mortality revealed that prostate cancer was a second leading cause of cancer deaths among Ghanaian men (Wiredu & Armah, 2006).

Prostate cancer has enormous effects which are eminent from the onset of diagnosis and throughout treatment. The effects have impact on the physical, psychological, social as well as spiritual wellbeing of the patient. Loss of desire for sex and erectile dysfunction are the most common problems. Evidence has shown that men who regain erection after treatment even have problem returning to their former erectile quality (Dalkin & Christopher, 2008; Kimura et al., 2015; C. J. Nelson, Scardino, Eastham, & Mulhall, 2013). In addition, PCa is associated with anxiety, relationship conflict and loss of self- esteem. Other troubling side effects of treatment include bowel and bladder problems (Roth, Weinberger, & Nelson, 2008). Other effects are fatigue, hair loss, nausea and vomiting, diarrhea, anaemia, hot flashes and weight gain (Urology Care Foundation, 2015).

After the struggle to survive from cancer, employment and work-related issues are other problems patients are faced with. Many studies have shown the extent to which cancer survivors have a significantly increased risk of unemployment; about 56% of those who return to work report changes in occupational roles following diagnosis (Mehnert, 2011; Park & Park, 2009; Steiner et al., 2008; Syse, Tretli, & Kravdal, 2008). The treatment

options available for clients with prostate cancer are active surveillance, surgical treatment, radiation therapy, cryosurgery, hormone therapy, immunotherapy, chemotherapy, radiopharmaceuticals, and clinical trials (American Cancer Society, 2016; National Comprehensive Cancer Network, 2016; Prostate Cancer Foundation of Australia, 2014).

Prostate cancer does not only affect the men suffering from the disease but affects the caregivers as well. Cancer affects couple as a unit rather than the isolated individuals. These effects from cancer cause the couple to react to even the cancer diagnosis. Spouses are the main caregivers in the family, who play an important role in decisions concerning treatment options and provide emotional and instructional support to the patient (Hagedoorn, Sanderman, Bolks, Tuinstra, & Coyne, 2008). According to friends of the researcher and some patients, the support from patients' spouses are of great significance that perhaps support from friends or other family members does not compensate for inadequate spousal support. This perception makes caring for a spouse obligatory. The stereotypic roles of women within the Ghanaian society expect a spouse to be caring, child friendly, selfless and empathetic in the family (Hussain, Naz, Khan, Daraz, & Khan, 2015; Olah, Richter, & Kotowska, 2014). In as much as one tries to render his or her best support to the spouse, studies have shown that there is a reciprocal relationship between men and their spouses whereas men's problem increases, spouses' quality of life decreases (Harden et al., 2011).

Furthermore, spouses of prostate cancer survivors exhibit distinctive experiences going through the survivorship process, and often have more distress than the patient themselves which is a reflection of what the patient himself is going through (Couper, Bloch, & Love, 2009; Hagedoorn, Sanderman, Bolks, & et. al., 2008). This distress result in lower quality of life and health risk behaviours among women. The anxiety level alone, is overwhelming as compared with the patient (Lambert, Girgis, Lecathelinais, & Stacey,

2012; Regan et al., 2014). Couples who are survivors of prostate cancer are faced with interruptions in their intimate relationships, communication and overall quality of life (Galbraith, Fink, & Wilkins, 2011). The diagnosis of cancer puts couples through the stress of breaking the bad news, negotiating changes in occupational and family roles and managing household and childcare responsibilities (Lopez, Copp, & Molassiotis, 2012a).

1.2 Problem Statement

Caring for a sick relative such as a spouse, is challenging. This is because it is associated with deeply held moral expectations, especially for women who are socialized into a caring role and as a result, an unwillingness to care remains hidden. Some researchers acknowledge that the family relationships cannot really be understood unless a wife shares her experiences through interviews (Eilat-Tsanani, Tabenkin, Shental, Elmalah, & Steinmetz, 2013). However, caring is demanding and has its own negative consequences such as fatigue, insomnia, anorexia and illness on the spousal caregiver in advanced prostate cancer (Blum & Sherman, 2010). The sexual needs of the spouse poses problems which cannot be ignored and therefore must be addressed (Sadovsky et al., 2010).

Nonetheless, partners of men with prostate cancer sometimes report higher levels of cancer related distress than are expressed by the men themselves (Chambers, Pinnock, Lepore, Hughes, & O'Connell, 2011). Spousal caregivers often fail to express their own needs and feelings while focusing on providing support for their partners with cancer. In such situations, these spouses face the risk of succumbing to wide spectrum of hidden mental, physical and social morbidities, as consequences of their caregiving. In general, these morbidities are more in female spousal caregivers than male spousal caregivers (Chu et al., 2011; Li & Loke, 2013). Li and Loke, (2013) in their studies, focused on only a quantitative study. However, the study recommended that a qualitative study will aid a

better understanding of spouses' experiences as a result of caring for cancer patients. The concentration on the men masks the needs of the spouses.

Spouses in most situations must conceal and suppress their own emotional support needs in order to protect their husbands. This is because they do not know how to tell other family members (Paterson, Robertson, Smith, & Nabi, 2015) and the men are right to maintain confidentiality about the prostate cancer diagnosis (Sinfield, Baker, Ali, & Richardson, 2012). It was also found in other studies that the spouses of men with prostate cancer are not able to meet their needs such as lack of understanding of how best to support their partners to cope with changes in their relationship (Evertsen & Wolkenstein, 2010; Sinfield et al., 2012).

According to Yamoah (2013), Ghanaian men diagnosed with prostate cancer present with very advanced stage disease. At the Genitourinary Ward of the Korle-Bu Teaching Hospital, there have been 20 advanced prostate cancer patients on admission from February 2015 to April 8, 2015. The caregivers of these patients were mostly spouses. Spouses who are working will have to combine work with caring for their partners with advanced illness. One of the challenges to treatment is loss of income due to absence or inability to (Yamoah et al., 2013). This study offers the opportunity for spouses to share their experiences as partners of men living with advanced prostate cancer. The study proposes to adapt the conceptual framework of Quality of Life Model applied to Family Caregivers developed by Ferrell in the year 2000. The constructs of the model give detailed understanding of what constitutes the quality of life of a family caregiver.

1.3 Purpose of the study

The purpose of this study is to explore the experiences of spouses of men with advanced prostate cancer in the Accra Metropolis of Ghana.

1.4 Objectives of study

The study seeks to achieve the following:

- i. explore the physical wellbeing of spouses caring for husbands with advanced prostate cancer
- ii. explain the social wellbeing of spouses of men with advanced prostate cancer
- iii. investigate the psychological consequences of advanced prostate cancer on spouses
- iv. examine the spiritual impact of caring for spouses with advanced prostate cancer.

1.5 Research Questions

The research is focused on answering the following questions:

1. To what extent does advanced prostate cancer influence the physical wellbeing of spouses?
2. What is the social impact of caring for a spouse with advanced prostate cancer?
3. What are the psychological consequences of advanced prostate cancer on spouses of men with the condition?
4. What is the spiritual impact of caring for a spouse with advanced prostate cancer?

1.6 Significance of the study

The findings of this study will give insight to nurses and other health workers such as doctors and clinical psychologists on exactly what spouses of men with prostate cancer experience. This will encourage nurses to render a holistic care to couples for them to become adjusted to the patient's condition. Healthcare administrators will design and ensure protocols on the couples of advanced prostate cancer. The research findings will add to existing literature, and will serve as a source of reference to other researchers who may wish to conduct studies in the same area. The discoveries of the study will transform the perception of religious leaders and associations concerning superstitions surrounding

the care of advanced prostate cancer patient. Again, the findings will enable the spouses to understand the condition better. In addition, it will be very resourceful to the Ministry of Health, the Ghana Health Services and other stakeholder in their policy formulations. Finally, the research findings will give reasons for the establishment of prostate cancer support groups (PCASG) for women in Ghana.

1.7 Operational definitions

Experience: everything the spouse goes through because of her partner's disease condition.

Patient: a person suffering from advanced prostate cancer.

Spouse: female partner of a man suffering from advanced prostate cancer.

Quality of life: the spouse's satisfaction with life condition, encompassing the interaction of her physical, psychological, social and spiritual wellbeing.

CHAPTER TWO

LITERATURE REVIEW

The focus of this literature review is to discover issues on the experiences of spouses of men with advanced prostate cancer. The discussions under the literature review are under four main headings; the influence of advanced prostate cancer on the physical wellbeing of spouses (fatigue, sleep disruption, aches/pain, appetite, and effects of pre-existing diseases); the social wellbeing of spouses of men with advanced prostate cancer (isolation, role adjustment, financial burden, affection and sexual functioning, leisure activities, employment, fidelity/honesty and thoughts of divorce); psychological consequences of advanced prostate cancer on spouses (anxiety, depression, fear, distress, difficulty coping, concentration, empathy, secrecy, perceived relationship with husband and perception of roles); the spiritual impact of caring for a spouse with advanced prostate cancer (meaning, hope and religiosity); and spousal involvement (knowledge on disease and consent on treatment). The literature was retrieved from electronic data bases such as the ScienceDirect, PubMed, Wiley, SAGE, Google search and Google Scholar. The key terms used to retrieve relevant literature were spouse, experiences, advanced prostate cancer, physical wellbeing, social wellbeing, psychological wellbeing, spiritual wellbeing and caring.

2.1 Models used for the Study

The study led into the consideration of models as the organizing framework for the study. The biopsychosocial model was first considered. The biopsychosocial model has both the philosophy of clinical care and clinical guide (Borrell-Carrió, Suchman, & Epstein, 2004). The philosophical aspect is a way of understanding how suffering, disease and illness are affected by various levels of organization. The clinical aspect is a way of understanding the patient's subjective experience as a vital contributor to accurate diagnosis, health

outcomes and human care (Borrell-Carrió et al., 2004). Engel believed that to understand and respond adequately to human suffering and to give human a sense of wellbeing understood, there is the need to attend to the biological, psychological and social dimensions of illness simultaneously (Engel, 1977). Engel's combined these three domains and named it the biopsychosocial model. This model dominated the biomedical model which was already in existence (Ghaemi, 2009). However, Engel had a lot of critique of the biomedical model. (Borrell-Carrió et al., 2004).

According to Engel (1977), the biological domain of his model encompassed genetic predisposition, effects of medications, neurochemistry, hypothalamic pituitary axis and fight-flight response. The psychological domain of the model comprises emotions, attitudes, perceptions, beliefs and thinking, learning, memory and stress management strategies. The social domain of the model comprised social support, family background, interpersonal relationships, cultural traditions, medical care, socioeconomic status, poverty, physical exercise and biofeedback. This might infer that this model focuses on the experiences of an individual diagnosed with a disease. Despite all the attributes of his model, it had no spiritual domain to guide the exploration of the spiritual wellbeing of the study participants in this study. Spirituality as a caregiver support is a key concept in the socio-cultural context of Ghana. Thus, could not be used in this study.

Other models with a spiritual component were considered. City of Hope Quality of Life model applied to caregiver communication burden was a framework that was one of the models with spiritual component. The model has physical, social, psychological and spiritual domains. However, the subthemes under the various domains were only relevant to difficulties associated with caregiver communication. Hence, this model could not be used in this study.

2.2 Model used for the Study

The QoL model originally referred to as conceptual model of pain and quality of life (Ferrell, 1994; King & Hinds, 2003) was developed to produce theory that describes the areas of quality of life in clients with cancer. It was developed precisely to explore the experiences of pain and fatigue and its relationships to QoL. Padilla and Grant in 1985 developed a theoretical model to show the relationship between the nursing process and the dimensions of quality of life (Padilla & Grant, 1985). This was later used by Ferrell, Wisdom and Wenz in the development and testing of Quality of Life instrument which was used in a survey (Ferrell, Wisdom, & Wenzl, 1989). The survey intended to measure the QoL as an outcome variable in the management of cancer pain. Other studies were carried out in which the instrument was used to gather data showing the relationship between pain and Quality of Life. A conceptual model known as City of Hope emerged from the study to illustrate the influence of pain on the dimensions quality of life. The dimensions were physical, social, psychological and spiritual wellbeing (King & Hinds, 2003). Other models developed from the first model includes the Quality of Life Model Applied to Family Caregivers in 2001 (see Fig 1).

The physical wellbeing domain refers to the physical functioning of the caregiver. The assumption is that certain health problems accompany the physical functioning and these are: fatigue, sleep disruption, function, nausea, appetite, constipation, aches or pain. The social wellbeing domain explains the interaction of the caregiver with the patient and others. Isolation, role adjustment, financial burden, roles/relationships, affection/sexual function, leisure activities, burden and employment are the variables under the social wellbeing. The psychological wellbeing is the emotional functioning of the caregiver who may experience anxiety, depression, helplessness, difficulty coping, fear, uselessness, loss of concentration, control and distress. The spiritual wellbeing refers to the spiritual impact

of caring for a relative with cancer. It involves meaning, uncertainty, hope, religiosity, transcendence and positive change. All four domains interact to determine the overall quality of life of a family caregiver.

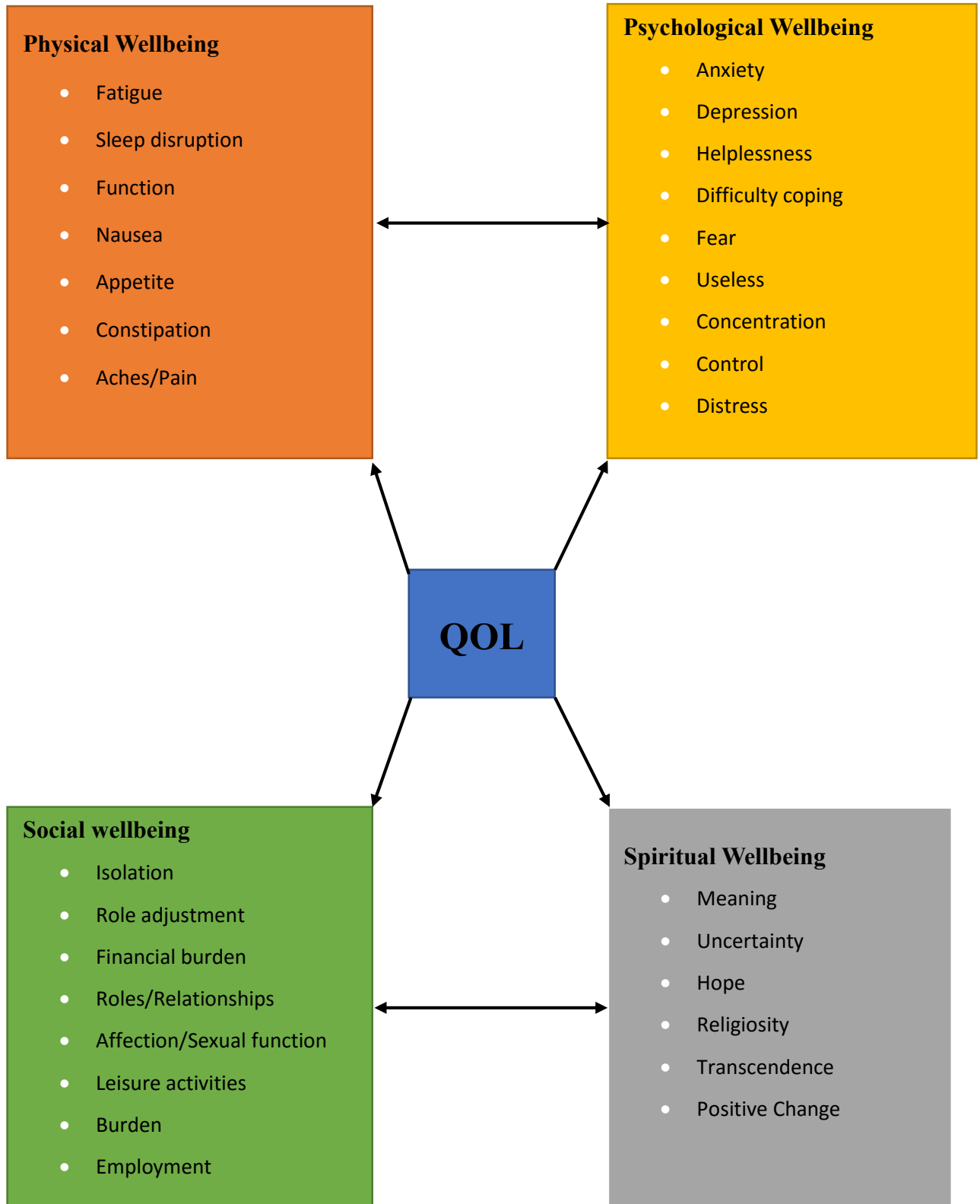


Figure 1: Quality of Life Model Applied to Family Caregivers (Ferrell, 2001)

The concept of quality of life is central to nursing care (B. Ferrell et al., 1992). This implies that researchers will have to mention quality of life in their study of cancer and its effects on the patients and their family. The QoL Model Applied to Family Caregivers has all the domains found in the Padilla & Grant's Model of 1985. The model also has all the components in the Ferran's 1990 model on quality of life (Ferrans, 1990). The QoL Model Applied to Family Caregivers was developed precisely for relatives of patients living with cancer who are involved with the care of the patients. There were other researchers who have also used the domains in the model to conduct their studies on the effects of cancer on the quality of life of patients and their families (Fujinami, Otis-Green, Klein, Sidhu, & Ferrell, 2012; Kim & Given, 2008; Lu et al., 2010). Therefore, the experiences of spouses of men with advanced prostate cancer would be studied using the Quality of Life Model Applied to Family Caregivers (Ferrell, 2001).

The term 'quality of life' has several definitions. The term was stated in vogue and has become popularized (Farquhar, 1995). According to (Dow, Ferrell, Leigh, Ly, & Gulasekaram, 1996), it refers to a general sense of wellbeing and addresses multiple dimensions of life and denotes satisfaction, happiness, achievement of goals and personal control. For the purpose of this study, quality of life encompasses the interaction of physical, social, psychological and spiritual wellbeing of spouses of men with advanced prostate cancer. Caregiver is a term which refers to "anyone who provides assistance to someone else who is incapacitated and needs help to some extent" (Family Caregiver Alliance, 2001p.1). Caregiver is either formal or informal. Informal caregivers or family caregivers as unpaid individuals such as family members, friends, and neighbours who provide care (Family Caregiver Alliance, 2014). In Ghana, members of the extended family render informal care to some extent.

2.3 The Physical Wellbeing of Spouses Caring for Men with Advanced Prostate

Cancer

Physical wellbeing is a significant component of caregivers' quality of life such as those caring for patients living with cancer. As the needs of the patients living with cancer fluctuate, so do the needs of the caregiver. It involves total devotion and makes the caregiver fatigued throughout the care. It is a matter of being there 24 hours a day and 7 days a week (Esbensen, Thome, & Thomsen, 2012; Martin, Sanders, & Griffin, 2012). Hughes, Closs, & Clark, (2009) found that aging is a contributing factor to fatigue. From the onset of the cancer to even when the patient's life is ended, there is no end to the caregiver's day. Informal cancer caregivers are engaged in a lot of activities which make them work around the clock. In some cases, assisting the patient in his activities of daily living (ADL); bathing, toileting, shaving, eating and dressing becomes the responsibility of the spousal caregiver (Hagedoorn, Sanderman, Bolks, Tuinstra, & Coyne, 2008). Given, & Sherwood, (2012) also found out other activities such as serving medication, managing symptoms, meals and nutritional assistance, supervision of treatment, errands/bill paying, emotional support, coordinating care, monitoring using electronic devices, and communication with providers during their study in the challenge of quality cancer care for family caregivers such as spouses. An intensive work was done since the researchers included the formal caregivers as well as some policies in place, and did not isolate only family caregivers. In some other studies, it was found that cancer caregivers who render care to their loved ones suffer from cardiovascular effects because of fatigue. Perhaps this may be since they see these loved ones suffering (Monin & Schulz, 2010).

A study on a brief behavioural sleep intervention for family caregivers of persons with cancer, lack of sleep was one of the challenges to the physical wellbeing of family caregivers of advanced cancer (Carter, 2006). Spouses are interrupted in their sleep due to

the fact that the spouses live with the patient suffering from cancer, or in some instances the spouses experience insomnia as a result of anxiety and depression (Glajchen, 2012a). (Cetinkaya, Okanli, Celebioglu, & Ozyigit, 2010) in their quantitative study on the stress levels of caregivers of cancer patients, issued questionnaire to their participants and the findings revealed that stress levels in female informal caregivers were higher than male caregivers. However, an in-depth (one on one) interview through a qualitative study would have revealed more stressors and why the caregivers were stressed.

Assuming the role of informal caregiver poses alterations in the body. Alterations such as headache and pain (Given, Sherwood, & Given, 2011), cardiovascular disease, chronic conditions, mobility limitations, self-related health, and depressive symptoms (Debra & Montez, 2010; Hughes & Waite, 2009; Zhang & Hayward, 2006). Altered appetite is similarly affects the physical wellbeing of spouses caring for their husbands during the cancer trajectory. (Beesley, Price, Webb, & Australian Ovarian Cancer Study Group, 2011) during their study into the health behaviour and weight changes after becoming a caregiver of a family member diagnosed with ovarian cancer found that the caregivers exhibited loss of appetite. Forty percent of the caregivers ate less than two servings of fruits whereas 80% ate less than five servings of vegetables, and 37% of caregivers consumed alcoholic drinks. Although the study conducted might have been an intensive study, the topic did not clearly reflect the content of the study. The purpose of their study indicated concentration on only women but the topic stated caregiver in general. In addition, spouses who have negative relationships with their husbands but caring for the men, also have problems with their physical health (Northouse & Katapodi, 2010).

Studies show that marital history over the life course shapes a range of health outcomes, including cardiovascular disease, chronic conditions, mobility limitations, self-related health, and depressive symptoms (Debra & Montez, 2010; Hughes & Waite, 2009;

Zhang & Hayward, 2006). Headache and pain are all problems the spouses experience as a result of cancer caregiving (Beach, Schulz, Yee, & et. al., 2011; Given et al., 2011). Some also had loss of control of their chronic diseases such as diabetes or heart disease and high blood pressure.

2.4 The Impact of caring for partner with Advanced Prostate Cancer on the Social Wellbeing of Spouses

Marriage is perhaps the most studied social tie. Social wellness is an important scope of wellness which enables an individual to survive in the society through interaction with friends, family, co-workers, and caring for others, as well as the entire community (Rehman, Hussain, Syed, & Khan, 2014). Communication is key in every form of relationship. Isolation between the couple occurs when there seem not to be regular or open communication. Open communication is key to helping spouses cope successfully with stressors induced by prostate cancer and its treatment (Jones et al., 2008). In addition, communication is important to the quality of life of spouses as go through caring for their husbands. It is evident that spouses who have been able to maintain communication do not isolate themselves, and report higher quality of life (Manne, Badr, Zaidler, Nelson, & Kissane, 2010). However, the study was focused on couples with localized prostate cancer and not advanced prostate cancer. Again, isolation occurs and spouses report less communication when there is the issue of erectile dysfunction (Badr & Taylor, 2008).

Existing literature shows that better communication between couples would have positive effect on intimacy between the couple which will in turn improve the caregiving outcomes by the woman as a caregiver (Li & Loke, 2014). Couple's relationship and their engagement in communication sustains and or enhances the relationship in times of stress (Manne et al., 2010). Studies on mutual constructive communication between couples have shown that patients and partners who report high levels of mutual constructive

communication give an account of greater marital adjustment along the cancer trajectory (Badr & Taylor, 2009). However, in spite of the constructive communication which could exist, often both couple find it difficult to talk about sensitive issues (Couper et al., 2009; Gustavsson-Lilius, Julkunen, & Keskivaara, 2007; Hagedoorn, Sanderman, & Bolks, 2008; Hodgkinson, Butow, & Hunt, 2008; McCorkle, Seifert, & Dowd, 2007; Perez, Skinner, & Meyerowitz, 2007; Sjovall, Attner, & Lithman, 2009).

Although spouses are deeply concerned with partners living with advanced prostate cancer, the spouses communicate less about the impact of advanced prostate cancer. (Boehmer & Clark, 2001). This presupposes that women try to hide their feelings to protect their husbands and to avoid questions. However, this is not the same in younger couple. Younger spouses experience more distress during prostate cancer trajectory (Berg & Upchurch, 2009; Harden, Northouse, Cimprich, & et. al., 2008; Schindler, Berg, Butler, & et. al., 2010; Sjovall et al., 2009). Certain times, open communication could not take place between couples because of the couples' personal characteristics and pattern of communication. Characteristics such as self-absorption, counter dependency, exaggerated dependency, and being overly controlling on the part of the patient; and the spouse solution driven approach, unchecked anger, and failure to reach out to others (Fergus & Gray, 2009), contribute to inadequate communication between the couple. In addition, the pattern of communication change over time and by role, with perceived levels of open communication decreasing at a slower rate for patients than for their partners (Song, Northouse, Zhang, Braun, Cimprich, Ronis, & et. al., 2012)

There is greater role adjustment along the cancer trajectory (Badr & Taylor, 2009). The diagnosis of cancer has its consequences on the usual arrangement in a household; priorities shift and plans reconsidered. (Li & Loke, 2014) in their study on mutual impact of the spousal caregiver-cancer patients' dyads, concluded that role adjustment was

dependent on open communication. The study was a mixed study that is both qualitative and quantitative designs, making their findings more generalized. Similar studies also found that women assume many more roles as a result of rendering care to husbands suffering from cancer (Kim et al., 2008; Li & Loke, 2013). Some women take over the breadwinner role, and manage the household (Lopez, Copp, & Molassiotis, 2012b).

Another study conducted by (Chambers et al., 2011) revealed that the caregiver role compelled spouses to take on many roles in the family that the patient once assumed, including home maintenance, paying bills and maintaining social connections. Their study was a mixed study (quantitative and qualitative) involving patients and their partners. The researchers concluded that there is an urgent need for researchers to focus on men with advanced prostate cancer and their families, however their discussion did not highlight much on the role of women as caregivers.

Providing caring for a loved one with an advanced or serious disease is one of life's greatest stressors (Schulz & Beach, 1999) and spousal caregivers may be particularly vulnerable, since they are ready to make sacrifices to care for their partner (Haley, LaMonde, Han, & Burton, 2003). According to friends and some patients, the supports from patients' spouses are of great significance that perhaps good support from friends or other family members does not compensate for inadequate spousal support. This perception makes caring for a spouse obligatory (Pistrang & Barker, 1995). In as much as one tries to render his or her best of supports to the spouse, studies have shown that there is a reciprocal relationship between men and their spouses whereas men's problem increases, spouses' quality of life decreases (Harden, 2011).

Affection plays great role in marriage. Sexual intimacy occurs in a relationship with another person. At times, it seems like a threat for not able to perform sexually due to erectile dysfunction after the treatment of prostate cancer and therefore, men see it as loss of their

identity. However, studies report that women give up sexual intercourse rather to ensure their partner's survival is worthwhile. On the other hand, some of these women also claim they feel unattractive and unwanted when their husbands withdraw or withhold physical affection or do not respond to their attempts to initiate physical intimacy. The presence of distress or depression related to erectile dysfunction most often leads to relationship problem among the couple due to increased stress. When a man experience erectile dysfunction, he often pulls away from sexual contact or sexual intimacy (Muller, Ruof, Graf-Morgaentern, Porst, & Benkert, 2001; Riley & Riley, 2000; Roth et al., 2008). Other studies also revealed that spouses reluctant as women to initiate any form of intimacy, and therefore perceived such role as artificial, involving too much planning and too little spontaneity (Beck, Robinson, & Carlson, 2009; Boehmer & Clark, 2001; Sanders, Pedro, O'Carroll-Bantum, & et. al., 2006). Again, the role of caring and repositioning of a partner leading to exhaustion by spouses, make the partner to be seen as a patient and not a sexual partner (Hawkins et al., 2009).

Furthermore, a similar study revealed that the inability to engage in sexual intercourse was a source of frustration for men and women. Some of the women had to reassure their husbands that sexual problems will not break their marriage whereas other spouses accepted life without intercourse (Ervik, Nordoy, & Asplund, 2012). Moreover, some studies have discovered that the relationship between advanced prostate cancer patients and their spouses before hormonal therapy is satisfactory, or normal, devoid of any problems apart from the usual arguments that happen in all families. Even spouses who are not able to have sex are not affected in their close relationships because sexual satisfaction was derived from masturbation and sexual fantasies. However, this is not the same among all couples.

There is disruption in intimacy after treatment due to changes in personality and bodily appearance which distance spouses (Navon & Morag, 2003). A significant number of women caring for their partners with prostate cancer have reported substantial decrease in their own sexual desire and experience of intimacy. The spouses rather concentrate on the interventions for the treatment of their partners (Hawkins et al., 2009). The issue of role adjustment cannot be overlooked during prostate cancer trajectory.

Terminal illness has consequences on the arrangement in a household, priorities shift and plans reconsidered. Couples have a mutual impact on each other in their quality of life, psychological health, and adjustment to their roles (Kim et al., 2008; Laurel, Northouse, Mood, Templin, Mellon, & George, 2000). These changes and mutual impact may affect the structure of the couple's relationship and their roles and responsibilities (Dankoski & Pais, 2007; Li & Loke, 2013). The man's condition causes the woman to take over the breadwinner role, and so even women who have the title of a housewife will then have to go seek for jobs to pay the children's school fees. A diagnosis of cancer puts couples to the stress of breaking the bad news, negotiating changes in occupational and family roles, and managing household and childcare responsibilities (Lopez et al., 2012b).

There is a lot of burden especially financial burden, when the spouse has to give up work in order to care for the man. The financial implication of caregiving is usually a challenge especially among low income families. Another burden of the men condition to the women is the worry over the fact that the man will undergo surgery (operation). Partners bear a larger proportion of the burden of care than do other primary caregivers. In addition, caregiving seems to have a greater negative impact on female partners, especially younger female partners. Spouses who live alone with their patients (husbands) and those with lower incomes experience difficulties. Some of these spouses themselves have unmet needs, and for that reason, find it very difficult to meet the needs of their husbands (Rees, O'Boyle, &

MacDonagh, 2001). The economic and monetary stressors are common with caregivers of cancer due to high cost of cancer care (Short, Moran, & Punekar, 2011). Bearing the cost of care is one of the major problems of family caregivers as some insurance policies do not cover all medications (van Ryn, Sanders, Kahn, & et al., 2011).

Caring presents to spouses a lot of challenges in their work life. It diminishes productivity or the quality of work, and leads to missed opportunities for promotion. Work influences quality of care for the patient and the relationship with the patient, which eventually leads to work being given up for caring. Most spouses succeed in balancing work and care however, there are negative effects the work can have on their care (Roth et al., 2008). Balancing the two responsibilities often requires meeting conflicting demands which can cause considerable stress especially in the advanced stage of illness. The spouses decide on exhausted alternative arrangements by reducing or adjusting working hours, but many eventually give up work (Gysels & Higginson, 2009). Moreover, others have their individual opinions when it comes to reconciling work and caring for their husbands. Such spouses are no longer able to cope and find it difficult to concentrate at work and therefore can no longer be creative at work.

In addition, there are a lot of factors that make spouses give up work to caring: negative impact of caring on work; increase of burden, multiple responsibilities, invading thoughts and worries about home, compromised quality of work, loss of job and guilt due to being unable to reciprocate favours in work environment; failure to reconcile work and care: resilience on temporary solutions, separate out multiple roles and guilt for not to give it all to caring; negative impact of work on caring: perceived compromised commitment to care, deteriorating health of husband, deteriorating relationship with husband and social expectation of wife as sole caregiver. This does not mean that all spouses give up on work to care for their husbands. Few women are able to work and still care based on the following:

resistance to husband's demands, resistance to social expectations, prepare to handover or share care with professionals, admitting limits of own caring capabilities, acknowledge the need for care for oneself, and assuming work as coping mechanism (Roth et al., 2008). This means that these variations in caring arrangement for a partner with advanced prostate cancer depends on the relationship with the patient; on family situations, values attached to role expectations (culture), and commitment to other responsibilities.

Apart from family and friends, some of the most important domains of social connections include engagement with workmates either inside the workplace or outside of it (Helliwell & Huang, 2010), engagement with people at places of worship (Lim & Putnam, 2010) and connection with people in clubs and social organizations (Boreham, Povey, & Tomaszewski, 2013; Ziersch & Baum, 2004), all impact the social wellbeing of spouses. Sometimes the burden is just unbearable.

Spouses are the main caregivers in the family, who take dynamic role in decisions concerning treatment options and provide emotional and instructional support to the patient (Hagedoorn, Sanderman, Bolks, Tuinstra, et al., 2008). Spousal caregivers (wives) often fail to express their own needs and feelings while focusing on providing support for their partners with cancer. In such situations, these spouses face the risk of succumbing to wide spectrum of hidden mental, physical and social morbidities, as consequences of their caregiving. In general, these morbidities are more in female spousal caregivers than male spousal caregivers (Chu et al., 2011; Li & Loke, 2013).

It may sound as if caring for a spouse has a lot of negative implications on the social wellbeing of women however, it has some level of positive implications as well. Literature attests the positive aspect of the role of these women, with unleash increased sense of self-esteem, pride, gratification, and feeling closer to their spouse. Most women accept the fact that caring for their partners make them more caring to others (Rees et al., 2001).

2.5 Psychological Consequences of Advanced Prostate Cancer on Spouses

Spouses of patients living with cancer experience a lot of challenges. Being mentally strong is what most spouses believe in (O'Brien et al., 2011). O'Brien et al. (2011) examined the unmet psychosexual needs of patients suffering from prostate cancer during follow-up after treatment. Although their research topic did not indicate the involvement of spouses in the study, the researchers encouraged patients living with prostate cancer to extend invitations to their spouses to be interviewed with the men. According to (Nelson, Jacobson, & Weinberger, 2009) in a study on religion and spirituality of prostate cancer patients, spouses were less depressed when they had a sense of meaning and peace.

Existing literature reveals that spouses of cancer patients have a higher prevalence of certain psychiatric disorders, especially anxiety disorders, than the patients (Li & Loke, 2013). The diagnosis of cancer comes with a lot of distress which a caregiver cannot do without. Older spousal caregivers are vulnerable to caregiver distress. This is because the spouses have co-morbid conditions themselves. Older spouses also provide the most extensive care, maintain their role longer and tolerate greater levels of patient disability before the spouses consider institutionalizing the patient (Senden et al., 2015). Spouses manage their distress in many ways referred to as cognitive emotional management. The spouses decide on taking anti-anxiety medication, alcohol, meditating, expressing emotions to family and friends, avoiding information on the diseases, distancing themselves from the patient, taking action to address problems and finding happy outcomes to things that avoid distress (von Scheve, 2012).

According to Olson (2011), distraction was one of the most coping strategies engaged by spouses of partners diagnosed with cancer. Some employed themselves with paid work, housework, holiday planning or exercise, whereas others also cataloged their thoughts and worries in order to focus on the care they render (Olson, 2011). Although

carrying for partners living with cancer rendered the caregiver with lots of fatigue, (Senden et al., 2015) were of a different view. In the researchers' study on the interaction between lived experiences of older patients and their family caregivers confronted with cancer diagnosis and treatment, the caregivers accepted the extra work as normal and adjusted to the situation as if it never brought major changes in their lives. Few studies have reported positive association between mental health and spirituality among caregivers (Kim, Carver, Spillers, & et al., 2011; Vallurupalli, Lauderdale, Balboni, & et al., 2012). Existing literature showed that caregivers had their level of depression reduced when they used spirituality as a way of coping (Son, Lee, Park, & et al., 2012). In addition, many classical works have also shown different ways by which spouses gave accounts of how they coped with giving care to the patients living with cancer: The spouses change their feelings about the situation while others seek information, assess the problem, get guidance, and act or prevent action (Braithwaite, 1990; Folkman & Lazarus, 1980; Maex & De Valck, 2006); others restrain their feelings, detach themselves from the problem, deny or avoid their problems (Carpenter & Miller, 2005; Toseland, Blanchard, & McCallion, 1995).

In some other study by Olson (2011), it was realized that to ensure some level of concentration, spouses blocked communication with family and friends who were perceived to be too negative or insufficiently focused on the patient. Furthermore, patients and spouses with high religiosity better engage in active coping but the association between religiosity and coping is inadequate to explain the religious needs of patients and their spouses (Hunsberger, Cheng, & Aslakson, 2014).

2.6 The Spiritual impact of having a Partner with Advanced Prostate Cancer

Many people including those who had disregarded religion (Gall, Guirguis-Tounger, Charbonneau, & Florack, 2009) use religion for comfort and support when faced with life-threatening illness such as cancer (Biegler, Cohen, Scott, & et al., 2011). The beliefs of life

and religion have been found to play essential roles in the lives of most family members of patients of prostate cancer (Ka'opua, Gotay, & Boehm, 2007), pediatric cancer (Hexem, Mollen, Carroll, Lanctot, & Feudtner, 2011) and ovarian cancer (Frost, Johnson, & Athernton, 2012).

The heterogeneity of religious beliefs and practices across cultures make it relevant to elicit the impact of advanced prostate cancer on spouse's spiritual wellbeing. Studies indicate that while Buddhist want the opportunity to chant or hear others chanting, Hindus have a strong preference for dying at home and Muslims for dying facing Mecca, surrounded by loved ones (Sloan, Bagiella, VandeCreek, & et al., 2000), Some spouses think that cancer is as a result of witchcraft or a curse (Kale, 2011a) and therefore believe in miracles (Daugherty, Fitchett, & Murphy, 2005; Sulmasy, 2006). Another study also showed how religious activities increase among people with cancer; whereby there was higher religious activities in Protestants than Catholics, Buddhists and those associated with no religion (Jang, Kim, Kim, & et al., 2012). In addition, a study conducted by (Hunsberger et al., 2014) on spirituality and religiosity during the perioperative period of cancer patients and their family, showed how differences in religious involvement among Christians enabled patients and their family to cope with cancer depending on the level of support from their religious denominations. However, their study focused on prostate cancer with good prognosis, which they have stated as a limitation in the study. This is because the advanced stage of the cancer would have elicited more religious reactions and different meaning among spouses as the patient may be faced with inevitable death. Again religiosity enables spouses to deal with the man's condition (Hunsberger et al., 2014).

How to live in the present, and what matters given the time available give a lot of meaning to cancer caregivers. One of the central issues in the experiences of patients with cancer and their families is their spirituality (Peteet & Balboni, 2013). Cancer is most

fearsome once it compromises hope and also, raises the questions of what are one's deepest hopes and ultimate basis for hope (Rusteen, 1995). According to Olson, (2011), spouses were optimistic about the conditions of their husbands suffering from prostate cancer. They managed their hope based on their orientation with time. Some of these spouses were positive about the present time they share with their husbands; concentrating rather on the time in the present and reminiscing on the pleasant occurrences each day instead of focusing on the loss that laid ahead. Again, some received encouragement from health workers whereas others were discouraged by health workers.

2.7 Spousal Involvement in the care of a partner

Spousal involvement in the care and treatment choices for a husband with advanced prostate cancer cannot be overlooked. Existing literature in similar studies revealed that, although spouses were directly involved in the care of their partners, and accompanied the partners to the hospital, spouses lack knowledge in the care and treatment of their partners (Harcourt, 2006). According to (Staberg, Ruland, & Miaskowski, 2010) spouses do not receive quality information about the patient's care from workers. It was indicated in the work of (Rowland & Metcalfe, 2014) that, spouses wished for more information on their partners' conditions. The need for adequate information on the disease and its treatment was also reported by other studies (Woloski-Wruble & Kadmon, 2002), whereas other spouses also reported having satisfied information from health professionals (Hoga, Mello, & Dias, 2008). In addition, most spouses obtain information from the patient, the family members and television as sources of their information (Beaver & Witham, 2007).

Furthermore, Docherty, Brothwell, & Symons, (2007) in their study on the impact of inadequate knowledge on patient and spousal experience of prostate cancer, reported that, most cancer caregivers were more concerned with cure than the knowledge of the condition. Caregivers struggle with many issues that lead to inadequate management of cancer pain

(Vallerand, Collins-Bohler, Templin, & Hasenau, 2007). Other researchers were of the view that the spousal caregiver should be incorporated in the care of the management of patients with prostate cancer (Hazelwood, Koeck, Wallner, Anderson, & Mayer, 2012). In an earlier study in the experience of research participation for family caregivers of palliative cancer patients, it was reported that the spouses' support and involvement depended on how much knowledge they have regarding palliative care (Hudson, 2003). However, in a study conducted in Nigeria, husband's knowledge on cervical cancer was reported to be more adequate (Suzu, Akin-Odanye, & Adejumo, 2014).

According to (Fang, Shu, & Fetzer, 2011), some patients thought of their spouses first before making treatment choices. Existing studies have revealed the importance of spousal involvement in the diagnoses and choice of treatment (Ballinger, Mayer, Lawrence, & Fallowfield, 2008; Fang et al., 2011; Fouladi et al., 2013; Hawley et al., 2009).

2.8 Summary of the Literature Review

In summary, the literature reviewed for the experiences of spouses of men with advanced prostate cancer covers the physical, social, psychological, spiritual wellbeing and spousal involvement of the topic under study. From the literature reviewed, it was found that other studies adopted the model used as the organizing framework for those studies but did not cover all the domains of the model. In addition, few studies have been conducted on the spousal experiences, and not the experiences of spouses of men with advanced prostate cancer in Ghana. Most of the studies involved both husband and wife, this is likely to potentially influence free expression of the women.

CHAPTER THREE

METHODOLOGY

This chapter describes the research design, research setting, target population, inclusion and exclusion criteria, sample size and technique, and procedure. In addition, the data collection tool, rigour, data management, data analysis, and ethical considerations are included.

3.1 Research Design

The study employed an exploratory descriptive qualitative research approach to enable the participants share their experiences regarding care provided to their spouses (Babbie, 2002). An exploratory descriptive qualitative research also gives detailed elaboration of what constitutes human experience. It aids the researcher to describe the process relative to its context rather than the outcomes (Mayan, 2001). It is believed that human nature is complex. The feelings, thoughts and behaviour of the participants were best elicited using a qualitative study. Thus, the unique experiences of the participants were explored. In addition, experience is subjective therefore using a qualitative method was appropriate in exploring the individual experiences of the spouses of men with advanced prostate cancer within the cancer trajectory (Fossey, Harvey, McDermott, & Davidson, 2002).

3.2 Research Setting

The study used the Radiotherapy Centre, and the Genitourinary (GU) Ward popularly known as GU of the Korle-Bu Teaching Hospital (KBTH) as recruitment outlets.

The Radiotherapy Center is a National Oncology Center. The unit is semi-autonomous within the KBTH. It has three Oncologist consultants and two residence doctors. It is headed by a Director and his deputy (oncologist consultants). Each day of the

week is for specific cases; Mondays for breast cancer, Tuesdays for cervical cancer, Wednesdays for ear, nose and throat (ENT), Thursdays for prostate cancer, and Fridays for sarcomas. However, patients who are already on treatment, are allowed on any day provided the time for treatment is due, without considering which type of cancer that patient is having.

3.3 Target Population

This refers to the people that the researcher is interested in to draw conclusions at the end of the study (Korb, 2012). The target population for the study were spouses of men with advanced prostate cancer who live within the Accra Metropolis.

3.4 Inclusion Criteria

Eligible participants included: women aged 18 years and above who were married, or cohabiting, with men with advanced prostate cancer, and who could communicate fluently in English, Ewe or Twi.

3.5 Exclusion Criteria

The study excluded women who are family members, women who do not have an intimate relationship with the man suffering from advanced prostate cancer, and those who are sick or have any psychiatric problems.

3.6 Sample Size and Sampling Technique

In qualitative study, the quality of data gathered were of great worth to the researcher, however, there was no predetermined method for arriving at the sample size. According to (Ajjawi, 2013), the quality of the data, useful information from the participants, the number of interviews per participant, and even the nature of the topic are all determinants of the sample size. A number of 12-15 participants was targeted by the researcher (Creswell, 2014). A purposive and snowball sampling technique was adopted in

selecting the participants for the study. This is an intentional decision to select a participant because of the characteristics that participant possesses (Tongco, 2007), and also the interest of the researcher to select the participants who could provide the needed information about the phenomenon of study and their willingness to participate (Padgett, 1998; Patton, 2002).

The researcher submitted an introductory letter from the School of Nursing, University of Ghana to the Directors of the Korle-Bu Teaching Hospital, and the 37 Military Hospital where the instrument for data collection was piloted. The researcher visited the hospitals' units after being granted the permission to make the scope and objectives of the study known to the nurses and doctors. Flyers with the contact number of the researcher were left behind for distribution to the spouses. Interested participants contacted the researcher for scheduled interviews.

3.7 Data Collection Tool

A background information sheet was used (see Appendix A) for data collection of the demographic information of the participants of the study. A semi structured interview guide was the tool for data collection (see Appendix B). This enabled an adequate exploration of the phenomenon under study. A semi structured interview guide is flexible in nature and allows probing into specific areas of interest to the researcher (Mason, 2004). A semi structured interview guide was appropriate for the study because it allowed the participants to express themselves freely and also the researcher to use probes during the interview to solicit for more divergent views that may arise (Kusi, 2012). A semi structured interview guide is again useful for data collection because it enables direct interaction with the participants, whose responses could be recorded and later cross checked for accuracy (Khan, 2012).

The constructs of the Quality of Life Model applied to Family Caregivers and the objectives of the study were used as a guide for the formulation of the interview guide.

Section A of the interview guide comprised of the demographic data about the participants (Appendix A) while section B consisted of the open-ended questions and probes (Appendix B).

3.8 Data Collection Procedure

An initial contact was made with the participants' partners at the Out-Patient Department (OPD) of the Department of Surgery at KBTH who introduced the researcher to their spouses. Later, the researcher booked appointments with participants who met the inclusion criteria. The venue, date and time were at the convenience of the participants. Each participant was given a consent form to read, those who did not have the literacy ability were assisted by their children, and clarify all misunderstandings about a week before the interview. Participants signed or thumb printed the consent form before the interview. Each interview lasted between 45 – 60 minutes and was face to face. The interviews were conducted at homes of participants, classroom, under tree and at the shrine. The researcher probed or redirected responses when necessary to focus on the interview. Participants were informed ahead of time about further interview sessions for clarifications when necessary. The interviews were recorded with an audio-tape with the consent of the participants, and then later transcribed. Transcribing data was concurrently done with the interview. The researcher kept records on her experiences in the field diary; nonverbal communications of the participants; the participants' mannerisms and anything vital to the study was recorded in a field diary to help the researcher understand the data generated.

3.9 Piloting of Instrument

This was to pretest the instrument by administering it to a few number of participants before administering it to the main study participants in order to “fine-tune” the instrument ((Dane, 2010). The interview guide was piloted at the 37 Military Hospital, Accra. The 37

Military Hospital is a Teaching Hospital situated about 5 Kilometers from the Accra International Airport on the main Airport-Accra- Central Road. It is also a United Nations Level 4 Medical support facility within the sub-region. This makes the hospital the highest medical facility that provides definitive medical care and a Specialist treatment in all fields of surgery and medicine. The analysis of their responses were used to make changes in the interview guide. However, the information gathered during the pilot interview was not part of the study data.

3.10 Methodological Rigour

Rigour is the extent to which the findings of the research can be trusted. The trustworthiness of the study can be achieved through four main criteria namely credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985b).

Credibility in a qualitative research is achieved when the findings in a research reflects exactly what the participants perceive of a phenomenon (Koch, 2006a) and (Krefting, 1991b) suggested the need for the researcher to become more aware of himself. To ensure that the findings of the study were congruent with reality, the researcher recruited only participants who met the inclusion criteria. Iterative questioning was adopted to uncover inconsistencies. A field diary was kept for recording nonverbal communication of respondents and the experiences of the researcher in the field. The researcher spent adequate time with respondents to build rapport and documentation of true responses was ensured.

Transferability is when the findings of a study are applicable in a similar context or the extent to which the findings can be applied to other settings (Krefting, 1991a). To achieve transferability the researcher gave detailed description of the context of this study. The sample for the study and the methodology used to arrive at the findings were fully described. All the documents and data collected from the field were discussed with the

research supervisors to ensure that correct interpretation of data was generated. Again, all transcribed data and field notes were kept for audit trail.

Dependability refers to the extent to which research findings can be repeated among same sample or context (Koch, 2006b; Lincoln & Guba, 1985). To ensure reproducibility, a detailed account of the entire research process was given; sample, setting, methodology and analysis, were described in detail. Each interview was transcribed and analysed with same processes to arrive at themes and sub-themes.

Confirmability refers to the extent to which a research finding reveals the experiences of participants devoid of researcher biases (Lincoln & Guba, 1985). To ensure that all findings of the research are the exact ideas, views and experiences of the participants, the researcher transcribed information from the participants just after each interview. The services of transcriptionist was used for the interviews conducted in Ewe and Twi, whereas those conducted in English were transcribed verbatim. During the data collection, the researcher sought explanation of what she did not understand from participants and debriefed them on their responses to confirm what they shared. Data were collected until the data were saturated. Again, the researcher kept an adequate audit trail which contained interview transcripts, field notes, audiotapes and documents on emerging themes and categories from the participants. Data analysis was centered on the information given by the participants. The researcher's beliefs and values were made clear and considered so as to help the researcher avoid biases in data interpretation.

3.11 Data Analysis

Data analysis is the procedure whereby a researcher reduces data in order to explain it (LeCompte & Schensul, 1999). Analysis of data was done concurrently with data collection using thematic content analysis. Similar codes were grouped to form sub- themes

and the sub-themes were grouped into themes (Anderson, 2007). The constructs of the model were used to name the themes and sub-themes. The data were analyzed using Braun and Clarke's technique of qualitative data analysis. The procedure included familiarizing with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun, Clarke, Braun, & Clarke, 2006).

In this study, data were transcribed verbatim and analysis done simultaneously with the data collection. The researcher read the transcribed data several times and coded all responses that were similar in nature and were grouped. Subsequently, all similar grouped responses were regrouped into sub-themes. Sub-themes that were similar were regrouped into themes. The transcripts were exported to the NVivo software version 11 for the data to be organized. Analysis of the data was devoid of the researcher's feelings or thoughts. Participants' direct quotes were used to support the themes generated. The researcher paid attention to the divergent views and minor responses raised by the participants during the interview to be able to draw conclusions and verify data.

3.12 Data Management

Data management refers to the storage and easy access or retrieval of data for easy analysis (Miles & Huberman, 1994). The main purpose of data management in a qualitative study is to "store data for maximal efficiency in retrieval and analysis" (Padgett, 1998). The researcher kept records of the date, time and place where the interviews were conducted. Participants were identified by identification codes S1, S2, and S3 up to the last participant which was written in a file kept separately for everyone for easy retrieval. The demographic information and consent forms were kept separately and these were accessible to only the researcher and her supervisors. Also, the recorded tape, transcribed data, field notes and diaries as well as all project documentations were kept in a cabinet with the key accessible to only the researcher. The transcribed data was backed up electronically on a CD-Rom and

external hard disc to prevent data loss. New files were created for each category and all information that were related to each category were kept in this file.

3.13 Ethical Considerations

The researcher sought ethical approval from the Institutional Review Board (IRB) of the Noguchi Memorial Institute for Medical Research (see Appendix D). Copies of the ethical approval letters and an introductory letter from the School of Nursing and Midwifery, University of Ghana were sent to seek permission from the selected hospitals. The researcher explained the purpose, objectives, benefits and potential risks of the study to the participants and allowed them to ask questions for clarification. Only participants who consented to participate in the study were recruited.

Participants were assured of confidentiality and privacy of any information provided. Participants were informed of their right to withdraw at any time during data collection and that any such withdrawal will not affect their marital status. The researcher used identification codes to represent participants who were interviewed. Participants were given a consent form to read, and given the opportunity to seek clarifications where necessary at least a week before they signed the consent form on the interview day. This gave participants ample time to decide on their participation. Participants were told that the information provided would be kept for five years in a locked cabinet and the key kept by the researcher after which the data will be destroyed according to the policy of ethics.

The researcher ensured the comfort of the participants. Any stressful situation or psychological trauma was handled professionally by referring the affected participants to a Counsellor, Dr. Samuel Atindanbila, at no cost to them. He was readily available and accessible and his contact number is 0277532705

CHAPTER FOUR

FINDINGS

This chapter presents the findings of data generated from the participants on their experiences of having husbands with advanced prostate cancer. Thematic content analysis was used, and five (5) themes that emerged from the data were physical wellbeing, social wellbeing, psychological wellbeing, spiritual wellbeing and spousal involvement. These major themes and their sub-themes are presented with verbatim quotations from the participants using pseudonyms. A background description of the participants of the study is also provided.

4.1 Description of Study Population

The study participants were 13 and were aged between 50 and 68 years. The number of years of marriage by participants was from 11 to 58 years. Twelve participants were Christians, and one of the participants was a Muslim. One of the Christians booked her interview at a shrine. They were all Ghanaians. All participants were married with children. One participant had only one child. Three participants had children before marrying their husbands, and out of those three participants, two never had children with their current spouses. One of the 13 participants had 8 children; two others had 7 and 6 children respectively while the remaining participants had 4, 3, and 2 children, and an only child. Two participants were government workers and of which one was on retirement. Eleven participants owned their businesses such as dressmaking, selling corn and used clothing at the market and petty trading. Most participants preferred to speak Twi and Ewe which were their native language. However, participants could speak several other languages such as English, Ga, Ga Adangme, Fante, Hausa, Brem, Nzema, and Awutu. The residential location for the spouses within the Accra Metropolis varied between urban and rural settlements.

In answering the first research question, “To what extent does advanced prostate cancer influence the physical wellbeing of spouses?” the study identified a major theme “physical wellbeing”, which is presented below.

4.2 Physical Wellbeing

Participants shared their experiences on their physical wellbeing. The demands of caring for partners with advanced prostate cancer each day and performing activities such as washing, preparing his bed, transferring him in and out of bed resulted in a lot of physical effects on the spouses. The gravity of influence of advanced prostate cancer depended mostly on whether the man was ambulant or bedridden. The subthemes that emerged were fatigue, sleep disruption, pain appetite and effects of pre-existing diseases which emerged as a new sub-theme.

4.2.1. Fatigue

Fatigue was a common experience shared by all the spouses during the study. Most of the spouses reiterated getting very tired because of doing all the work alone. Participants were stressed out from the daily assistance of the bedridden partners.

“For me, I get very tired. None of our children lives with us. Everything is on me. However, I am never discouraged. I prayed a lot. So, I never worry him with anything.” (S1)

“I get tired a lot. The work is a lot. You have to wash his clothes. Help him up. Sometimes he is not able to walk. Moreover, when it is time for bed, you have to help him lie down and sleep. It is a lot of work and I get very tired. By the time the day is over, I feel pains all over my body.” (S12)

One of the participants said she had help when they relocated to their son’s house.

“When I get tired, I lie down for a while. I am the only person with him at where we live. I am the one who sweep and fetch the water so I get tired a lot. But my last born here helps since we came here.” (S8)

Another participant indicated that she had to combine her caring role with work. This same participant was responsible for another member of the family who had a physical challenge.

“But you know, what I have noticed is that, when I walk for a long time or stress myself, I become tired. That is what I have been experiencing nowadays. When you called me, I was lying down. I got tired yesterday. I did not close early. I have to go and see my girl and run some errands for her. So I got tired. You know, I have got two troubles. My girl too cannot see properly so she is now at the school for the blind.”(S13)

However, few participants accepted that they took some rest during the day

“Sometimes when am tired, I relax since he likes watching television a lot.” (S7)
“When I get tired, I lie down for a while.” (S8)

4.2.2. Sleep Disruption

The participants reported that sleep disruption is one of the characteristics of caring for a partner with advanced prostate cancer, which affected their physical wellbeing. Most of the spouses stayed awake to keep an eye on their husbands because their partners were bedridden and dependent on the spouses. Others also had insomnia. Those who had their husbands on admission stayed wake thinking about him. Some of the spouse went to bed late after 11pm but still had to wake up early. Few of the spouses took a nap during the day whereas others slept well.

Some participants had sleepless nights.

“I stayed beside my husband in a chair for a month. It got to a point where a certain nurse told me I should go home because they do not allow a caretaker to sleep in the room. And I told her that if I leave my husband alone, he might pass on... In fact, sometimes I stay awake till morning.” (S3)

“Well, for me sleeplessness has become part and parcel of me and I am used to it.” (S3)

“I hardly sleep. Sleeplessness is my main problem.” (S5)

“I stay with him in the house. Now that he is not there when I am going to sleep, I think about him.” (S6)

Participants indicated that they had to wake up from time to time to keep an eye their husbands

“At night by the time I finish everything, I will be tired. So I ask if he has taken his drugs or if he would like to eat something and he will tell me what he wants to eat. When he finish eating before I go to bed. I am always vigilant; I wake up and keep an eye on him. I do not sleep. So, yesterday when he was alright, I had a very deep sleep. I woke up at 2 o’clock and found him asleep but he was not comfortably asleep”. (S10)

“When I finish my chores, I sleep. But I wake up from time to time to find out how he is feeling. So I am not able to sleep fully. If I sleep and wake up, I will not be able to sleep again”. (S11)

One of the participants took sedatives to enable her sleep.

“I do not sleep, that was when we came back from the hospital, however, sometimes, I do take sleeping tablets to enable me to sleep... Oh it was the nurses who gave me. I do go to the clinic for check-up. They give me the tablets whenever I tell them I am not able to sleep.” (S9)

However, there were few participants who narrated they slept well.

“I sleep well. Sometimes I sleep at 10 o’clock or 11 but I make sure he sleeps before I take my bath and go to bed.” (S12)

“I can no longer keep wake. I only do what my strength can take me. I feel very sleepy.” (S7)

One of the participants said she had to relocate the family’s sleeping place to the hall.

“For about four (4) years now, because of my husband’s illness, we all slept in the hall because I want to keep watch throughout the night on him. I have only little sleep. We do not sleep on our beds. The bedroom is there but we sleep in the hall.” (S13)

4.2.3. Pain/Aches

Pain also influenced the physical wellbeing of the spouses. Nine participants described the pain they experienced in different parts of the body. Participants complained that they experienced pain at different parts of the body such as in the shoulder, chest, arm, waist, knee, leg and whole body. Participants also experienced headache and back ache. The severity and nature of pain was relative and specific to the individual spouses based on their

level of activity. Some spouses resorted to self-medication in order to reduce the pain. Participants bought ointments and herbal medicines from drug vendors and churches. In addition, there was the use of a common over the counter analgesic, acetaminophen (paracetamol).

Participants attributed the pains they experienced to their caring roles, such as massaging and lifting their sick partners.

“In the two to three years since I have been massaging him, I had problems with my leg. Even this morning, I have had pains in my hand because of the herbal drug I applied on it. I have pains in my chest.” (S8)

“I feel a lot of pain. My waist hurts a lot. Yesterday, it was my head that was aching I do not feel like I used to at first. When I hold a thirty-two sized bucket of water, I feel pain in my arm.” (S10)

“My waist. Lifting him up demands a lot. It strains my body. So when I am done, I have to take some painkiller. I like to take para...I just go and buy it. Sometimes I use rub. In the evenings after my bath, I use it before I go to bed.” (S12)

“Sometimes when I get tired and feel pains. I take some pain medications and also put some ointment on my body... No. Doctor did not prescribe it. When I take it, the pain stops.” (S2)

Other participants attributed the pains to their inability to rest, as well as the sleeplessness experienced by those participants. The majority of the participants self-medicated to manage the pains experienced.

“I feel very tired at times. My shoulders also. So, I bought a balm, which I apply to my body after I take my bath.” (S1)

“The sleeplessness brought me headache. You see that I have got so many plants here. I have ‘bitter leaf’, moringa, noni and dandelions. So if I feel the headache and I feel That it is malaria. I take in the ‘bitter leaf’. I take the noni also. Someone also taught me to take in lots of water.” (S13)

“Within these two weeks I feel a sharp pain around my waist but I bought a medicine by myself.” (S3)

4.2.4. Appetite

The spouses narrated their experiences on whether the ability to eat well or not. For spouses who could not eat well, it was either there was no appetite for food, or the spouses had no time to eat. Each of them had specific reason for her inability to eat.

Some participants explained that there was lose of appetite for food.

“I do not feel for food; I stay for a whole day without thinking of food... No please. I am not fasting. Sometimes I am able to eat a little. I do after I see to his welfare, I find something to eat.” (S3)

“I could not eat yesterday. When I drank porridge in the morning, I even forgot I had not eaten again. I do not feel for food. Even yesterday, I took only a half ball of ‘banku’. Just this morning, it is just some tea that I have drunk. After giving him food and watching him eat, I felt better and asked what we were also going to eat.” (S10)

“If I tell you I eat, I am lying. I do not eat. I cannot eat because my husband is in the hospital. How can I eat? I do not need food. I am thinking about my husband. I eat when I am very hungry. When the children buy food, I sometimes force myself to eat with them.” (S6)

“I do not really eat. It is water I drink. I eat when I have to take my medications.” (S8)

“I do not have appetite. I do not feel like eating. But I drink water. I do not fast. I had ulcer when I fasted, so I have stopped. But eating is a problem for me.” (S13)

Besides the lose of appetite and interest for food, some participants engaged in spiritual activities, such as fasting and prayers. The participants fasted from food to pray. It is a common belief and practise in Ghana to engage in fasting for a quick answer to prayers.

“I prayed and fasted all the time. Sometimes, I do it until 5pm then I break. Today I fasted until 12 pm. Sometimes, I eat porridge and bread.” (S2)

“When you finish fasting, you cannot eat well. But if I take a blood tonic, I can eat about three times. Now, all I have drank is tea. I do not feel hungry. When I eat around two or three in the afternoon, I do not eat again. When I get some soft drink or biscuits, I eat it around seven or eight when I feel hungry.” (S10)

Few spouses, however, did not have problem with food. Participants were able to eat well

“I eat all right. I eat well.” (S7)

“I eat well.” (S9)

“I am able to eat little by little. I eat what I get. I have eaten kenkey this morning.” (S11)

One of the participants was selective of what to eat

“Because of my problem, I mostly eat unripe plantain. I have sugar problems. Sometimes I make ‘fufuo’ with the plantain. When I eat in the morning, I wait until evening. I do not get hungry very often.” (S12)

4.2.5. Effects of pre-existing diseases

It was found that some of the participants lived with certain chronic physiological conditions. Participants described the symptoms as though the symptoms were being aggravated by the demands of their caring roles. Participants complained of cough, which was self-limiting. Others have high or low blood pressure, diabetes, and asthma.

Participants reported blood pressure increase.

“I have BP. Since 2004, 1st January. It happened when my husband was abroad. One morning, I realized that my foot was swollen, so I called him and he urged me to go to the hospital at Achimota. So I kept on visiting the hospital until recently, they put something under my tongue because the BP had risen too high.” (S2)

“Personally, I have been battling with severe headache and BP as well but by the grace of God am still fit but his sickness did not affect me in anyway. My BP went very high but I thank God.” (S9)

Other spouses complained of a rise in their sugar level.

“Last month, when I checked, my sugar level has gone up. Taking care of him, makes me very tired. That's what I think is making my sugar lever rise.” (S12)

Few of the participants lived with more than one health problems.

“I may say blood pressure (BP) has been normal all this while. At times I check both the BP and the sugar level anytime I get to Korle-Bu but I may say about five days ago that I went and checked my sugar level again and it rose to 8.3” (S5)

One of the participants was advised to consume alcohol to help improve her low blood pressure.

“I took Guinness because I was advised by a doctor. I have very low BP. So now I take red wine and hot Guinness. They advised me to take salt but I do not like it.” (S13)

Two of the participants also narrated episodes of asthma.

“God has made me wonderful because am not sick but just that am coughing all those days in Korle Bu. The cough goes and comes back. I have been to the hospital but I cannot see any improvement. One doctor says it is asthma” (S3)

“I have pains in my chest. I cough. The cough is persistent... I have been there (hospital) several times. One doctor told me to be careful of the food I eat. So I have noticed that when I eat rice or yam I suffer the coughs.” (S8)

“I have an illness that my husband knows about. I have asthma. So I do not take drugs because they will trigger it. I do take the asthmatic drug whenever I am going out. I even brought it here. I have had about four attacks around this period. When I went to the hospital and had the attack, I hid it from my husband and told him I have a problem with my stomach. I am looking for a doctor to get me some drugs from the hospital.” (S6)

4.3. Social Wellbeing

This main theme considered the outcome on the social wellbeing of spouses of husbands with advanced prostate cancer. It elaborated the following sub-themes: isolation, roles/role adjustment, affection/sexual function, leisure activities, financial burden and employment. Fidelity/honesty, thoughts of divorce, perceived relationship with husband and perception on roles were new subthemes which emerged.

4.3.1. Isolation

Participants gave certain reasons which described feelings of isolation. Participants felt isolated because family members did not show concerns; again there was lack of communication between the spouse and the patient because the patient was in pain most of the time.

Participants reported that their family members neglected them.

“The family members know he is sick but they do not come and visit us. Only his friend, co-workers visit us. Am just a married woman, am not supposed to tell his families before they visit him. His step brother, who brought the person treating my husband only comes to visit. It was when we were in Korle -Bu that one of his siblings came but up till now we have not heard from any of them. Well, when someone likes or loves you, you have to see. It is their brother who is sick so they have to call and not I, I only came to marry. Am I lying?”(S3)

“What really makes me think a lot is for the fact that I don’t see his family members. I keep asking myself what if I were not married to him, what would have been his fate. Have they left him alone for me? Hmm, it is difficult. They just want him to die based on their actions. At least they should give me a phone call to encourage me but none of them did.” (S5)

Some also said that their husbands are often not in the good mood for conversations. Thus, participants hardly engage in conversation with their husbands. This made them felt lonely and isolated.

Participants initiated only short conversations.

“Hmm, No. We do not sit together to converse simply because that is how he behaves so am use to it and have to adopt to it. He usually watches television alone. I am careful with him because I do not want to disrupt him. I make our conversations short in order not to bring problems.” (S7)

“Not really but whenever he wakes up, we greet each other and do ask him about his health. Even before this time, we do not really sit together to chat. I initiate conversation between us.” (S9)

However, some of the participants claimed they did not feel isolated. They spoke about the fact that they were able to converse with their sick husbands and other family members based on previous relationships with the man, or according to advice.

“I like to converse with him. Because the doctor told me to talk to him. And that I should not disturb him which I was not doing, so it was not difficult.” (S1)

“Once in a while we will converse in the night. In the morning I don’t have the time but at night around eight, eight-thirty, we talk.” (S10)

“Our conversations are fine.” (S12)

4.3.2. Roles /Role Adjustment

This sub-theme describes the various roles played by the spouses as well as the role adjustment of the participants. The roles played and the adjustments in those roles were influenced by whether the men (patients) were ambulant or bedridden. All the spouses were involved in cooking, feeding, washing cleaning, and bathing. Lifting of the patient was performed by some spouses alone without assistance whereas others relieved pain through

massage. Again, payment of utility bills, hospital bills, accompanying husband to the hospital, reminding husband of reviews, follow-up visits, buying of medication, ensuring husband takes medication, protecting husband from injury, and accompanying husband to prayer camps for healing and praying for husband were reported. Moreover, those who still had their children in school took the responsibility of paying school fees which was formerly done by the man. A number participants stated that it was their responsibility to care for their husbands. Few of the participants received support from their children.

Some participants prepared special meals for their husbands.

“I also ask him what he likes to eat then I do it for him. I also prevent him from foods that will harm him. Foods like cooked unripe plantain or banku which I use little cassava dough when I prepare it. I also make light soup which I add ‘dawadawa’ and ‘prekese.’” (S1)

“So this morning, he said he will sleep for a while. His son said I should blend watermelon for him. So in the morning I gave him some brown bread with eat. He said he liked it but he did not want to drink a lot. I served him food and fruits. I also used ‘ama julie’, kontomire in his soup. At times I change what I give him. I give him oats, porridge and tea. When he is tired of the brown bread, I buy doughnut for him.” (S10)

“I cook every day for them. This morning I even washed, I woke up early and washed.” (S4)

“I cook for him. His elder daughter washes his clothes.” (S6)

Participants fed and assisted their husbands in feeding.

“He is not able to eat, or stand or sleep either. So my children and I hold him as a baby. We bath him on the bed and do everything else for him...Sometimes, he's like a baby, so you can be easily fed up with him. Even feeding him was a problem. You have to spoon feed him. It took us about 2 hours just to feed him with porridge.” (S13)

“So actually it is a sickness that if you do not have family members around you... It is my son that has been helping me carry him on bed and doing everything for him when he messes the bed, even food you have to feed him. That is what we are on till now.” (S3)

Participants cleaned and bathed their husbands.

“The toilet is just here but I do not let him go. I make him use the chamber pot and then go and throw it away. I bathe for him. When you do not bathe from morning till

evening, you realize you do not feel comfortable. So when I bathe for him, he feels comfortable and I am also comfortable.” (S10)

Other participants made time to accompany their husbands to the hospital for reviews.

“We were asked to return in two weeks. When we came home, it got worse and he could not urinate at all and the pains started. So, I rushed him to the clinic but they told us to take him to Korle- Bu. We were asked to take him to the Emergency... We were asked to go and come back in six weeks. Slowly, the blood from the urine ceased. Six weeks later when we went, the catheter was removed.” (S10)

Some participants also ensured that their husbands took the prescribed medications.

“To stop the pain, I gave him some Paracetamol and he was able to sleep. About seven in the morning he started feeling better. We were given a strong pain killer but I could not get one of those in the drugstores. I did not have money to buy it so his son said he will go and get it for him. He also could not get the drugs and I said I will go to Okaishie to buy it for him. This is what we are dealing with. At night by the time I finish everything, I will be tired. So I ask if he has taken his drugs.” (S10)

“We are not flippant about his drugs. So we make sure he gets everything he needs. When he misplaced some of the drugs, we had to go to the doctor again to get a new prescription. He is supposed to be on that drug for two years.” (S1)

Participants interceded for their husbands at prayer camps and prayed for them towards early recovery.

“I do go myself. I go to stand in for him. I do not send him there. He could not sit for too long and at that time, he had to urinate all the time so I could not send him there.” (S13)

“Once again the Prophetess called him and he went there that evening for prayers. He was able to sleep well that night. However, the sickness came again and we decided to move from one prayer camp to the other in search of long lasting solution.” (S3)

“Every time we are at home, we chat a lot. And sometimes when he doesn't feel well I pray for him. He likes to pray also even when he was at the hospital.” (S2)

Participants massaged their husbands and administered analgesic to relieve the patients of pain.

“So I normally send the kids to the pharmacy to get him some pain killers of which if he takes, he feels relieved and this has been the practice all the time... On the Sunday he complained about pains and numbness in his left thigh, so I thought it was fatigue. I gave him some balm to massage the affected place.” (S3)

“At times he says if he tells me how difficult it has been for him, I would be worried. At times I will massage him with hot water and when I find a balm in town, I buy it for him.” (S2)

The participants were also involved in lifting the patients.

“The problem is how my husband fell the other day. This has contributed to his inability to walk. Previously he was able to stand and walk a little but no more. There is nobody to help. Lifting and turning him is not easy. I do the washing and sometimes the ironing as well.” (S5)

“There are times when he is not able to walk so he crawls. When I wake up and see him, I lift him up and help him to the toilet or washroom. So we have been through a lot of challenges but thanks to God we have been successful.” (S8)

Furthermore, most of the participants lamented on how certain changes had to occur in addition to what they were doing because their husbands were no longer capable of paying for the utility bills and caring for the home.

“I am the only person taking care of my child. They are six. It was recently that he sent me some money to take care of the water bill. I have six grandchildren. They are all in the house.” (S6)

“I pay electricity, water bill and buy gas for cooking. His son is working but does not contribute to any of our utilities in this house.” (S5)

“Daddy buys the prepaid electricity and I buy the gas. We share the rest of the utility bills. The electricity and the gas are the most expensive. He gives me money for the market and I add mine to it. So I go to the market weekly.” (S4)

“He gives me GHC 30 for the first two weeks of the month, and then GHC 5 for the last two weeks this means that I have to add all that I make. I need to keep the house running. So we have to depend on the little I get for the running of the house.” (S7)

“We took care of things together. When he pays the electricity bill, I pay the water bill. And as for food, he is old, so I took care of things myself. And when he gets something, he adds it to what I have. When I go to the market I buy anything that we need but now that he is ill, I take care of everything.” (S12)

4.3.3. Affection/Sexual function

The participants were frank in expression concerns on sexual matters. Sexual expression was associated with age groups among the participants. Although none of them was young, few of them in their middle ages had strong desire for sex, and hoped husbands

will recover for their sexual needs to be satisfied whereas the aged among them did not. Furthermore, all the spouses tuned mind off sex. The reasons they gave was that the man had no strength for sex and also, and they did not want to worry the sick husband. Two of them said they did not have feelings for sex based on certain health problems. Some of the participants joked with their husbands about their sexual function depending on the cordiality between them. The rest preferred to remain silent about it. Few spouses preferred to reminisce about the past. However, one participant said there was no love between them.

The participants said they would not like to worry their husbands because of the disease.

“Before he fell sick, anytime he wanted it, I never held back. Because I did not want him to sleep around with others. Maybe the one he finds outside will think he has money and will follow him. When that happens, you will realize that the problem will then become my problem... Now, he does not have the strength, so I do not worry him. I do not think about it. What has happened has happened. You cannot go and replace him with someone else for it to work that way. So you will take it like that.” (S1)

“It is young ladies who would be bothered about it. I am not. I was all right when he travelled abroad. I just pray and hope that one day would regain his strength.” (S2)

“Laughs...I have forgotten about that one. For sexual feelings I have made up my mind because he is sick but for him I have not asked him anything about that... Oh the person has been sick so I do not want to worry him I cannot also cheat on him either.” (S3)

“Because he is not strong, I do not bother him with sex. So that I do not make him worry. He also knows he is not doing any good, so he does not talk about it.” (S4)

“He is not well so we do not. I am not worried about sex.” (S8)

Few of the participants reported that they had sexual feelings but engaged themselves in diversional therapies.

“Hmm, for some time now my husband and I have not lived as husband and wife. Nothing really, sometimes I do have some feelings but there is nothing I can do so I just get a book to read then that is all. Laughs... Oh like I said. It is not necessary. I am now 68 and he is 74. It is not necessary. After all we are old.” (S9)

“Since the illness started, once in a while he feels it and I also feel it but I do not want to worry him because of the nature of the illness. He has also told me if I ask him to do anything of that sort, it will hurt him. I also told him it will be difficult for me to tell him to do that. So I have taken those thoughts out of my head. After all he is my husband. Once in a while we play romance to satisfy each other. If his condition improves and I feel like it, I will let him know. But now, he does not have that strength. The way you may want it he will not be able to perform. Am also worried when the angels descend and are coming-laugh, am worried.” (S10)

“Yes. But now we do not do it. Since daddy did the operation we cannot do it. The thing is sleeping. But we do not care. We have gotten our children already. The doctor told us... Oh at times, I feel for it because you are a human being. But immediately it comes, I brush over it. Once in a while it comes. When it comes, I just find something to do until it is gone. I just turn on the radio or the television to watch some movies.” (S13)

Some of the participants would not have sex because their spouses have catheter in-situ.

“Hmm, my sister. I have already told you that he had catheter inserted for the past eight years. We are just there as brother and sister. I even had fibroid and went for surgery before he married me. I am used to. I also have diabetes and on medication. You know that one has low feelings for sex when having diabetes.” (S5)

“Now he is ill, so I do not think about it. Before he fell ill we did it. Because he is ill, he suggested that we sleep separately. So he calls me anytime he needs something. No I do not get such feeling any longer. I was diagnosed with fibroid and my womb was removed so I do not get such feelings. And that was about 8 years ago. And even when he had his strength we use fight all the time, so it never bothers me at all.” (S12)

Participants were of the view that affection towards the man will lead to his recovery.

“When I remember the struggles we have been through I realize if we do not stay together, he would not get well. I am an Anlo and he is a Fante. If I do not show him love, he will die and leave me.” (S6)

“We chat and watch movies every day to keep closer. If it was not for your visit, we would be inside chatting.” (S13)

“An ill person needs to be pampered” (S12)

One participant reported that there was no affection between her and the spouse.

“No we do not have it. It is not there. It depends on how the whole relationship started. I was with my grandmother at Chokor. I was being maltreated and did not have a better place to sleep and so I thought I will get a better place to sleep if I should get married to someone. The marriage was not based on love it even from frying pan to fire. Laughing... If am not lying, I will say, he has been masturbating because of his attitude towards me. Am sure by this time his thing (manhood) is

almost dead but I must say I will not flirt as a lady. If I should flirt, it means am destroying my own body and contract a lot of diseases. All I focus on is my business and how to make money. I am not happy. I do not get amused. There is no love.” (S7)

4.3.4. Leisure Activities

Participants did not have time for leisure activities apart from few of them who managed to watch television with their husbands depending on whether the men were in less pain and were in the mood to watch television. Most of the participants said there was no time for such things like leisure activities and therefore going out was nil.

Participants referred to their immediate family members as friends. Participants spent time with children to share and discuss memorable moments of the family.

“So here, I do not have friends. My husband and my children are my friends” (S1)

“We talk a lot. Sometimes about our family, sometimes about the bible, and at other times about things that happened in the past.” (S2)

Some participants could not engage in recreational activities because of their husbands’ condition. Others were engaged with the role of caring for their spouses.

“There are many forms of entertainment. But now that my husband is not well, I do not have any entertainment. How can I entertain myself when my husband is not well? Yes. Both of us. When he was well, we used to go out in his car to entertain each other on holidays. But we cannot do that now.” (S6)

“I would not get the time. It is not that I am busy doing something but looking at the illness, how can I leave him and go out? When he was well I always told him we should go out and he will say we will go when he got money. We used to joke about that.” (S10)

Others said they sang to praise God

“I go for lessens at church. For instance, I prepared enough food for the house before coming here. Our last child is with him at home.” (S7)

“I sing songs of praise to God. He was the one going out when we were young” (S8)

Some spouses did not have friends as they shared their experiences. Even those who had friends were church members.

“For me having friends ‘paa’ no, I do not have. I say hello to anybody I see at church and that is all. It’s only one church member at my area but it’s been a long time now since I saw her. She visited us once before my husband went to Korle Bu. She called to know whether we are back from the hospital about three days ago.” (S3)

One participant said she liked dancing and could make time to go out.

“I make myself happy. If I feel like going to sit somewhere to drink coke, beer or Guinness, I would go. I like dancing very much. So I like places where live bands play. Before daddy fell ill, when it is Valentine’s and he does not want to go out with me, I will go by myself and dance and come back and sleep.” (S13)

4.3.5. Financial Burden

All of the participants admitted they had financial difficulties. Some participants claimed they did not have financial support therefore they went through a lot of financial problems. Others had financial support from children, family members, church and friends. Participants also depended on the pension benefits of the men. Those who had their own businesses said they were bankrupt to the extent that they had to make certain changes such as reducing their expenditure and spending on only the very necessary in order to survive. According to the participants, the high cost of medication, laboratory tests, and hospital bills caused their financial difficulties.

Participants had to depend on some of their children for financial support.

“His children that are working help us. It was one of his brothers who also provided money for his care.” (S8)

“It is the children who assist me. Even my daughter who bakes, brings us bread and some amount of money. Our youngest child also assists; he even bought his father’s medication the other day. From our children... In fact they did not leave us and more so he is a retired educationist so we rely on his monthly salary as well. I must say all our children are doing their best to provide for our needs. We also took care of some other children so they also help. My husband was also a teacher and so he gets some money from his pension salary.” (S9)

“It is the kids. Formerly when I could go out to trade, I brought home foodstuff and others for our food. And if I had some money, I brought it also. But currently, all the financial burden is fallen on our children” (S11)

“At first, my siblings used to contribute money for me to use in checking my how far but the economy has gotten bad so you cannot rely on what people tell you they are

going to do for you. So I am here. When they bring me something, I will take it and if they do not bring it too, I will take it like that.” (S10)

A participant had some assistance from her church.

“Hmm, it is not been that easy, sometimes we get support from our church members but God being so good, he made some savings so that is what we depend on but for the family members, I have not set my eyes on any of them. It is only their family head that came to greet him the last time and left. So I asked him to call the uncle but he also could not make but rather sent us GHC100 since he is also going for an operation on his knee.” (S5)

Participants reported that the cost of laboratory tests and medications were high and these led to financial difficulties.

“Yes! Even 30 million (GHC 3000). And sometimes we do not even have enough for food. So it makes me very sad. Even the medicines is very expensive. Let alone the admission fee and numerous lab tests that you have to do. Sometimes you cannot even do the lab tests inside the hospital because the equipment are broken. So you have to do it outside. The health insurance does not cover it all.” (S12)

“Yes they are. But today I borrowed from somebody, hoping I would get money to pay back later. Because if we do not do that, we would be humiliated here. So I went to borrow from a friend to pay for his lab tests.” (S12)

“As to the amount of money we spent, I cannot tell. With this illness, if you do not have money, you will die. We were charged about GHC 200 or GHC 300 per test. Even at Korle-Bu, he paid almost GHC 800 for a radiotherapy test.” (S13)

Few participants spent no money on things that were not necessary in order to gain financial survival.

“In terms of money, no one did. That is why I said that I had to make certain changes. For instance, I stopped buying things that were not necessary. Sometimes people will come around with clothes but I decided not to buy those things. The illness made those things unattractive. So I saved what I get to take care of my husband.” (S1)

Participants reported that life was difficult for them. Some allowed their children to look for assistance from elsewhere.

“Currently, it is his illness that is worrying me. I am not doing any business so I do not have any money. Once in a while it is difficult to get food to eat. The last child is still in school. The last but one has just completed SSS. I have a brother in a hospital and he goes to help him out and he uses the money for classes.” (S10)

4.3.6. Employment

It was found that spouses who were working managed their own finances when they did not have the support from elsewhere, whereas those who were not working depended on others for financial survival. The participants openly expressed themselves regarding the stresses at work because of caring for a partner with advanced prostate cancer. Some of the spouses had to stop work, and spouses who sell at the market went to market late. Again spouses who own shops were not frequent at their shops, and therefore lost customers.

Participants left their businesses in the hands of trusted friends.

“I manage. I set up shop, make someone look after it, then I give tips to the person who takes care of the shop.” (S1)

“He was admitted on the 4th of January, since then I have not been to the market. So I left my corn with some of my friends there. I went there yesterday, and they had sold enough. Sometimes, I also call them to find out what is going on.” (S2)

“I used to go to market every day. Because of daddy's illness, I do not go at all. It has reduced my income. But by God's grace, we are able to live off what loved ones bring to us.” (S2)

There were some participants who neither went to work nor left their shops in the hands of trusted friends. They had to stop work totally.

“I no longer have time to sew. I have to stop work to cook, wash and even I have to heat water for him to bath. It delays my work. My customers have reduced. Hmm.” (S7)

“I am not able to work at all. Because of his illness, I am not able to leave him at home. When he has to visit the toilet, I have to help him up and take him there. He does not want to do it in a... Previously, even when he has to urinate, he would like to get up and go out. But now, it is hard for him to control it. So it causes him a lot of worry.” (S12)

“I hope by the grace of God, he will be fine. Because this two years now, he has not gone to work. It is because he cannot drive. So everywhere he goes, I have to take him there. I missed work” (S13)

Some participants went bankrupt and lost contact with customers because of their absenteeism from their businesses.

“I am now bankrupt, since I have not been working for some time now. As for the money issue a whole lot of money is being spent and for the business now that am not there myself no one is there to sell for me as I usually do it myself unless my first child comes back from school to sell small. As I speak, there is no one at home, the doors are shut.” (S3)

“I would have earned more income. I can call out the customers if I were there” (S2)

“I lost my relationship with customers. When a customer comes and does not find me, he or she may go somewhere else. And they may never come to me again.” (S12)

“I do not give my things out on credit. So there is no problem there. Now that I am not around, it is difficult for those who want to buy. Honestly, due to my husbands’ illness, we do not have money anymore. So because of the money, I will like it very much if my husband gets well. So I do not go to the retailers for more goods.” (S6)

4.3.7. Fidelity/Honesty

Participants felt it was good to remain committed and honest in their marriage. All participants had personal reasons for being faithful and honest in their marriage. Participant expressed their thoughts that infidelity would not yield good results in their work.

“For example, I commit our life into the hands of God and ask Him to bless my work so that I can have enough to look after my husband. And to help me stay truthful. So that I do not do immoral things. Such as taking another man. God hates such things and whatever you do would not work well.” (S1)

Some of the participants were of the view that infidelity and dishonesty could kill a sick husband.

“Oh the person has been sick so I do not want to worry him. I cannot also cheat on him either. My parents did not teach me that. God abhors a promiscuous wife. I cannot sleep around with any man also, because when I do that I have sinned and more over I cannot do that and come back to a sick partner, then I have killed him.” (S3)

In addition, others said showing love will rather heal their sick husbands.

“My love will heal him. I do not have anything left for another man” (S6)

Another participant also thought it was better to remain faithful than to flirt and contract diseases.

“Am sure by this time his thing (penis) is almost dead but I must say I will not flirt as a lady. If I should flirt, it means am destroying my own body and contract a lot of diseases... He

gets angry and complains a lot. But I do not react to his complaints. It is not based on mistrust. This is because he knows who I am. He is someone who does not like going out even before he became sick” (S7)

4.3.8. Thoughts of divorce

The agony of caring for a husband with advanced prostate cancer left participants with mixed feelings as to whether to give up in their caring roles or not. Participants gave reasons why they would not separate with the man.

“I do not have any desire for any man. The love we have for each other, if it is another man, he would not have that love for me. He buys things for me. He was the one who bought the dress I am wearing now. He buys things I want for me so I do not have an eye for another man. When he is not here, I don’t sleep. I can wake up around three o’clock and sit on the bed.” (S6)

“Oh, at this age? No. I already have two children, male and female. Even the elder child will soon get married. Eight years has not been easy my sister but I have been able to cope. I would have left him if I had wanted to but it is something I will not do. Unless death that will separate us.” (S5)

However, two participants had the thoughts of leaving their husbands.

“For instance, when I got discouraged, I thought of leaving him. I felt it was too difficult for one person to do the work two people are supposed to do. That was even before I brought my mother to help. But I thought of the kids and the help I had to give them. What if I leave them and they do not turn out well? So, I decided to take all those thoughts from myself and stay with the man.” (S1)

“But I sometimes threaten him that I will pack and leave when I feel he is worrying me. All he says is that he will soon die for everything to be over. Then I will ask him if he does not have faith” (S5)

4.3.9. Perceived relationship with husband

Participants related with their husbands beyond husband-wife relationship. Some of them referred to their husbands as uncles.

“We are very close; I regard him as my uncle” (S1)

participants also saw their husband as brothers.

“Hmm, my sister. I have already told you that he had catheter inserted for the past eight years. We are just there as brother and sister.” (S5)

Furthermore, there were participants who perceived their husbands as fathers.

“So I have vowed to take care of him. Not only here. I will follow him anywhere. The other day, a man was asking me about my relationship with him. I told him he's my father but he said no. He did not believe me. I was very young when we married.” (S12)

4.3.10. Perception on roles

The participants had their own perceptions concerning their caring roles based on what they claimed was socially acceptable. Participants deemed it their responsibility to care for a sick husband.

“Yes. It is my responsibility to care for him. Nobody knows what will happen tomorrow. My husband has helped me before so if he is also not well and needs help, I must also stand firm and look unto the Rock.” (S8)

“It is right to care for him. As a married woman, you should be able to take care of your husband if he should fall ill.” (S2)

“There are some people who get married because of money and those who do it for love. If you married for love, then if your partner is ill, then you are also ill.” (S1)

Some participants said it was time to reciprocate what the men used to do for them.

“Yes it is my responsibility to take care of him. The secret is that, I had three (3) children before I met him. I do not have any child with him. So when he married me, he took proper care of me. He provided everything for me. So I would do the same for him (sharing tears)”. (S12)

Some also thought society will point accusing fingers at them if they do not show concern.

“Now, with his illness, I am not able to go anywhere. I only go to the market. Apart from that, I am always at home. Or when his relatives come around, I tell them to keep an eye on him whilst I attend to other errands. And because of the state he is in, it is impossible to leave him alone. And also people might speak badly about me if I leave him alone.” (S12)

4.4. Psychological wellbeing

This major theme seeks to answer the third research question, “Are there any psychological consequences of advanced prostate cancer on spouse of men with the condition?” The subthemes under this major theme were anxiety, depression, fear, distress,

difficulty coping and concentration. Empathy and secrecy were the newly emerged sub-themes.

4.4.1. Anxiety

The toll on caring for a loved one with advanced prostate cancer is accompanied with lots of anxiety. Participants demonstrated lots of worries on several issues.

Participants shared worries on their husbands' conditions.

"His sickness caused me a lot of worry because he had never been that sick before." (S1)

"I feel worried sometimes but God told me that I should not worry so it shall be well." (S3)

"I am thinking about my husband. I do not have menopause. It is my husband's illness that I am thinking about... I stay with him in the house. Now that he is currently here and on admission, when I am going to sleep, I think about him." (S6)

Some participants also worried about whether they were going to lose their husbands.

"I get worried he will die. Simply because of how he looks and also we are now putting things together for him to undergo the operation. So far we have just been able raise GHC 400. When are we going to raise the amount of GHC 200"? (S7)

"I worried about so many things. Was he going to die? Would he be able to walk again? Would I have to stop my work to take care of him? So many things." (S13)

Participants also worried about their businesses and money.

"Currently, it is his illness that is worrying me. I am not doing any business so I do not have any money. I think about the illness. If I start thinking about my own illness, then he will also think about it. So I tell him to forget about it and that when he gets well, I will also get rest" (S10)

"Because he is not able to take care of himself, I've had to stop my own work to take care of him." (S12)

Participants worried about the upkeep of their children.

"At first, I was very worried. But now, I know God is in control. I worried about him dying and leaving me alone to fend for our kids. Because one of them is at Kwame Nkrumah University of Science and Technology, the other one has finished and is doing the national service." (S13)

4.4.2. Depression

Most participants showed different states of depression. Participants expressed sadness because of their spouses' sickness and the persistent pain. Others were also depressed about the pain their husbands were going through, the nature of illness, lack of support, and lack of money.

Participants cried as they lamented on their experiences.

"Hmm, the way he is not walking and the continuous pain. 'Crying.' Because if someone is sick, he has to recover which means the person is been healed but now he recovers slightly and the sickness comes back again, he sleeps small and wakes up." (S3)

"He is not well. Why should I also come and add my illness to his worries? So when he asked me whether I was ill, I did not respond. I have had patience and I am taking care of him." (S6)

"The secret is that, I had 3 children before I met him. I do not have any child with him. So when he married me, he took proper care of me. He provided everything for me. So I would do the same for him 'Crying'" (S12)

Participants openly said they were sad because they could not do anything for themselves to earn money.

"I get sad because I am not able to do anything. That I am not able to go about my work and earn some money. So more often I do not have money. The other day, I was very sad when he was admitted to the hospital. I know taking care of people with his illness costs a lot of money." (S12)

Some participants were sad because money had been spent and had little money to buy food.

"Yes! Even 30 million. And sometimes we do not even have enough for food. So it makes me very sad. Even the medicines is very expensive. Let alone the admission fee and numerous lab tests that you have to do. Sometimes you cannot even do the lab tests inside the hospital because the equipment are broken. So you have to do it outside. The health insurance does not cover it all." (S12)

Participants were depressed for lack of family support.

"I wept a few days we came back from the hospital due to his condition. There was no help, no help from his family members. I called our church Apostle to tell him and crying. Indeed, I felt so sorry because he was in pain and there is absolutely

nothing I could do for him, and I said to God “this cross is too heavy for me.” I felt sad and I began to weep.” (S5)

4.4.3. Fear

Participants showed a lot of fear. Participants anticipated and feared the possible death of their husbands.

“Well, I panicked a little when he told me he was lucky to have the cancer where it was and not on his spinal cord... Because he talked about death. But as a Christian, I know it is not the end. I realized it was just human nature to panic a little.” (S4)

“What I am afraid of is my husband dying and leaving me here alone. His death will cause a lot of problems.” (S6)

“Hmm, when it was severe and was admitted at the hospital, I was scared he will die because there was a time he asked me to bring his church communion card, so there he told me when he dies he does not want to be buried as a chief since he is holding the chieftaincy duties for the town which really scared me” (S9)

“I feared that daddy would die and leave me and children.” (S13)

“I wondered if he would ever be well” (S2)

Participants bargained the death of their husbands.

“Yes, had it not for God something terrible might have happened by now. The men of God said he will suffer but will get well at last. However, when God the giver of life wants to take him I have nothing to say because death is inevitable as far as mankind is concerned. I also know he will suffer but he will be healed in Jesus name. We are the children of God and if he is suffering and God says he will take his life we don't have any say but we are saying that God should fight for him so that he will be alive so that my suffering will not be in vain. God should add another 10 years to his age.” (S3)

“If I get 15 years more, I would be quite happy. He is 85 now, so if he lives up to a 100, I would be very happy. He should live a little more for me” (S12)

However, there were some participants who showed acceptance of any outcome of their husband's condition.

“I don't have doubts. I know God will do it. Because from where we were to now, If God calls him, I would give praise to God. Everybody has seen what God has done.” (S13)

“Ok, I focused on the fact that, everything is in God's hands, so I was ready to accept any outcome. So I stopped thinking about it and rather prayed for him.” (S4)

4.4.4. Distress

Participants grieved over two things under this subtheme. Participants grieved over the pains and certain deformities their husbands had.

“I really get distressed and sad because he has reduced in stature. He does not look like he used to be. I wonder whether he is going to die or not” (S7)

“Sometimes I feel a lot of pain inside me. It is difficult for one person to be going through all this pain from different parts of the body.” (S8)

“In every marriage, there are misunderstandings which come and go. There was a little quarrel. There are things that I do not understand. Some is from my side and sometimes it’s from him.” (S6)

Some participants lamented on their own inner pain which they kept to themselves.

“I feel pains in my body. I do not want them to see it. They would be worried and I do not want them to be worried.” (S13)

Participants were distressed with the workload and fatigue.

“I do not get angry but it’s tiredness I must say. My granddaughter is full of laziness. This is not our own house therefore I need to keep the house clean at all times so that the owner will be happy. I do all the work and so it is due to tiredness.” (S9)

Some participants also anguished over the quarrels and anger from their sick husbands.

“We do quarrel a lot but we do make up by the following morning. If I brought the quarrel and daddy is annoyed with me, I go and sit by him or sometimes, I will offer him candy which he would refuse and then I would pretend to force it into his mouth. Or sometimes, I pretend to need something, and then I would go and worry him with it. That is how we start to solve our own problems.” (S13)

However few participants said there was no need to bear grudges with their sick husband.

“I know it is not his fault so when he gets angry, I do not hold it against him. I laugh at him and say that I am leaving then he calms down. An ill person needs to be pampered.” (S12)

4.4.5. Difficulty Coping

The participants lamented how difficult it was for them to cope with some of the things they experienced. Participants found it difficult to cope with queries and insults from the patients.

Husbands showed gestures of dissatisfaction.

“This is because the way the person is, he is the one going to insult you and shout at you. Sometimes when you serve him food in the afternoons, he will just be shouting and asking, ‘why have you served me with this hot food’? For instance, he normally goes to private before his breakfast so get furious if you go and call him for his breakfast while he has not moved his bowels” (S5)

“Sometimes he gets angry when he thinks of his past, when he was strong and could do things well. So sometime he might get angry as he realizes he cannot do things as he used to. Someone may get angry and the little thing you say to them, they may become furious because he will be thinking of the old good days when he was strong doing all sorts of things. And now that he cannot do anything, he will become angry.” (S4)

The other issue some participants complained bitterly on was the unconcern attitude of some people they live under the same roof with.

“Hmm, sometimes I think of the fact that he has a son but the son does not care, he does not get close to the father. For a long time, the boy does not get close to his father. The son does not also talk to me, and based on that I think he feels guilty to close to his father. I asked my husband to give me their family head’s phone number so that I could report the issue to the family head.” (S5)

“I do not have anywhere to go to. I must do it. My son, whose house we live in, cannot care for his father. My daughter-in-law does not care. She never went to visit my husband on admission. My son was angry with her. Even when they were in this house with us, she never said hello to my husband who is her father-in-law. It is my responsibility and I will do it till the end when God will take my life.” (S9)

4.4.6. Concentration

Participants said they had to adopt certain strategies to enable them pay attention to the task they have committed themselves to perform. The participants reported that they the participants had to disconnect from relatives and friends who discouraged them. To some of the participants, staying focused was strength derived from God.

Participants had to avoid relatives and friends who discouraged them in order to concentrate.

“When my mother came she realized that I was the breadwinner, so she discouraged me. So I had to send her back home... I am not sad, that is why when my mother advised me to leave him, I decided against it. So I quickly sent her back home so that I can have peace of mind to do what I was supposed to do.” (S1)

Participants acknowledged they could not have remained focused without the strength from God.

“God is the provider of my strength. I am not a strong person but God knows I need to be strong in order to care for him and so am able to wake up each morning with my strength renewed by God. That is what is keeping me not to break down.” (S5)

“It is because I have Christ in me because with Christ all things are possible since I always pray for him and he sometimes joins us in prayers.” (S7)

“It is from God. What we are going through is very difficult. God is my helper and he has been helping me.” (S8)

Some participants took consolation from the word of God to stay focused.

“I am able to do it because I have realized that just as the word of God says that you should help your neighbour, I cannot say he is sick therefore I must leave him.” (S9)

“Because we live by His laws, and guidance, we do not do anything that will put us in harm’s way. We are advised to care for each other.” (S1)

Participants said they need not think about the difficulties involved in the care for patients with advanced cancer. They do it anyway.

“It is not as though somebody will come and do it for me so I have to do it myself. So, I do not think about it too much.”(S8)

Participants were also motivated by appreciation shown them by their husbands and friends.

“Who will take care of him? His family, no. But his friends appreciate what I do. When they come, they ask of me and thank me. They also talk to me about taking care of him. They do not say things that will worry me.” (S10)

“Also he appreciates the fact that am taking care of him. He even says thank you and well done whenever I serve him food. I am also glad.” (S9)

4.4.7. Empathy

This was the extent at which participants identified themselves with exactly what they thought their husbands were going through. Participants felt that part of them was sick.

“Because we live by His laws, and guidance, we do not do anything that will put us in harm’s way. We are advised to care for each other. So I take it that a part of me

is sick. I do not complain; it will be like I am disgracing him. I do not tell anybody our situation. There are some people who get married because of money and those who do it for love. If you married for love, then if your partner is ill, then you are also ill.” (S1)

Some participants also empathized with their husband’s pain.

“I felt so sorry because he was in pain and there is absolutely nothing I could do for him, and I said to God, this cross is too heavy for me. I felt sad and I began to weep.” (S5)

“I feel sorry for him. I can see that he is going through a tough period.” (S12)

4.4.8. Secrecy

Some participants were of the view to keep their experiences as a secret for their personal reasons. They also had preferences even when they had to let others know about their situation. Some participants told only their close siblings.

“I do listen to the radio a lot. So I also get some inspiration from the radio stations. Because if you tell someone what you are going through, and you do not take care, what the person might tell you will cause your death. I only told my sister... they also came. They prayed and advised me. I only take their advice when it is good.” (S13)

“The kids know it. Apart from them, my elder sister who has gone out also knows. He and her husband went to see the same doctor.” (S4)

Other participants just did not want people to be aware of the real situation.

“So, he started little by little in the house, walking. One time I said let us go to the park. We will go around 4:30am because I do not want other people to see him. When we return, I will fetch water for him to bath and find something for him to eat.” (S1)

“Some of the people in the house we live in know he is not well. But I do not take his story outside so they do not know exactly what is happening” (S11)

Some participants preferred to have only church members as their confidants.

However, those church members were elderly.

“Those I attend church with. Two women that I know. They are the only ones who know. They are advanced in age and would not talk any how about his condition. Well, it is something that you shouldn’t be eager to put out there” (S2)

“Those from the church did not come to visit. So they do not know about it. There are these two women who know about his condition and sometimes come to visit. I do not have the time to go and make friends.” (S8)

“I do not go near friends. I have friends but I do not go near friends. If it is a friend, then maybe a church member... Some know. Those who come; only two elderly members. A man and a woman.” (S6)

“I have two networks. But if I do not reach him directly, I call someone else to check on him. There is a man over there, Bro AB. I call him and he tells me when he went my husband was asleep... we attend the same church.” (S1)

In addition, participants were of the view that they cannot let other people know about their real situation.

“No. I cannot do that. I am not sure it is nice to tell people that my husband is . . . well the church visitation team came to see him before the surgery, but I am not sure if they were informed of his condition. I cannot tell.” (S4)

“I do not complain; it will be like I am disgracing him. I do not tell anybody our situation.” (S1)

Other participants had best friends they could confide in.

“It is been like this all this while of which a friend of mine is equally aware of the situation at hand so she sometimes advises me. Just one friend. She is my best friend. She gives me pieces of advice” (S7)

4.5. Spiritual Wellbeing

This was the fourth major theme which seeks to answer the last research question.

The subthemes were: meaning, hope and religiosity.

4.5.1. Meaning

It was observed that the participants had individual connotations and inferences with regards to their experiences. The spouses interpreted what they were going through in diverse ways.

Participants felt that their situation was spiritual and that other people were responsible for their husbands' conditions.

“I believe the illness is spiritual. Somebody gave it to him, someone collected my husband's car. He returned the car and my husband sat in it. After that, my husband

complained of his waist. That was all. This is where the illness is from, from a friend.” (S6)

“When he went to see the pastor he came back home to tell me that after the pastor placed his hands on him the pastor said someone has “juju” my husband. The pastor then prayed for him and gave him some anointing oil to come and use, but still the pain was there. He kept complaining of pain in the thigh and arm.” (S3)

“He was well before we went for the funeral. His mother was the one having catheter and was not feeling well. After the removal of the old lady’s catheter, my husband started experiencing urinary difficulties. There are spiritual issues my sister. It was a spiritual thing that was transferred to my husband.” (S5)

“Initially I thought as much during the initial stage but I believe in one thing that it is only God that can take the life of someone, so I took mind off it. There was a land issue between him and some people and above all his legs were swollen so I had so many things running through my mind but my son always tells me it is prostate.” (S9)

Some participants were superstitious.

“It was his close friend who gave me twenty cedis for transport home. I used my left to collect the money and gave it to my daughter to use it to buy prepaid credit for electricity.... What I know is his friend is a bad friend. You should depend on God rather than friends. That is why I collected the money with my left.” (S6)

Participants reported that sickness is part of life and were normal for one to fall sick.

“It is a situation that has arisen. I do not blame God. Diseases have always been there, so I do not blame anyone. It is Adam that has brought illness and disease to man so I do not blame anybody.” (S1)

“It is the world. Some have it worse than this. It is life. You cannot get it easy all the time. Every year and its problems. I never thought I would face this problem in 2017. But it is already here so you have to cope with it.” (S12)

There were participants who said their situation was both physical and spiritual.

“When his sickness started and it was not severe, I did go and stand in for him. Because some of these things, you see at as physical but the spiritual aspect is also there. So whilst dealing with the physical, you also deal with the spiritual.” (S13)

Some participants perceived their situation as a result of some form of sin they committed.

“I thought he was going to die. And I did not know what to do or how to live on my own. And I did not want to get married to another man. So, I prayed to God for forgiveness. If we had unwittingly committed a sin.” (S1)

Participants also lamented that their situation was either a cross or a test from God.

“You know sometimes God brings something on us to test our pulse. And I always say that if God gives you something to carry, He would also give you something to put on your head before you carry the load. I encourage myself that, it is the cross God has for me. If it is time to lift it off, He would do so.” (S13)

“I said to God, this cross is too heavy for me.” (S5)

4.5.2. Hope

Participants expressed their faith and expectation. All participants hoped for their husbands' recovery. Participants expressed the hope that their husbands were already healed by God.

“I have faith in God. I believe he is already been healed. When I think about what others go through, I think he had it easy.” (S2)

“I have faith in God. I believe he is already been healed. When I think about what others go through, I think he had it easy.” (S1)

“He has already healed him. He has healed him in the spirit. It is only left for it to appear physically. We met many people at the hospital but not all of them were able to go back home. We trust in God and we have put all our trust in him. He is the one who heals.” (S13)

However, some participants hoped in the healing of their husbands from other gods.

“Somehow yes, there is hope here (shrine) than the hospital. He said we have been to the hospital for some time now and he is not getting well, besides the doctors at the hospital were the one who told us to leave and not us. My hope is for him to get well.” (S3)

Participants also trusted God for their husbands' recovery in anticipation.

“God has not failed me. God is Just. Whatever he promises, he never fails so he has not failed me. Whatever He says, He does it. It is only human nature to fall sick. He has got his early and is on treatment. So God has not failed me. And fortunately, he has drugs to treat it.” (S4)

“I know he will recover. My hope is that he will recover, and that all that I am doing would not be in vain” (S12)

“The pastor from my church came to pray for him. When the pastor came, he told him he could not walk and that he could not even see properly. But after he was operated upon, his eyes are able to see. I am hopeful that by the time we leave Korle-Bu, my husband will be well. They said they were working on him. They took him for x-ray. When his children came, his children were told that their father was standing again so we were all happy.” (S6)

“Now he is able to walk but not properly. I hope by the grace of God, he will be fine and start walking properly soon.” (S13)

4.5.3. Religiosity

All participants were Christians except one who was a Muslim. As the investigator seeks to participants expressed their religiosity in various ways. Participants believed in God.

“I believe we should involve God in everything we do. And that we should be honest as God requires of us... So I try my best to live by God's standards. It is not money. It is that that has helped me.” (S1)

“God would have answered. Because he loves those who love Him. And whoever follows Him would not be disgraced. So I knew He would not have forsaken me.” (S2)

“I ask God to help me so that he gets well because I do not get any help from any family member. No family member comes to see us. So at times I get sad. ‘Crying.’” (S6)

Participants were involved in a lot of prayers towards the recovery of their husbands.

“I have faith in God. I pray all the time. Jesus Christ is the great healer. So I prayed to Jesus to heal him.” (S2)

“When things got out of hand, I prayed to Him and He heard me.” (S6)

“With such an illness, if you do not know how to pray to take care of yourself, you would die.” (S13)

“However, the sickness came again we decided to move from one prayer camp to the other in search of long lasting solution.” (S3)

The situation in which participants found themselves got them closer to God.

“Before the illness, I did not know God but now I know him. I have spoken to Him (God) and he has answered my prayers.” (S6)

“I will say that my relationship with God has increased than it used to be. This is because without God, I would not have had the strength I have. God is my strength.” (S5)

“God has been so good to us. If you see him at first, he is so lean but by the grace of God he is ok so I must give thanks to God. His sickness has also increased our faith in the teaching of God. We are closer to God.” (S9)

Participants could not leave their sick husbands to go to church and stated the church is in the house.

“Now that my husband is in the hospital, I do not go to church. But I take money to church every week. I will take some of the money to church tomorrow.” (S6)

“If he is well, I can leave him and go out. But you don’t know what will happen to him if you leave him and go out. God will listen to you if you pray in house.” (S8)

“Church? My sister, let me tell you, it has been long since I went to church. I pray in my room a lot. Because I could see that the church is inside you. Because daddy is ill, I could not leave him and go to church.” (S13)

4.6. Spousal involvement in the care of a partner

Spousal involvement in all aspect of the man suffering from advanced prostate cancer emerged as a major theme from the study. Two subthemes also emerged and there were: knowledge on disease condition and consent to treatment.

4.6.1. Knowledge on disease condition of a partner

Participants reported a lot of views on what prostate cancer is. Participants lack knowledge on the signs and symptoms of the disease and had their own interpretations of what the man was experiencing. Participants lack adequate information on the presentations of the disease.

“Two years ago, he started complaining about his legs. He said it hurt a lot. All these while, we didn’t know that it was prostate.” (S2)

“But I would like to know if it can be cured? I would have asked the doctors if I had gone along with him on his hospital appointments.” (S1)

“Well, I want to know if cancer can cause a person to paralyze. We were expecting the doctors to tell us more about my husband’s sickness, but they rather said cancer has taken over all the body.” (S3)

Participants were not familiar with their husbands’ medications.

“He’s supposed to be on that drug for two years. They are very little. They break them into two.” (S1)

4.6.2. Consent to treatment

Participants' involvement in the palliative treatment of the advanced prostate cancer patient was less. Only one participant was directly involved in the treatment option for her husband.

“On our third visit, a certain doctor told us of the risks involved in surgery. He explained that, some people might be able to ejaculate, others are not able to ejaculate. And also that, some are not able to wake up at all. So it is about luck... So the doctor urged us to go and think over it because some people come back to quarrel with the doctors over adverse results after an operation. I insisted on going ahead with the operation.” (S13)

“Moreover, the reason why am saying this is because when my husband was placed in a machine at the hospital, we did not see any change.” (S3)

4.7. Summary

The findings written were all from the data generated from spouses of men with advanced prostate cancer in the Accra Metropolis. The findings revealed the experiences spouses go through with their partners along the trajectory of advanced prostate cancer. Findings of this study will add to the gaps in existing knowledge within the areas of similar studies. The findings will also lead to amendments if not new policies on the care of both husband and wife unit rather than only the cancer patient by stakeholders.

The conceptual framework which steered the study was Quality of life model adopted by family caregivers by Betty Ferrell (2001). The study used all the constructs in the frame work which were: physiological wellbeing, social wellbeing, psychological wellbeing and spiritual wellbeing. The framework supported all the findings of the study including the new themes that emerged in addition to those within the framework. A major theme; spousal involvement fell outside the framework. From the findings of the study, fatigue, sleep disruption, pain, appetite were consistent with the model. Pre-existing diseases emerged as a subtheme but fits under the physical wellbeing domain. The social wellbeing domain was also consistent with the following subthemes of the finding: isolation, role/role

adjustment, affection/sexual function, financial burden, and employment. Fidelity/honesty and thoughts of divorce were the emerging subthemes for the social wellbeing domain. Anxiety, depression, fear, distress, concentration were all consistent with the psychological domain of the model.

However, four subthemes which emerged under this domain were empathy, secrecy, perceived relationship with husband and perception of roles. In addition, the findings for meaning, hope and religiosity, were also consistent with the spiritual domain of the model. Nevertheless, knowledge on diseases and consent on treatment which emerged under a major theme spousal involvement, were not consistent with the model. The themes and the sub-themes are as below in Table 4.1.

Table 4.1: Summary of Themes

THEMES	SUBTHEMES
1. Physiological wellbeing	a. Fatigue b. Sleep disruption c. Pain d. Appetite e. Pre-existing diseases
2. Social wellbeing	a. Isolation b. Role/role adjustment c. Affection/sexual function d. Leisure activities e. Financial burden f. Employment g. Fidelity/honesty h. Thoughts of divorce
3. Psychological wellbeing	a. Anxiety b. Depression c. Fear d. Distress e. Difficulty coping f. Concentration g. Empathy h. Secrecy i. Perceived relationship with husband j. Perception of roles
4. Spiritual wellbeing	a. Meaning b. Hope c. Religiosity
5. Spousal involvement in the care of partner	a. Knowledge on disease condition of partner b. Consent on treatment

CHAPTER FIVE

DISCUSSIONS

This chapter presents the discussion of the findings of the study. The study findings reported on the experiences of spouses of men with advanced prostate cancer in the Accra Metropolis of Ghana. The participants showed keen interests in the study as participants reported the ordeals of their partners with advanced prostate cancer. The chapter includes discussions of the major themes as applied in the literature. The themes are Physical, Social, Psychological and Spiritual wellbeing of spouses of men with advanced prostate cancer. The discussion also focused on spousal involvement as a new emerging theme of this current study.

5.1. Characteristics of Participants of the Study

In this study, most of the participants were above fifty years of age and have marriage life experiences between eleven and fifty eight years. Thirteen (13) participants were involved the study, twelve of the participants were Christians and the rest a Muslim. The religion of participants as seen in this study was reflective of the Ghana Statistical Survey organized in 2010 that majority of the populace are Christians. All the participants in this study have children with their husbands diagnosed with advanced prostate cancer except two who although had children but not with their current husbands. Majority of the participants were petty traders representing the economic status of the Ghanaian populace (Dolphyne, 1991). The study revealed that spouses of the terminally-ill husbands had to endure both psychosocial and physical stresses. Most of the participants stopped work and businesses in order to fend for the family since their partners were not in the right conditions to take responsibilities of their families. As reflected in the work of (Aziato, Odai, & Omenyo, 2016), most of the participants sought spiritual help for their spouses as they would do for themselves as participants. Places like the shrines were consulted.

5.2 Physical Wellbeing

Under this theme, the study explored the experiences of participants regarding fatigue, sleep disruption, pain/ache, appetite and the effects of pre-existing diseases. The study findings were consistent with the findings of (Ferrell, Ferrell, Rhiner, & Grant, 1991) regarding these subthemes. Most of the participants reported fatigue based on the daily assistance they provided to their bedridden spouses. (Martin et al., 2012) confirmed the assertions that the caregivers of advanced prostate care patients work throughout the day in the process of caring for their sick husbands. Furthermore, (Esbensen et al., 2012) confirmed that, in some instances the caregiver experiences fatigue as a result of the enormous caring task of caring for their prostate cancer partners. It was realized that throughout the cancer trajectory, both patient and partner must together cope with the practical issues and difficulties that the couple may encounter (Dankoski & Pais, 2007). However, in the case of this study, spouses of husbands with advanced prostate cancer had to cope all alone with the demands of the conditions and hence, this was not reflective of the situations among the participants of this very study. It was also realized that the older the participant, the highly likely they complained of fatigued with task of care. This findings mirrored that of (Hughes et al., 2009).

Sleep disruption was reported among most of the participants. Some participants had sleepless night and others had to take sedatives (sleep medication) in order to be able to sleep. This finding corroborates the study by (Glajchen, 2012a) that lack of sleep is a challenge to the physical wellbeing of the caregivers. Spouses are interrupted in their sleep due to the fact that the spouses live with the patient living with cancer and the instances of insomnia was as a result of anxiety and depression. Similar research were carried out by (Ashing-Giwa, Lim, & Tang, 2010; Aziato & Adejumo, 2015; Greimel, Winter, Kapp, & Haas, 2009) confirmed these assertions.

Pain was common among participants in the current study. Most of the participants attributed their pain to the caring roles such as massaging and lifting their sick husbands. These may be as a result of wrong lifting and positioning techniques, lack of support and their inability to rest. Pain is a problem in cancer care giving (Beach et al., 2011; Barbara A. Given et al., 2012) and this was the case of all the participants recruited in this study. This suggests that participants may need some education on body mechanics from nurses to enable caregivers assume appropriate positions during lifting care roles. In- service training on pain for family caregivers at all levels must be encouraged. Again specialist programmes in preparing nurses for pain management as suggested by scholars in pain (Aziato & Adejumo, 2014) must be encouraged.

Some participants also reported that, they had no appetite for food. There were others who engaged in fasting and these prevented them from eating. Though others had no problem with food, some were selective of the kind of food. The study supported the initial study by (Aziato et al., 2016) on the religious beliefs of Ghanaian women. It was clear from this study that, most women will avoid food in order to seek help for the cure of their husbands. There were similar studies which confirmed the assertion that altered appetite affect the physical wellbeing of spouses caring for their husbands during the cancer trajectory (Beesley et al., 2011; Yesilbalkan & Okgun, 2010).

Participants presented increase in their blood pressure with associated pre-existing conditions such as diabetes and asthma. A study by (Northouse & Katapodi, 2010) explained that some spousal caregivers had loss of control of their chronic diseases such as diabetes or heart diseases. Moreover, the researchers opined that these caregivers developed high blood pressure and alteration in lipid profiles. The participants further reported altered immune responses. Sherwood, (2016) also confirmed this response among a similar population in USA.

5.3 Social Wellbeing

The study explored the social wellbeing of spouses and identified various subthemes including isolation, roles/role adjustment, affection/sexual function, leisure activities, financial burden and employment. The study identified new subthemes that were not part of the model employed regarding fidelity/honesty, thoughts of divorce, perceived relationship with husband and perception on roles.

Most participants reported family neglect and isolation. The study reported that, most participants were left to care for their spouses with advanced prostate cancer and this resulted in loneliness. Participants also reported that, they were not able to engage their spouses in conversations which increased the participants' levels of loneliness. Though several studies have reported on the benefits of open conversation among couples as may directly or indirectly enhance both spouses and their partners' sense of self-efficacy (Campbell et al., 2004; Kershaw et al., 2008; Song, Northouse, Zhang, Braun, Cimprich, Ronis, & Mood, 2012), this was otherwise seen in this current study. Participants reported reasons as being a burden to their partners and hence would not want to complicate their partners' situations. The researchers further opined that, open conversations among such couples give a boost for positive reciprocal influences on the conditions.

Most participants in this study also carried out their roles responsibly and assisted their partners as an obligation. Some of the spouses prepared their partners' meals and assisted the partners during bedtime and feeding. These roles might have been obligatory to the spouses considering the cultural setting of the study. In addition, Waterhouse, Hill, & Hinde, (2017) explained the roles of women as mothers, and this make the spouses assume complete caregivers as seen in this current study.

Sexual feelings were one of the issues participants expressed. While some of the participants said they sought to diversional therapies anytime there was some feeling for

sex, others had no feelings at all because of the state of their husbands. This was because spouses get worried and anxious at their partners' conditions and hence, are not in good mood to start any romance. Other studies revealed that, because caregivers tend to be enshrined in a vast number of roles, the feeling of sex is difficult to be perceived in such situations. Participants in this study may require proper coping skills to enable them overcome their stresses and have a normal living statuses.

The participants raised lots of concerns on financial burden. Most of the patients were retirees and the middle aged spouses were also into petty trading. For example, most of the participants sold foodstuffs and household equipment. The caring role also made participants abandon their business. Despite the financial difficulties, the spouses reported that they would not leave their husbands unlike reported in another study where financial problems caused divorce (Andersen, 2001). Morgan, Small, Donovan, Overcash, & McMillan, (2011) also reported that although financial burden is a significant factor to consider, nevertheless, it was a pertinent negative finding because financial problem is a significant stressor for couples. The cost of hospital bills coupled with inadequate health insurance coverage on cancer was another major problem raised by the participants of the study. The participants reported depleted financial accounts, this findings mirrors a similar findings in the United States (Andersen, 2001; Ware, Kosinski, & Keller, 1993). This calls for the nurse' advocacy roles. Patients living with advanced prostate cancer in the Ghana so as to gain the maximum support from all stakeholders in connection with insurance and financial support.

Again the findings of the study disclosed that majority of the participants were informal workers where the participants are not protected by any labour legislations like mandatory annual leave, casual leave and maternity leave (Government of Ghana, 2003). The spouses managing their own businesses had some form of flexibility in their work,

which enabled them concentrate on their caring role. This was contrary to the work of (Clarke, 1999) which highlighted the need for informal wholesalers and traders to work at certain times of the day to get the best business. Some of the spouses also referred to their sick husbands as babies, which interrupted with their work as reported by Clarke's (1999) in a study of Asante traders. Similarly, the staff of University of Ghana saw child illness and picking of children from school as a challenge to work (Annor, 2014).

Participants referred to their immediate family as friends and did not have time for leisure activities due to the demanding nature of the care the participants render to their sick husbands. This is found in existing literature (Miedema et al., 2011). Some also claimed going out for fun would raise eyebrows because it was not morally accepted for a caregiver to leave the sick and engage in any fun (Treas & Mazumdar, 2004). Other studies have attributed this to the feeling of shame and guilt which might be preventing the caregiver from engaging in pleasurable activities while caring for a loved one like a husband (Wakui, Saito, Agree, & Kai, 2012).

5.4 Psychological Wellbeing

With regards to the psychological wellbeing of spouses of men with advanced prostate cancer, this study unveiled that participants were anxious and depressed about many issues such as the condition of their husbands, loss of their jobs, financial issues and others. Furthermore participants expressed fear, distress and difficulty coping with their situations. However, they were able to concentrate on their caring roles. Again the study revealed that participants empathized with their sick husbands, and ensured secrecy. In Ghana where the belief system of the married couple does not permit couples to expose the marital issues, this study concluded that, this might have accounted for the high levels of secrecy upheld by the participants (Gibson-Davis, Edin, & McLanahan, 2005).

In addition, the participants ensuring secrecy had perceived or personal reasons for avoiding open communication about their situations as reported by other studies. Some of the participants in the study shielded their pain and distress from the patient and children so as to maintain normal happiness among their families. Other studies also reported on this (Canary & Dainton, 2006; Knapp & Daly, 2002) Keeping to one's self and not making the attempt to disclose their status of wellbeing to other family members probably might be due to dissatisfaction relationship with those family members (Cupach & Spitzberg, 2007). The participants were also of the view that telling other people about their experiences will not solve the problem hence it was better to keep it private as disclosed by (Elal-Lawrence & Celikoglu, 1995) in their study. There were others who also kept their situations secret because they had the hope that with time and with God, everything will return to its normalcy. This, was also discovered in an earlier study by (Goldsmith, Wittenberg, Platt, Iannarino, & Reno, 2016).

Participants were anxious about their husbands' conditions; whether they will lose their husbands or not, lose their jobs and the upkeep of their children in case the man passes on. Participants were also worried about their businesses and financial difficulties. These worries if not controlled, may exacerbate anxiety disorders among the spouses as ascertained by (Zwahlen et al., 2008) in their study on the quality of life and psychiatric morbidity in patients with cancer and their wives in Zürich, Switzerland. The findings of the aforementioned study revealed that wives of patients living with cancer have high prevalence of some psychiatric disorders especially anxiety disorders than the patients. The findings of the study also coincided with the study by (Mitchell, Ferguson, Gill, Paul, & Symonds, 2013) that anxiety and depression levels among spouses of patients living with cancer are as high as the anxiety and depression among the patients. The spouses may need counseling to enable them cope with the situation.

This study also identified the different states of depression among participants. Participants expressed emotions as the participants presented their experiences of living with husbands with advanced prostate cancer. Furthermore, some were helpless and depressed for being unable to provide the family needs considering the states of their husbands. The study reported lack of support from the extended families. Notwithstanding the conditions of participants, they were keen in their roles as spouses to support their terminally ill husbands because they had no option and perhaps their cultural background will not permit them to do otherwise. Few studies have reported positive association between mental health and spirituality among caregivers (Kim, Schulz, & Carver, 2007; Vallurupalli et al., 2012). The participants were keen on their roles due to their beliefs.

Participants reporting on distress were consistent with existing literature (Bevans & Sternberg, 2012). The attempts of the spouses hiding their pain and anguish could cause them lots of distress coupled with fatigue which might probably contribute to their inability to sleep soundly, even when their sleeping hours were short. The study did not target the distress levels of caregivers and the patients however, it had been reported in other studies that the cancer caregiver level of distress is greater than that of the cancer patient (Kim et al., 2007; Morgan et al., 2011).

The findings also revealed that spouses had difficulty coping with the unconcern attitude of some of the people they lived with, such as step son and daughter in-laws. Although all the participants were recruited from the Accra Metropolis, the study did not target the upbringing and cultural beliefs of the participants. According to the Juarez (2003) in her work on the perceptions of caregiving experiences, the traditional beliefs and norms may define the meaning of caregiving. Continuous education by clinical psychologists and nurses on cultural dynamics and marriage may be encouraged right from the onset of the diagnosis of cancer to patients, family members including all significant others. Furthermore

the responsibilities associated with caring for patient living with advanced prostate cancer can take vast toll on the entire family as reported by existing literature (Otis-Green & Juarez, 2012). The study concentrated on only spouses but the findings revealed that other members of the family were involved in the care. Future study may involve the experiences of other family members of the patient living with advanced prostate cancer.

5.5 Spiritual Wellbeing

This study revealed much religious connotations regarding the beliefs surrounding cancer patients and the disease conditions. Most of the participants attributed their spouses' situations to spiritual causes and others believed that some other supernatural forces were responsible for their husbands' conditions. The assertion that cancer was as a result of external forces was confirmed by other research (Docherty et al., 2007; Kale, 2011b). It was not surprising participants went in sought of a miracle in this study. Furthermore, a similar one carried out by Hunsberger and his colleagues in 2014, showed how different religious involvement among Christians enabled patients and their family to cope with cancer depending on the level of support from their religious denominations (Hunsberger et al., 2014). However, some participants accepted their situations as being of the human life and so were normal for individuals to fall sick. Among the population who reported this, sought cure and hope to overcome the problems. This affirmed the report by (Olson, 2011) that, some spouses felt guilty for being optimistic and therefore focus on the future by believing that they will overcome the disease. It was also clear from the study that most participants used their religious affiliations for comfort and support. They reported how their husbands were affirmative of their devotions in hope of joy and happiness. Praying in a group, individually and at different times of the day and singing and reciting the word of God (Jesse, Schoneboom, & Blanchard, 2007) during prayers are characteristic of the Christian and Islamic religions in Ghana. Fellowship among prayer group members was reported as

reassuring and emotionally comforting (Hoga, Rodolpho, de Souza Penteado, Borges, & Chávez Alvarez, 2013; Jesse et al., 2007).

Participants also attributed their situations to God. The participants perceived their experiences as test or a cross from God. These perceptions made the participants to conclude that they leave everything in the hands of God as the Supreme Being. According to (Nukunya, 2003), most Ghanaians believe in the supreme God, deities or lesser gods and this makes the Ghanaian society a religious society. Similar studies revealed that participants needed to find meaning in God (Kim & Given, 2008) and also spouses who had faith in God in connection with the care they give, were able to overcome the stress of care giving on their mental health (Colgrove, Kim, & Thompson, 2007). Based on their faith, some participants interceded for their husbands at the prayer camps and prayed for their husbands towards early recovery. This was consistent with the findings of (Aziato et al., 2016) that women will like to seek help from their religious leaders.

All the participants expressed hope in the recovery of their husbands. The study confirmed the spiritual beliefs as portrayed in various studies that, the beliefs of life and religion play essential roles in the lives of most family members of patients with cancers (Frost et al., 2012; Hexem et al., 2011; Ka'opua et al., 2007). This heterogeneity of religious beliefs and practices across cultures make it relevant to elicit the impact of advanced prostate cancer on spouse's spiritual wellbeing. As the participants hope for treatment and recovery of their loved ones, spouses may be living without any guilt. However, complications in patients living with prostate cancer cause the feeling of guilt in their spouses. The feeling of guilt may raise doubts among spouses to think that their best was not enough to save their loved ones. Nurses should have special care programs for spousal caregiver of advanced and terminally ill patients. There may also be the need to address culturally sensitive spiritual care in the anticipation of the grief of the spousal caregiver.

It is obvious that satisfying the spiritual needs of spouses of patients living with advanced prostate cancer could be a vital component for nurses' assessment of the patients living with cancer and their caregivers. This is congruent with the recommendations of (Hodge & Horvath, 2011) that, an initial brief assessment should be made to assess the relevance of spirituality to clients' care within the clinical practice. In addition, the findings of this study were consistent with the work of (Hodge & Horvath, 2011) as they listed six kinds of spiritual needs during their work on spiritual needs of health care settings. The needs were: "meaning, purpose and hope; relationship with God; spiritual practices; religious obligations; interpersonal connections and professional staff interactions." The onus lies on nurses and other health care providers to open up to patients and their caregivers in order to satisfy some level of their spiritual needs. This may lead to the discovery of the religious affiliations of the patients and caregivers. The value of staff interactions with patients and caregivers may be perceived to be spiritually important because it promotes respect and dignity during nursing (Draper, 2012). Although other researchers like Paley is of the view that the nurse has no role to play in terms of the spiritual needs of clients (Paley, 2009), the context of this study may prove otherwise.

5.6 Spousal involvement in the care of a partner

It was realized from the study that two different sub-themes emerged from the participants' involvement in the care of a partner living with advanced prostate cancer. These were identified as the knowledge of participants on the disease condition and the consent for treatment. The study revealed that participants lacked knowledge on their husbands' conditions. Docherty et al., (2007) reported that, most non-professional cancer caregivers were more concerned with cure than the knowledge of the condition. This was the situation in this study, as spouses were not too sure of the right diagnosis of their

husbands. Caregivers struggle with many issues that lead to inadequate management of cancer pain (Vallerand et al., 2007).

Participants' knowledge concerning their spouses' conditions influenced their participation in the palliative care. It was realized that women participate less in the palliative care due to limited information of their spouses' conditions. Although the cancer patient might be the focus of the health care professionals, the findings of this study attested that the spouses experienced the same suffering as the patient. This is because the spouses were living with the partner suffering from prostate cancer and therefore are inevitably tied to their husbands. For this reason, it may be critical that spouses and other family caregivers be incorporated in the symptom management of cancer patients (Hazelwood et al., 2012). The report as derived from the responses of participants regarding their involvement was affirmed by (Hudson, 2003) in his report confirming the caregivers' experiences. The report confirmed that their support was dependent on how much knowledge they have regarding the palliative care. In a similar study in a neighboring country Nigeria, husbands' knowledge on cervical cancer was better than it was found in this study (Suzu et al., 2014).

Existing studies have revealed the importance of spousal involvement in the diagnoses and choice of treatment (Ballinger et al., 2008; Fang et al., 2011; Fouladi et al., 2013; Hawley et al., 2009) however, this was not demonstrated in this study. The issue was doctor-patient affair according to the reports from the participants. Most of the spouses felt left out in the choice of treatment for their husbands. This presupposed that the spouses were not responsible to giving consent in some of the surgeries performed in their husbands. This was also consistent in the works of Aziato and Clegg-Lamphey in their qualitative exploratory study within the Ghanaian setting (Aziato & Clegg-Lamphey, 2015).

The findings of the study disclosed that only one spouse was involved fully and consented to her husband's prostatectomy at the initial stages of the disease. This led to the

inability of the man to ejaculate after the surgery. Evidence from their sexual satisfaction showed that they have accepted the situation and have found other ways of keeping closer to each other as compared with those who did not have adequate knowledge and were not involved in some form of treatment for their husbands.

Previous researchers (Ferrell & Baird, 2012; Glajchen, 2012b; Otis-Green & Juarez, 2012; Yeh, Wierenga, & Yuan, 2009) have also used the Quality of Life Model Applied to Family Caregivers adopted in this study but looked at the domains of the model separately. Nonetheless, this study applied all the four domains to explore the experiences of spouses of men with advanced prostate cancer.

5.7 Evaluation of the model used

The Quality of Life Model Applied to Family Caregivers (Ferrell, 2001) was used to explore the experiences of spouses of men with advanced prostate cancer in the Accra Metropolis. The model has four major domains namely physical, social, psychological and spiritual wellbeing. The physical wellbeing domain has fatigue, sleep disruption, function, nausea, appetite, constipation and aches/pain as the subthemes. Function, nausea and aches/pain were not reported by the participants therefore did not emerge in this study. However, a new subtheme emerged from the study under the physical wellbeing construct and this was pre-existing diseases.

Isolation, role adjustment, financial burden, roles / relationships, affection/ sexual function, leisure activities, burden and employment are the subthemes of the social wellbeing domain of the model. Again, in this study, spouses of patients living with advanced prostate cancer reported on isolation, role/role adjustment, affection/sexual function, leisure activities, financial burden and employment. The rest of the sub-themes under this domain did not emerge but rather; fidelity/honesty and thoughts of divorce emerged for the social wellbeing domain.

The psychological domain of the model also has anxiety, depression, helplessness, difficulty coping, fear, useless, concentration, control, and distress for its subthemes. The findings of this study revealed anxiety, depression, difficulty coping, fear, concentration and distress emerged from the study, and the remaining subthemes did not emerge from the study. In addition, five new subthemes emerged from this study under the psychological wellbeing domain of the model. These were: empathy, secrecy, perceived relationship with husband and perception of roles.

Within the spiritual wellbeing domain are meaning, uncertainty, hope, religiosity, transcendence and positive change as the subthemes. Participants did not report on uncertainty, transcendence and positive change therefore only meaning, hope and religiosity emerged as the subthemes under this domain. No new subtheme emerged for the social wellbeing domain with respect to this study. There was also no modification made within any of the constructs of the model to suite this study.

The suggestion here is that, all the newly emerged subthemes within the domains could be unified into the model for future studies. In conclusion, the model was useful for the study.

CHAPTER SIX

SUMMARY, IMPLICATION, LIMITATION, CONCLUSION AND RECOMMENDATION

This chapter presents the summary of the study, the implications of the study to nursing, education, research and management. It includes the limitations, conclusion and recommendations of the study.

6.1 Summary

With the increasing rate of cancer and its effects on the family and caregivers, most burdens in the disease trajectory are borne by the spouses of the cancer patients. A qualitative exploratory descriptive method was employed to explore the experiences of spouses of men with advanced prostate cancer in the Accra metropolis with participants recruited from the radiotherapy centre and the surgical out-patient department of the Korle-Bu Teaching Hospital. A semi-structured interview guide was purposefully used to recruit thirteen (13) participants for this study. Ethical approval was given by the Institutional Review Board at the Noguchi Memorial Institute for Medical Research, University of Ghana. Participants who consented were interviewed and the data were transcribed verbatim. Participants were identified with codes and the data gathered were analysed using the technique of Braun and Clarke's data analysis. The study revealed findings based on the framework of quality of life model applied to family care givers (Ferrell, 2001). Participants ranged from the ages of 50 to 68 years. There were five major themes that emerged with their subthemes. Spouses of men with advanced prostate cancer were fatigued; participants experienced sleep disruptions, loss of appetite, pain and reported effects of pre-existing diseases. Others presented isolation, adjustment of roles, suppressed their sexual feelings and had no time for leisure activities. Participants had worries about their husbands' conditions. This led to most of them losing their businesses in order to cater for their

husbands. Other participants believed that their husbands' conditions required spiritual panacea and so they visited one prayer camp to another. Participants also lacked adequate information on the presentation of their husbands' diseases and so were not directly involved in the treatment options.

6.2 Implications

The findings of the study revealed several implications that needed to be addressed. These implications are in relation to nursing education, practice, research and administration.

6.2.1 Nursing Education

There should be a curriculum developed on oncology to train nurses in the various health training institutions. This will equip nurses with the skills in rendering holistic care to patients with terminally ill conditions and their caregivers (families). There should be specific contents on caregiver support, education and care in the curriculum.

6.2.2 Nursing Practice

Nurses should consider spouses of patients living with cancer as equally important as the patient and render holistic care to spouses and patients. Nurses should consider counseling as a major part of nursing care to spouses/caregivers of patients with advanced prostate cancer. This will go a long way to help spouses of men with advanced prostate cancer develop coping mechanisms. Furthermore, there should be culturally sensitive care integration at all levels of care rendered to patients living with cancer and the caregivers. Again, curative nurses should hand over patients and their spouses to preventive nurses in their communities for continuity of care. Home-based nursing must be included in the care of caregiver and the patient living with advanced prostate cancer.

6.2.3 Nursing Research

It was realized that the spouses were not the only caregivers involved in the care but there were other family members who were also directly involved in caregiving and might also be presenting some issues of concern. Further research is required to explore experiences of other family members who might be involved in the care of men with advanced prostate cancer. Again, culture might play a role in the experiences of spouses with advanced prostate cancer and so further research is required among multicultural groups to help establish findings as per other cultures.

6.2.4 Nursing Administration

The findings from this study revealed that, most of the participants were not involved in the discussion of treatment options for prostate cancer therefore, nursing administrators should involve spouses at every level of their husbands' care.

6.3 Limitation

The findings of this study focused only on the experiences of spouses of advanced prostate cancer. It is likely that, this might have influenced the findings in this study as this may not be the case among spouses of men with acute or other stages of prostate cancers. The findings also revealed that most of the participants were Christians than Muslims. Spousal experiences might be different among the two religions.

6.4 Recommendation

Based on the findings of the study, the following recommendations have been made to the Ministry of Health, Ghana Health Service, Nursing and Midwifery Council of Ghana, Ministry of Gender, Children and Social Protection, Counselling Experts, Religious groups, Christian Council of Ghana, Women Support Groups and the Korle Bu Teaching Hospital

6.4.1 Ministry of Health

The Ministry of Health should:

- i. Lobby government for the total payment of costs for diagnostic tests and prostate cancer treatment in the Health Insurance Scheme.
- ii. Prepare educational materials in collaboration with stakeholders to meet the spouses at all oncology units.

6.4.2 Ghana Health Service

The Ghana Health Service should:

- i. Implement policies on regular patients and caregivers' education on advanced prostate cancer and the coping mechanisms.
- ii. Establish oncology units in all Districts, Municipal, Metropolitan and Regional Hospitals where care can easily be accessible to caregivers and patients living with advanced prostate cancer.
- iii. Implement policies for the establishment of focus cancer care where male healthcare professionals will have interactive educational fora to enhance understanding on prostate cancer, discuss misconceptions and emphasize the need for family and community support.

6.4.3 Nursing and Midwifery Council of Ghana

The Nursing and Midwifery of Ghana in collaboration with the Ghana College of Nurses and Midwives should:

- i. Integrate oncology nursing in the curricula of all health training institutions as a general course.
- ii. The course tutor/lecturer must be a Specialist in oncology nursing who would ensure that the nurse trainees will be able to render caregiver support, education and care as outlines in the curriculum.

6.4.4 Ministry of Gender, Children and Social Protection

The Ministry of Gender, Children and Social Protection should:

- i. Collaborate with the Ministry of Health to formulate policies to protect caregivers and patients living with advanced prostate cancer brainwashed and made to believe that cancer is a curse.
- ii. Collaborate with religious groups and traditional healers to ensure early referral of patients living with advanced prostate cancer and their caregivers to the appropriate referral centres.

6.4.5 Counselling Experts

Counselling Experts should:

- i. Liaise with all hospitals with genitourinary and oncology units to give counselling services to patients living with cancer and caregivers.
- ii. Collaborate with churches and religious groups to ensure that leaders of churches such as pastors who counsel church members, give appropriate counselling to caregivers of patients with terminally ill conditions.
- iii. Make counselling accessible to families and caregivers of patients living with advanced prostate cancer in the communities.

6.4.6 Religious groups

Religious groups should:

- i. Ensure that pastors, prophets and spiritualists are educated on prostate cancer to enable them to offer the right support services to spouses of patients living with advanced prostate cancer.
- ii. Eschew stigmatization and superstitions created around caregivers and patients living with advanced prostate cancer within congregations.

- iii. Refer caregivers and patients living with advanced prostate cancer within the congregations to counselling experts for counselling.
- iv. Give financial support to spouses and other caregivers of patients living with advanced prostate cancer.

6.4.7 Christian Council of Ghana

The Christian Council of Ghana should:

- i. Make it mandatory that all pastors who wish to counsel caregivers in churches, are qualified as professional counsellors from accredited institutions.
- ii. Collaborate with the Ministry of Gender, Children and Social Protection to ensure that prayer camps do not retain caregivers and patients living with advanced prostate cancer at the prayer camps without seeking treatment and care from hospitals.

6.4.8 Women Support Groups

Women Support Groups should:

- i. Give financial support to spouses of men living with advanced prostate cancer.
- ii. Champion the campaign on healthy reproductive and adolescent living.

6.4.9 Korle Bu Teaching Hospital

The Korle Bu Teaching Hospital's Genitourinary and Oncology Units should:

- i. Involve spouses and other caregivers of men with advanced prostate cancer at all levels of care concerning the patients.
 - ii. Give opportunity to caregivers of patients living with advanced prostate cancer to express their feelings concerning the patient and the condition.
 - iii. Assign caregivers to clinical psychologists and counselors for support.
1. There should be support groups for spouses of men with advanced prostate cancer.

2. Nursing should also increase advocacy among families of patients with advanced prostate cancer
3. The National Health Insurance Scheme should subsidize the cost of diagnostic tests and treatment for patients with prostate cancer.

6.5 Conclusion

This study explored the experiences of spouses of men with advanced prostate cancer. Most of the findings were consistent with the construct of the Quality of life model applied to family caregivers (Ferrell, 2001) and, findings from other studies. An additional theme emerged from the experiences of the spouses. This was spousal involvement. The study brought to light some of the issues relating to the physical, social, psychological and spiritual wellbeing of spouses of men with advanced prostate cancer.

The spousal caregivers of advanced prostate cancer patients experienced lots of challenges within the cancer trajectory as a result of the vital roles they played in the care of their sick husbands. Nurses should involve the spouses at all levels of treatment of the cancer patient. Spouses should also be given the opportunity to express their experiences openly in order to make room for appropriate support for them by nurses and other stakeholders. The spouse and the cancer patient should be treated and supported as a unit rather than the individual patients living with advanced prostate cancer. Again, the spouses had a lot of meaning to their experiences. Many of the meanings the spouses had were as a result of wrong interpretation of the spousal experiences from other members of their communities including pastors, prophets and spiritualists. Therefore there should be continuous education and advocacy to enable dissemination of adequate knowledge on prostate cancer and the expected experiences of spouses of the prostate cancer patients.

REFERENCES

- Ajjawi, R. (2013). Sample size in qualitative research. *Medical Education Research Network*. Retrieved from blogs.cmdn.dundee.ac.uk/mededresearch/2013/06/sample-size
- American Cancer Society. (2011). Cancer in Africa. *American Cancer Society*, 1–20.
- American Cancer Society. (2016). Treating prostate cancer. *American Cancer Society*, 1–49.
- Andersen, J. (2001). *Financial Problems as Predictors of Divorce: A Social Exchange Perspective* (Proceedings for the Western Region Home Management/Family Economic Educators) (pp. 35–44).
- Anderson, R. (2007). *Thematic Content Analysis (TCA): Descriptive presentation of qualitative data*. Retrieved April 22, 2014, from <http://www.wellknowingconsulting.org/publications/pdfs/ThematicContentAnalysis.pdf>
- Annor, F. (2014). *Managing work and family demands: The perspectives of employed parents in Ghana*. In Monkamane, Z. (Ed), *Work- family interface in Sub-Saharan Africa: Challenges and responses*. Springer, Cham, Switzerland.
- Ashing-Giwa, K. T., Lim, J.-W., & Tang, J. (2010). Surviving cervical cancer: does health-related quality of life influence survival? *Gynecologic Oncology*, *118*(1), 35–42. <https://doi.org/10.1016/j.ygyno.2010.02.027>
- Aziato, L., & Adejumo, O. (2014). Determinants of nurses' knowledge gap on pain management in Ghana. *Nurse Education in Practice*, *14*(2), 195–199. <https://doi.org/10.1016/j.nepr.2013.08.004>
- Aziato, L., & Adejumo, O. (2015). Psychological factors influencing Ghanaian family Caregivers in the post-operative care of their hospitalized patients. *Africa Journal of Nursing and Midwifery*, *16*(2), 112–124. <https://doi.org/10.25159/2520-5293/40>
- Aziato, L., & Clegg-Lampety, J. N. A. (2015). Breast cancer diagnosis and factors influencing treatment decisions in Ghana. *Health Care for Women International*, *36*(5), 543–557. <https://doi.org/10.1080/07399332.2014.911299>

- Aziato, L., Odai, P. N. A., & Omenyo, C. N. (2016). Religious beliefs and practices in pregnancy and labour: an inductive qualitative study among post-partum women in Ghana. *BMC Pregnancy and Childbirth*, *16*, 138. <https://doi.org/10.1186/s12884-016-0920-1>
- Badr, H., & Taylor, C. (2008). Sexual dysfunction and spousal communication in couples coping with prostate cancer. *Psychosoc Oncol*, *27*, 23–35.
- Badr, H., & Taylor, C. L. (2009). Sexual dysfunction and spousal communication in couples coping with prostate cancer. *Psycho-Oncology*, *18*, 735–746.
- Ballinger, R. S., Mayer, K. F., Lawrence, G., & Fallowfield, L. (2008). Patients' decision-making in a UK specialist centre with high mastectomy rates. *The Breast*, *17*(6), 574–579. <https://doi.org/10.1016/j.breast.2008.08.001>
- Beach, S. R., Schulz, R., & Yee, J. L. (2011). Negative and positive health effects of caring for a disabled spouse: longitudinal findings from the caregiver health effects study. *Psychol Aging*, *15*, 2259–2271.
- Beaver, K., & Witham, G. (2007). Information needs of the informal carers of women treated for breast cancer. *European Journal of Oncology Nursing: The Official Journal of European Oncology Nursing Society*, *11*(1), 16–25. <https://doi.org/10.1016/j.ejon.2006.01.006>
- Beck, A. M., Robinson, J. W., & Carlson, L. E. (2009). Sexual intimacy in heterosexual couples after prostate cancer treatment: What we know and what we still need to learn. *Urologic Oncology: Seminars and Original Investigations*, *27*(2), 137–143. <https://doi.org/10.1016/j.urolonc.2007.11.032>
- Beesley, V. L., Price, M. A., Webb, P. M., & Australian Ovarian Cancer Study Group. (2011). Loss of lifestyle: health behaviour and weight changes after becoming a caregiver of a family member diagnosed with ovarian cancer. *Support Cancer Care*, *19*, 1949–1956.
- Berg, C., & Upchurch, R. (2009). A developmental contextual model of couples coping with cancer across the adult life span. *Psychological Bulletin*, *133*, 920–954.
- Bevans, M. F., & Sternberg, E. M. (2012). Caregiving Burden, Stress, and Health Effects Among Family Caregivers of Adult Cancer Patients. *Jama*, *307*(4), 398–403. <https://doi.org/10.1001/jama.2012.29>

- Biegler, K., Cohen, L., & Scott, S. (2011). The role of religion and spirituality in psychological distress prior to surgery for urologic cancer. *Integer Cancer the E-Pub*. <https://doi.org/10.1177/153435411416456>
- Blum, K., & Sherman. (2010). Understanding the experiences of caregivers: a focus on transitions. *Seminars in Oncology Nursing*, 26, 243–258.
- Boehmer, U., & Clark, J. A. (2001). Communication about prostate cancer between men and their wives. *J Family Pract*, 50, 226–231.
- Boreham, P., Povey, J., & Tomaszewski, W. (2013). An alternative measure of social wellbeing: analysing the key conceptual and statistical components of quality of life. *Australian Journal of Social Issues (Australian Social Policy Association)*, 48(2), 151–172.
- Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry. *Annals of Family Medicine*, 2(6), 576–582. <https://doi.org/10.1370/afm.245>
- Braithwaite, V. (1990). *Bound to care*. Sydney: Allen & Unwin.
- Braun, V., Clarke, V., Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Campbell, L. C., Keefe, F. J., McKee, D. C., Edwards, C. L., Herman, S. H., Johnson, L. E., ... Donattuci, C. F. (2004). Prostate cancer in African Americans: relationship of patient and partner self-efficacy to quality of life. *Journal of Pain and Symptom Management*, 28(5), 433–444. <https://doi.org/10.1016/j.jpainsymman.2004.02.020>
- Canary, D. J., & Dainton, M. (2006). *Maintaining relationship*. In A. L. Vangelisti and D. Perlman (Eds.). New York: Cambridge University Press.
- Carpenter, E. H., & Miller, B. H. (2005). Psychological challenges and rewards experienced by caregiving men: a review of the literature and empirical case example. in B. J. Kramer, & E. H. J. Thompson (Eds), Men as caregivers (pp. 99-126). *Prometheus Books*.
- Carter, P. A. (2006). A brief behavioural sleep intervention for family caregivers of persons with cancer. *Cancer Nurs.*, 15, 271–283.

- Cetinkaya, F., Okanli, A., Celebioglu, A., & Ozyigit, N. (2010). Stress level of caregivers of cancer patients and affecting factors. *European Journal of Oncology Nursing, 14*(5), 549.
- Chambers, S. K., Pinnock, C., Lepore, S. J., Hughes, S., & O'Connell, D. L. (2011). A systematic review of psychosocial interventions for men with prostate cancer and their partners. *Patient Education and Counseling, 85*(2), e75–e88.
<https://doi.org/10.1016/j.pec.2011.01.027>
- Chu, L. W., Ritchey, J., & Devesa, S. (2011). Prostate cancer incidence rates in Africa. *Prostate Cancer and Prostatic Diseases, 14*(4), 277–280.
- Chung, C. C., Hsing, A. W., Edward Yeboah, null, Biritwum, R., Tettey, Y., Adjei, A., ... Chanock, S. J. (2014). A comprehensive resequencing-analysis of 250 kb region of 8q24.21 in men of African ancestry. *The Prostate, 74*(6), 579–589.
- Clarke, G. (1999). Mothering, work and gender in urban Asante ideology and practice. *American Anthropologist, 101*(4), 717–729.
- Colgrove, L. A., Kim, Y., & Thompson, N. (2007). The effect of spirituality and gender on the quality of life of spousal caregivers of cancer survivors. *Annals of Behavioral Medicine: A Publication of the Society of Behavioral Medicine, 33*(1), 90–98.
https://doi.org/10.1207/s15324796abm3301_10
- Couper, J., Bloch, S., & Love, A. (2009). Coping patterns and psychosocial distress of female partners of prostate cancer patients. *Psychosomatics, 50*, 375–382.
- Creswell, J. W. (2014). *Research Design, International Student Edition: Qualitative, Quantitative and Mixed Method Approaches*. (4th ed.). London: SAGE Publications.
- Cupach, W. R., & Spitzberg, B. H. (2007). *The Dark Side of Interpersonal Communication*. Psychology Press.
- Dalkin, B. L., & Christopher, B. A. (2008). Potent men undergoing radical prostatectomy: A prospective study measuring sexual health outcomes and the impact of erectile dysfunction treatments. *Urologic Oncology: Seminars and Original Investigations, 16*(3), 281–285.
<https://doi.org/10.1016/j.urolonc.2007.02.012>

- Dane, F. C. (2010). *Evaluating Research: Methodology for People Who Need to Read Research*. SAGE.
- Dankoski, M. E., & Pais, S. (2007). What has love got to do with It? *Journal of Couple & Relationship Therapy*, 6(1–2), 31–43. https://doi.org/10.1300/J398v06n01_04
- Daugherty, C. K., Fitchett, G., & Murphy, P. E. (2005). Trusting God and medicine: spirituality in advanced cancer patients volunteering for clinical trials of experimental agents. *Psychooncology*, 14, 135–146.
- Debra, U., & Montez, J. K. (2010). Social relationships and health: A flashpoint for health policy. *Journal of Health and Social Behavior*, 51(Supple), S54–S66. <https://doi.org/10.1177/0022146510383501>
- Docherty, A., Brothwell, C. P. D., & Symons, M. (2007). The impact of inadequate knowledge on patient and spouse experience of prostate cancer. *Cancer Nursing*, 30(1), 58–63.
- Dolphyne, F. A. (1991). *The emancipation of women : an African perspective / Florence Abena Dolphyne*. Accra: Ghana Universities Press.
- Dow, K. H., Ferrell, B. R., Leigh, S., Ly, J., & Gulasekaram, P. (1996). An evaluation of the quality of life among long-term survivors of breast cancer. *Breast Cancer Research and Treatment*, 39(3), 261–273. <https://doi.org/10.1007/BF01806154>
- Draper, P. (2012). An integrative review of spiritual assessment: implications for nursing management. *Journal of Nursing Management*, 20(8), 970–980. <https://doi.org/10.1111/jonm.12005>
- Eilat-Tsanani, S., Tabenkin, H., Shental, J., Elmalah, I., & Steinmetz, D. (2013). Patients' perception of radical prostatectomy for localized prostate cancer: A qualitative study. *IMAJ*, 15, 153–157.
- Elal-Lawrence, G., & Celikoglu, P. (1995). Social support and psychological wellbeing in breast cancer patients. *Health and Social Care in the Community*, 3, 1–9.
- Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science (New York, N.Y.)*, 196(4286), 129–136.

- Ervik, B., Nordoy, T., & Asplund, K. (2012). In the Middle and on the Sideline: The experiences of spouses of men with prostate cancer. *Cancer Nursing*, 1–8.
<https://doi.org/10.1097/NCC.0bo13e31824felef>
- Esbensen, B. A., Thome, B., & Thomsen, T. (2012). Dependency in elderly people newly diagnosed with cancer—a mixed-method study. *Eur. J. Oncol. Nurs.*, 16(2), 137–144.
- Evertsen, J. M., & Wolkenstein, A. S. (2010). Female partners of patients after surgical prostate cancer treatment: interactions with physicians and support needs. *BMC Family Practice*, 11, 6.
- Family Caregiver Alliance. (2014). Caregiving. Retrieved from <https://www.caregiver.org>
- Fang, S. Y., Shu, B. C., & Fetzer, S. J. (2011). Debilitating over mastectomy: Survival and social roles. *Cancer Nursing*, 34(2), 21–28.
- Farquhar, M. (1995). Elderly people's definitions of quality of life. *Social Science & Medicine*, 41(10), 1439–1446. [https://doi.org/10.1016/0277-9536\(95\)00117-P](https://doi.org/10.1016/0277-9536(95)00117-P)
- Fergus, K. D., & Gray, R. E. (2009). Relationship vulnerability during breast cancer: patient and partner perspectives. *Psycho-Oncology*, 18, 1311–1322.
- Ferlay, J., Shin, H. R., Bray, F., Forman, D., & Mathers, C. D. (2008). Cancer Incidence and Mortality Worldwide: IARC Cancer Base: International Agency for Research on Cancer. *GLOBOCAN*.
- Ferrans, C. E. (1990). Quality of life: conceptual issues. *Seminars in Oncology Nursing*, 6(4), 248–254.
- Ferrell, B., Grant, M., Schmidt, G. M., Rhiner, M., Whitehead, C., Fonbuena, P., & Forman, S. J. (1992). The meaning of quality of life for bone marrow transplant survivors. Part 1. The impact of bone marrow transplant on quality of life. *Cancer Nursing*, 15(3), 153–160.
- Ferrell, B. R., Ferrell, B. A., Rhiner, M., & Grant. (1991). Family factors influencing cancer pain management. *Post Graduate Medical Journal*, 67(2), 64–69.
- Ferrell, B. R., Wisdom, C., & Wenzl, C. (1989). Quality of life as an outcome variable in the management of cancer pain. *Cancer*, 63(11 Suppl), 2321–2327.

- Ferrell, Betty R. (1994). Ethical and professional issues in pain technology: a challenge to supportive care. *Supportive Care in Cancer*, 2(1), 21–26.
<https://doi.org/10.1007/BF00355236>
- Ferrell, Betty R., & Baird, R. P. (2012). Deriving Meaning and Faith in Caregiving. *Seminars in Oncology Nursing*, 28(4), 256–261. <https://doi.org/10.1016/j.soncn.2012.09.008>
- Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in the middle-aged community sample. *Journal of Health and Social Behavior*, 21(3), 219–239.
- Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*. 36: 717-732.
- Fouladi, N., Pourfarzi, F., Ali-Mohammadi, H., Masumi, A., Agamohammadi, M., & Mazaheri, E. (2013). Process of coping with mastectomy: A qualitative study in Iran. *Asian Pacific Journal of Cancer Prevention*, 14(3), 2079–2084.
<https://doi.org/10.7314/APJCP.2013.14.3.2079>
- Frost, M. H., Johnson, M. E., & Athernton, P. J. (2012). Spiritual well-being and quality of life of women with ovarian cancer and their spouses. *Journal of Support Oncology*, 10, 72–80.
- Fujinami, R., Otis-Green, S., Klein, L., Sidhu, R., & Ferrell, B. (2012). Quality of life of family caregivers: Challenges faced in care of the lung cancer patient. *Clinical Journal of Oncology Nursing*, 16(6), E210–E220. <https://doi.org/10.1188/12.CJON.E210-E220>
- Galbraith, M. E., Fink, R., & Wilkins, G. G. (2011). Couples surviving prostate cancer: Challenges in their lives and relationships. *Seminars in Oncology Nursing*, 27(4), 300–308.
<https://doi.org/10.1016/j.soncn.2011.07.008>
- Gall, T. L., Guirguis-Tounger, M., Charbonneau, C., & Florack, P. (2009). The trajectory of religious coping across time in response to the diagnosis of breast cancer. *Psychooncology*, 18, 1165–1178. <https://doi.org/10.1002/pon.1495>
- Ghaemi, S. N. (2009). The rise and fall of the biopsychosocial model. *The British Journal of Psychiatry*, 195(1), 3–4. <https://doi.org/10.1192/bjp.bp.109.063859>

- Gibson-Davis, C. M., Edin, K., & McLanahan, S. (2005). High hopes but even higher expectations: The retreat from marriage among low-income couples. *Journal of Marriage and Family*, *67*(5), 1301–1312. <https://doi.org/10.1111/j.1741-3737.2005.00218.x>
- Given, B. A., Sherwood, P., & Given, C. W. (2011). Support for caregivers of cancer patients: transition after active treatment. *Cancer Epidemiol Biomarkers Prev*, *20*, 2015–2021.
- Given, B. A., Given, C. W., & Sherwood, P. (2012). The challenge of quality cancer care for family caregivers. *Seminars in Oncology Nursing*, *28*(4), 205–212. <https://doi.org/10.1016/j.soncn.2012.09.002>
- Glajchen, M. (2012). Physical Well-Being of Oncology Caregivers: An Important Quality-of-Life Domain. *Seminars in Oncology Nursing*, *28*(4), 226–235. <https://doi.org/10.1016/j.soncn.2012.09.005>
- Goldsmith, J., Wittenberg, E., Platt, C. S., Iannarino, N. T., & Reno, J. (2016). Family caregiver communication in oncology: advancing a typology. *Psycho-Oncology*, *25*(4), 463–470. <https://doi.org/10.1002/pon.3862>
- Government of Ghana. (2003). Labor Act. The Government of Ghana.
- Greimel, E. R., Winter, R., Kapp, K. S., & Haas, J. (2009). Quality of life and sexual functioning after cervical cancer treatment: a long-term follow-up study. *Psycho-Oncology*, *18*(5), 476–482. <https://doi.org/10.1002/pon.1426>
- Gustavsson-Lilius, M., Julkunen, J., & Keskivaara, P. (2007). Senses of coherence and distress in cancer patients and their partners. *Psychooncology*, *16*, 1100–1110.
- Gysels, M., & Higginson, I. J. (2009). Reconciling employment with caring for a husband with an advanced illness. *BMS Health Services Research*. <https://doi.org/10.1186/1472-6963-9-216>
- Haas, G. P., Delongchamps, N., Brawley, O. W., Wang, C. Y., & de la Roza, G. (2008). The Worldwide Epidemiology of Prostate Cancer: Perspectives from Autopsy Studies. *The Canadian Journal of Urology*, *15*(1), 3866–3871.

- Hagedoorn, M., Sanderman, R., Bolks, H. N., Tuinstra, J., & Coyne, J. C. (2008). Distress in couples coping with cancer: A meta-analysis and critical review of role and gender effects. *Psychological Bulletin, 134*(1), 1–30. <https://doi.org/10.1037/0033-2909.134.1.1>
- Haley, W. E., LaMonde, L. A., Han, B., & Burton, A. M. (2003). Predictors of depression and life satisfaction among spousal caregivers in hospice: application of a stress process model. *Journal of Palliative Medicine, 6*, 215–224.
- Harden, J., Falahee, M., Bickes, J., Schafenacker, A., Walker, J., Mood, D., & Northouse, L. (2011). Factors associated with prostate cancer patients and their spouses' satisfaction with a family-based intervention. *Cancer Nursing, 32*(6), 482–492. <https://doi.org/10.1097/NCC.0b013e3181b311e9>
- Harden, J., Northouse, L., & Cimprich, B. (2008). The influence of developmental life stage on quality of life in survivors of prostate cancer and their partners. *Journal of Cancer Survivor, 2*, 84–94.
- Hawkins, Y., Ussher, J., Gilbert, E., Perz, J., Sandoval, M., & Sundquist, K. (2009). Changes in sexuality and intimacy after the diagnosis and treatment of cancer: The experience of partners in a sexual relationship with a person with cancer. *Cancer Nursing, 32*(4), 271–280. <https://doi.org/10.1097/NCC.0b013e31819b5a93>
- Hawley, S. T., Griggs, J. J., Hamilton, A. S., Graff, J. J., Janz, N. K., Morrow, M., ... Katz, S. J. (2009). Decision involvement and receipt of mastectomy among racially and ethnically diverse breast cancer patients. *Journal of the National Cancer Institute, 101*(19), 1337–1347. <https://doi.org/10.1093/jnci/djp271>
- Hazelwood, D. M., Koeck, S., Wallner, M., Anderson, K. H., & Mayer, H. (2012). Patients with cancer and family caregivers: management of symptoms caused by cancer or cancer therapy at home. *HeilberufeSCIENCE, 3*(4), 149–158. <https://doi.org/10.1007/s16024-012-0118-z>
- Helliwell, J. F., & Huang, H. (2010). “How”s the job? Well-being and social capital in the workplace’. *Industrial and Labor Relations Review, 63*(2), 205–227.

- Hexem, K. R., Mollen, C. J., Carroll, K., Lanctot, D. A., & Feudtner, C. (2011). How parents of children receiving pediatric palliative care use religion, spirituality, or life philosophy in tough times. *J Palliat Med., 14*, 39–44.
- Hodge, D. R., & Horvath, V. E. (2011). Spiritual needs in health care settings: A qualitative meta-synthesis of clients' perspectives. *Social Work, 56*(4), 306–316.
<https://doi.org/10.1093/sw/56.4.306>
- Hodgkinson, K., Butow, P., & Hunt, G. (2008). Life after cancer: couples' and partners' psychological adjustment and supportive care needs. *Support Care Cancer, 15*, 405–415.
- Hoga, L. A. K., Mello, D. S., & Dias, A. F. (2008). Psychosocial perspectives of the partners of breast cancer patients treated with a mastectomy: an analysis of personal narratives. *Cancer Nursing, 31*(4), 318–325. <https://doi.org/10.1097/01.NCC.0000305748.43367.1b>
- Hoga, L. A. K., Rodolpho, J. R. C., de Souza Penteadó, P. E., Borges, A. L. V., & Chávez Alvarez, R. E. (2013). Religiosity and sexuality: counseling provided by Brazilian Protestant pastors. *Sexual & Reproductive Healthcare: Official Journal of the Swedish Association of Midwives, 4*(2), 57–63. <https://doi.org/10.1016/j.srhc.2013.04.001>
- Hsing, A. W., Yeboah, E., Biritwum, R., Tettey, Y., De Marzo, A. M., Adjei, A., & Hoover, R. N. (2014). High prevalence of screen detected prostate cancer in West Africans: Implications for racial disparity of prostate cancer. *The Journal of Urology, 192*(3), 730–736.
<https://doi.org/10.1016/j.juro.2014.04.017>
- Hudson, P. (2003). The experience of research participation for family caregivers of palliative care cancer patients. *International Journal of Palliative Nursing, 9*(3), 120–123.
<https://doi.org/10.12968/ijpn.2003.9.3.11480>
- Hughes, M. E., & Waite, L. (2009). Marital biography and health at midlife. *Journal of Health and Social Behavior, 50*, 344–358.
- Hughes, N., Closs, S. J., & Clark, D. (2009). Experiencing cancer in old age: a qualitative systematic review. *Qual. Health Res, 19*, 1139.

- Hunsberger, J. B., Cheng, M. J., & Aslakson, R. A. (2014). Spirituality and religiosity during the perioperative period for cancer patients and their family: An integrative systemic review. *Palliative Medicine and Hospice Care - Open Journal*, *1*(1), 8–15.
- Hussain, M., Naz, A., Khan, W., Daraz, U., & Khan, Q. (2015). Gender stereotyping in family: An institutionalized and normative mechanism in Pakhtun Society of Pakistan. *SAGE Open*, 1–11. <https://doi.org/10.1177/2158244015595258>
- Jang, J. E., Kim, S. Y., Kim, J. M., & et al. (2012). Religiosity, depression, and quality of life in Korean patients with breast cancer; a 1 year prospective longitudinal study. *Psychooncology*. <https://doi.org/10.1002/pon.3083>
- Jemal, A., Bray, F., Center, M. M., Ferlay, J., Ward, E., & Forman, D. (2011). Global cancer statistics. *CA: A Cancer Journal for Clinicians*, *61*(2), 69–90. <https://doi.org/10.3322/caac.20107>
- Jesse, D. E., Schoneboom, C., & Blanchard, A. (2007). The effect of faith or spirituality in pregnancy: a content analysis. *Journal of Holistic Nursing: Official Journal of the American Holistic Nurses' Association*, *25*(3), 151–158; discussion 159. <https://doi.org/10.1177/0898010106293593>
- Jones, R. A., Taylor, A. G., Bourguignon, C., Steeves, R., Fraser, G., Lippert, M., & Kilbridge, K. L. (2008). Family interactions among African American prostate cancer survivors. *Family & Community Health*, *31*(3), 213–220. <https://doi.org/10.1097/01.FCH.0000324478.55706.fe>
- Kale, S. S. (2011). Perspectives on spiritual care at Hospice Africa Uganda. *International Journal of Palliative Nursing*, *17*, 177–182.
- Ka'opua, L. S., Gotay, C. C., & Boehm, P. S. (2007). Spirituality based resources in adaptation to long-term prostate cancer survival: perspectives of elderly wives. *Health Soc Work.*, *32*, 29–39.
- Kershaw, T. S., Mood, D. W., Newth, G., Ronis, D. L., Sanda, M. G., Vaishampayan, U., & Northouse, L. L. (2008). Longitudinal analysis of a model to predict quality of life in prostate cancer patients and their spouses. *Annals of Behavioral Medicine: A Publication*

- of the Society of Behavioral Medicine*, 36(2), 117–128. <https://doi.org/10.1007/s12160-008-9058-3>
- Khan, J. A. (2012). *Research Methodology*. New Delhi: A P H Publishing.
- Kim, Y., Carver, C. S., & Spillers, R. L. (2011). Individual and dyadic relationships between spiritual well-being and quality of life among cancer survivors and their spousal caregivers. *Psychooncology*, 20, 762–770.
- Kim, Y., & Given, B. (2008). Quality of life of family caregivers of cancer survivors. *J Cancer Survivorship*, 2, 53–64.
- Kim, Y., Kashy, D. A., Wellisch, D. K., Spillers, R. L., Kaw, C. K., & Smith, T. G. (2008). Quality of life of couples dealing with cancer: dyadic and individual adjustment among breast and prostate cancer survivors. *Annals of Behavioral Medicine*, 35, 230–238.
- Kim, Y., & Given, B. A. (2008). Quality of life of family caregivers of cancer survivors. *Cancer*, 112(S11), 2556–2568. <https://doi.org/10.1002/cncr.23449>
- Kim, Y., Schulz, R., & Carver, C. S. (2007). Benefit finding in the cancer caregiving experience: *Psychosomatic Medicine*, 69(3), 283–291. <https://doi.org/10.1097/PSY.0b013e3180417cf4>
- Kimura, M., Zodda, A. R., Mahmood, J., Das, S. K., Nguyen, G. B., Jackson, I. L., & Vujaskovic, Z. (2015). Pilot Study Evaluating a Rat Model of Radiation-induced Erectile Dysfunction Using an Image-guided Microirradiator. *Urology*, 85(5), 1214.e1-6. <https://doi.org/10.1016/j.urology.2014.12.020>
- King, C. R., & Hinds, P. S. (2003). *Quality of Life: From Nursing and Patient Perspectives : Theory, Research, Practice*. Jones & Bartlett Learning.
- Klufio, G. O. (2004). A review of genitourinary cancers at the Korle-Bu Teaching Hospital Accra, Ghana. *West African Journal of Medicine*, 23(2), 131–134.
- Knapp, M. L., & Daly, J. A. (2002). *Handbook of Interpersonal Communication*. SAGE.
- Koch, T. (2006). Establishing rigour in qualitative resaerch the decision trial. *Journal of Advanced Nursing*, 53(1). Retrieved from <https://doi.org/10.1111/j365-2648.2006.03.681.x>
- Korb, A. K. (2012). Conducting educational research. Retrieved April 11, 2014, from <http://korbedpsych.com/R05Population.html>

- Krefting, L. (1991). Rigor in Qualitative Research: The Assessment of Trustworthiness. *The American Journal of Occupational Therapy*, 45(3). Retrieved from <http://portal.limkokwing.net/modulernat/...>
- Kusi, H. (2012). *Doing Qualitative research- A guide for researchers. Accra-New Town: Emmpong Press.*
- Lambert, S., Girgis, A., Lecathelinais, C., & Stacey, F. (2012). Walking a mile in their shoes: anxiety and depression among caregivers of cancer survivors at six and 12 months post-diagnosis. *Support Care Cancer*, 21, 75–80.
- LeCompte, M. D., & Schensul, J. J. (1999). *Analyzing and interpreting ethnographic data.* Walnut Creek: CA: AltaMira Press.
- Li, Q., & Loke, A. Y. (2013). A spectrum of hidden morbidities among spousal caregivers for patients with cancer, and differences between the genders: A review of the literature. *European Journal of Oncology Nursing*, 17(5), 578–587. <https://doi.org/10.1016/j.ejon.2013.01.007>
- Li, Q., & Loke, A. Y. (2014). A literature review on the mutual impact of the spousal caregiver–cancer patients dyads: “Communication”, “reciprocal influence”, and “caregiver–patient congruence.” *European Journal of Oncology Nursing*, 18(1), 58–65. <https://doi.org/10.1016/j.ejon.2013.09.003>
- Lim, C., & Putnam, R. D. (2010). “Religion, social networks, and life satisfaction”. *American Sociological Review*, 75(6), 914–933.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.
- Lopez, V., Copp, G., & Molassiotis, A. (2012a). Male caregivers of patients with breast and gynaecologic cancer: experiences of caring for their spouses and partners. *Cancer Nursing*, 35, 402–410.
- Lu, L., Pan, B., Sun, W., Cheng, L., Chi, T., & Wang, L. (2010). Quality of life and related factors among cancer caregivers in China. *Psychiatry and Clinical Neurosciences*, 64(5), 505–513. <https://doi.org/10.1111/j.1440-1819.2010.02131.x>

- Maex, E., & De Valck, C. (2006). Key elements of communication in cancer care. In F. Stiefel (Ed.), *communication in cancer care* (pp. 1-6) Berlin: Springer, 1–6.
- Manne, S., Badr, H., Zaidler, T., Nelson, C., & Kissane, D. (2010). Cancer-related communications, relationship intimacy, and psychological distress among couples with localized prostate cancer. *Journal of Cancer Survivor, 4*(1), 74–85. <https://doi.org/10.1007/s11764-009-0109-y>
- Martin, M. ., Sanders, S., & Griffin, J. M. (2012). Racial variation in cancer caregiving experience: a multisite study of colorectal and lung cancer caregivers. *Cancer Nurs., 35*, 249–256.
- Mason, J. (2004). *Encyclopedia of Social Science Research Methods Encyclopedia of social science research methods*. 2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc. Retrieved from <http://knowledge.sagepub.com/view/socialscience/SAGE.xml>
- Mayan, M. J. (2001). *An introduction to qualitative methods: A training module for students and professionals*. Sage publication. CA.
- McCorkle, R., Seifert, M., & Dowd, M. (2007). Effects of advanced nursing practice on patient and spouse depressive symptoms, sexual function, and marital interaction after radical prostatectomy. *Urology Nursing, 27*, 67–77.
- Mehnert, A. (2011). Employment and work-related issues in cancer survivors. *Critical Reviews in Oncology/Hematology, 77*(2), 109–130. <https://doi.org/10.1016/j.critrevonc.2010.01.004>
- Miedema, K. G. E., de Bont, E. S. J. M., Elferink, R. F. M. O., van Vliet, M. J., Nijhuis, C. S. M. O... Tissing, W. J. E. (2011). The diagnostic value of CRP, IL-8, PCT, and sTREM-1 in the detection of bacterial infections in pediatric oncology patients with febrile neutropenia. *Supportive Care in Cancer: Official Journal of the Multinational Association of Supportive Care in Cancer, 19*(10), 1593–1600. <https://doi.org/10.1007/s00520-010-0987-6>
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.), Thousand Oaks, CA: Sage.

- Mitchell, A. J., Ferguson, D. W., Gill, J., Paul, J., & Symonds, P. (2013). Depression and anxiety in long-term cancer survivors compared with spouses and healthy controls: a systematic review and meta-analysis. *The Lancet. Oncology*, *14*(8), 721–732.
[https://doi.org/10.1016/S1470-2045\(13\)70244-4](https://doi.org/10.1016/S1470-2045(13)70244-4)
- Monin, J. K., & Schulz, R. (2010). The effects of suffering in chronically ill older adults on the health and well-being of family members involved in their care. *GeroPsych*, *23*(4), 207–213. <https://doi.org/10.1024/1662-9647/a000024>
- Morgan, M. A., Small, B. J., Donovan, K. A., Overcash, J., & McMillan, S. (2011). Cancer patients with pain: The spouse/partner relationship and quality of life. *Cancer Nursing*, *34*(1), 13–23. <https://doi.org/10.1097/NCC.0b013e3181efed43>
- Muller, M. J., Ruof, J., Graf-Morgaentern, M., Porst, H., & Benkert, O. (2001). Quality of partnership in patients with erectile dysfunction after sildenafil treatment. *Pharmacopsychiatric May*, *34*(3), 91–95.
- National Comprehensive Cancer Network. (2016). Prostate cancer. *National Comprehensive Cancer Network*, *1*, 1–112.
- Navon, L., & Morag, A. (2003). Advanced prostate cancer patients' relationships with their spouses following hormonal therapy. *European Journal of Oncology Nursing*, *7*(2), 73–80.
[https://doi.org/10.1016/S1462-3889\(03\)00022-X](https://doi.org/10.1016/S1462-3889(03)00022-X)
- Nelson, C. J., Scardino, P. T., Eastham, J. A., & Mulhall, J. P. (2013). Back to baseline: erectile function recovery after radical prostatectomy from the patients' perspective. *The Journal of Sexual Medicine*, *10*(6), 1636–1643. <https://doi.org/10.1111/jsm.12135>
- Nelson, C., Jacobson, C. M., & Weinberger, M. I. (2009). The role of spirituality in the relationship between religiosity and depression in prostate cancer patients. *Annals of Behavioral Medicine*, *38*(2), 105–144. <https://doi.org/10.1007/s12160-009-9139-y>
- Northouse, Laurel L., Mood, D., Templin, T., Mellon, S., & George, T. (2000). Couples' patterns of adjustment to colon cancer. *Social Science & Medicine*, *50*(2), 271–284.
[https://doi.org/10.1016/S0277-9536\(99\)00281-6](https://doi.org/10.1016/S0277-9536(99)00281-6)

- Northouse, L.L., & Katapodi, M. C. (2010). Interventions with caregivers of cancer patients: meta-analysis of randomized trials. *CA: A Cancer Journal for Clinicians*, *60*, 317–339.
- Nukunya, G. K. (2003). *Tradition and Change in Ghana: An Introduction to Sociology* (2nd ed.). Accra: Ghana Universities Press.
- O'Brien, R., Rose, P., Campbell, C., Weller, D., Neal, R. D., Wilkinson, C., ... Watson, E. (2011). "I wish I had told them" A qualitative study examining the unmet psychosexual needs of prostate cancer patients during follow-up after treatment. *Patient Education and Counseling*, *84*, 200–207.
- Odedina, F. T., Akinremi, T. O., Chingwundoh, F., Roberts, R., Yu, D., Reams, R. R., ... Kumar, N. (2009). Prostate cancer disparities in Black men of African descent: a comparative literature review of prostate cancer burden among Black men in the United States, Caribbean, United Kingdom, and West Africa. *Infectious Agents and Cancer*, *4*(Suppl 1), S2. <https://doi.org/10.1186/1750-9378-4-S1-S2>
- Olah, L. S., Richter, R., & Kotowska, I. E. (2014). *The new roles of men and women and implications for families and societies* (Families and Societies Working Paper Series No. 11) (pp. 1–61).
- Olson, R. E. (2011). Managing hope, denial or temporal anomie? Informal cancer carers' accounts of spouses' cancer diagnoses. *Social Science & Medicine*, *73*(6), 904–911. <https://doi.org/10.1016/j.socscimed.2010.12.026>
- Otis-Green, S., & Juarez, G. (2012). Enhancing the Social Well-Being of Family Caregivers. *Seminars in Oncology Nursing*, *28*(4), 246–255. <https://doi.org/10.1016/j.soncn.2012.09.007>
- Padgett, D. (1998). *Qualitative Methods in Social Work Research: Challenges and Rewards*. SAGE Publications.
- Padilla, G. V., & Grant, M. M. (1985). Quality of life as a cancer nursing outcome variable. *ANS. Advances in Nursing Science*, *8*(1), 45–60.
- Paley, J. (2009). Religion and the secularisation of health care. *Journal of Clinical Nursing*, *18*(14), 1963–1974. <https://doi.org/10.1111/j.1365-2702.2009.02780.x>

- Park, J. H., & Park, J. H. G. K. S. (2009). Effect of cancer diagnosis on patient employment status: a nationwide longitudinal study in Korea. *Psychooncology*, *18*, 691–699.
- Parkin, D. M., Chirenje, M., & et. al. (2008). Part 1: cancer in indigenous Africans-burden, distribution, and trend. *Lancet Oncol.*, *9*(683).
- Paterson, C., Robertson, A., Smith, A., & Nabi, G. (2015). Identifying the unmet supportive care needs of men living with and beyond prostate cancer: A systematic review. *European Journal of Oncology Nursing*. <https://doi.org/10.1016/j.ejon.2014.12.007>
- Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods*. SAGE.
- Perez, M., Skinner, E., & Meyerowitz, B. (2007). Sexuality and intimacy following radical prostatectomy: patient and partner perspectives. *Health Psychol*, *2*, 288–293.
- Peteet, J. R., & Balboni, M. J. (2013). Spirituality and religion in oncology. *CA: A Cancer Journal for Clinicians*, *63*(4), 280–289. <https://doi.org/10.3322/caac.21187>
- Pistrang, N., & Barker, C. (1995). The partner relationship in psychological response to breast cancer. *Social Science & Medicine (1982)*, *40*(6), 789–797.
- Prostate Cancer Foundation of Australia. (2014). Treating advanced prostate cancer. *Prostate Cancer Foundation of Australia*, 1–40.
- Rebbeck, T. R., Devesa, S. S., & Chang, B.-L. (2013). Global patterns of prostate cancer incidence, aggressiveness, and mortality in men of Africa descent. *Prostate Cancer*, *12*.
- Rees, J., O'Boyle, C., & MacDonagh, R. (2001). Quality of life: impact of chronic illness on the partner. *Journal of the Royal Society of Medicine*, *94*(11), 563–566.
- Regan, T. W., Lambert, S. D., Kelly, B., McElduff, P., Girgis, A., Kayser, K., & Turner, J. (2014). Cross-sectional relationships between dyadic coping and anxiety, depression, and relationship satisfaction for patients with prostate cancer and their spouses. *Patient Education and Counseling*, *96*(1), 120–127. <https://doi.org/10.1016/j.pec.2014.04.010>
- Rehman, R., Hussain, M., Syed, F., & Khan, R. (2014). Social wellbeing: A positive energy for wellness in medical students. *JPMI: Journal of Postgraduate Medical Institute*, *28*(2), 165–171.

- Riley, A., & Riley, E. (2000). Behavioural and clinical findings in couples where the man presents with erectile disorder: a retrospective study. *Int J Clin Pract*, *54*(4), 220–224.
- Roth, A. J., Weinberger, M. I., & Nelson, C. J. (2008). Prostate Cancer: Quality of Life, Psychosocial Implications and Treatment Choices. *Future Oncology (London, England)*, *4*(4), 561–568. <https://doi.org/10.2217/14796694.4.4.561>
- Rowland, E., & Metcalfe, A. (2014). A systematic review of men's experiences of their partner's mastectomy: coping with altered bodies. *Psycho-Oncology*, *23*(9), 963–974. <https://doi.org/10.1002/pon.3556>
- Rusteen, T. (1995). Hope and quality of life, two central issues for cancer patients: a theoretical analysis. *Cancer Nursing*, *18*, 355–361.
- Sadovsky, R., Basson, R., Krychman, M., Morales, A. M., Schover, L., & Wang, R. (2010). Cancer and sexual problems. *Journal of Sex Med*, *7*(1), 349–373.
- Sanders, S., Pedro, L. W., O'Carroll-Bantum, E., & et. al. (2006). Couples surviving prostate cancer: Long-term intimacy needs and concerns following treatment. *Clin J Oncol Nurs*, *10*, 503–508.
- Schindler, I., Berg, C., Butler, J., & et. al. (2010). Late-midlife and older couples' share possible selves and psychological wellbeing during times of illness: the role of collaborative problem solving, *65*, 416–424.
- Schulz, R., & Beach, S. R. (1999). Caregiving as a risk factor for mortality: the Caregiver Health Effects Study. *JAMA*, *282*, 2215–2219.
- Senden, C., Vandecasteele, T., Vandenberghe, E., Versluys, K., Piers, R., Grypdonck, M., & Van Den Noortgate, N. (2015). The interaction between lived experiences of older patients and their family caregivers confronted with a cancer diagnosis and treatment: A qualitative study. *International Journal of Nursing Studies*, *52*, 197–206.
- Sherwood, P. R., Price, T. J., Weimer, J., Ren, D., Donovan, H. S., Given, C. W., ... Marsland, A. L. (2016). Neuro-oncology family caregivers are at risk for systemic inflammation. *Journal of Neuro-Oncology*, *128*(1), 109–118. <https://doi.org/10.1007/s11060-016-2083-3>

- Short, P. F., Moran, J. R., & Punekar, R. (2011). Medical expenditures of adult cancer survivors aged more than 65 years in the United States. *Cancer, 117*, 2791–2800.
- Sinfield, P., Baker, R., Ali, S., & Richardson, A. (2012). The needs of carers of men with prostate cancer and barriers and enablers to meeting them: a qualitative study in England. *European Journal of Cancer Care, 21*, 527–534.
- Sjovall, K., Attner, B., & Lithman, T. (2009). Influence on the health of the partner affected by tumor disease in the wife or husband on a population-based register study of cancer in Sweden. *Journal of Oncology, 27*, 4781–4786.
- Sloan, R. P., Bagiella, E., & VandeCreek, L. (2000). Should physicians prescribe religious activities? *New England Journal of Medicine, 342*, 1913–1916.
- Son, K. Y., Lee, C. H., & Park, S. M. (2012). The factors associated with the quality of life of the spouse caregivers of patients with cancer: a cross - sectional study. *Journal of Palliative Medicine, 15*, 216–224.
- Song, L., Northouse, L., Zhang, L., Braun, T., Cimprich, B., Ronis, D., & Mood, D. (2012). Study of dyadic communication in couples managing prostate cancer: a longitudinal perspective. *Psycho-Oncology, 21*(1). <https://doi.org/10.1002/pon.1861>
- Staberg, U., Ruland, C. M., & Miaskowski, C. (2010). Review of literature on the effects of caring for a patient with cancer. *Psychooncology, 19*, 1013–1025.
- Steiner, J. F., Cavender, T. A., Nowels, C. T., Beaty, B. L., Bradley, C. J., & Fairclough, D. L. (2008). The impact of physical and psychosocial factors on work characteristics after cancer. *Psychooncology, 17*, 138–147.
- Sulmasy, D. P. (2006). Spiritual issues in the dying patients. *Journal of American Medical Association, 296*, 1385–1392.
- Suzu, C. A., Akin-Odanye, E., & Adejumo, A. (2014). Husbands' knowledge, attitude and behavioural disposition to wives screening for cervical cancer in Ibadan. *African Journal for the Psychological Studies of Social Issues, 17*(2), 167–176.
- Syse, A., Tretli, S., & Kravdal, Q. (2008). Cancer's impact on employment and earnings-a population-based study from Norway. *Journal of Cancer Survivorship, 2*, 149–158.

- Tongco, D. C. (2007). Purposive Sampling as a Tool for Informant Selection. Retrieved April 16, 2014, from <http://scholarspace.manoa.hawaii.edu/bitstream/handle/10125/227/i1547-346505-147.pdf?sequence=4>
- Toseland, R., Blanchard, C., & McCallion, P. (1995). A problem solving in for caregivers of cancer patients. *Social Science & Medicine*, *40*(4), 51.
- Treas, J., & Mazumdar, S. (2004). Kinkeeping and Caregiving: Contributions of Older People in Immigrant Families. *Journal of Comparative Family Studies*, *35*(1), 105–122.
<https://doi.org/10.2307/41603919>
- Urology Care Foundation. (2015). *Urology Care Foundation*.
- Vallerand, A. H., Collins-Bohler, D., Templin, T., & Hasenau, S. M. (2007). Knowledge of and barriers to pain management in caregivers of cancer patients receiving homecare. *Cancer Nursing*, *30*(1), 31–37.
- Vallurupalli, M., Lauderdale, K., Balboni, M. J., Phelps, A. C., Block, S. D., Ng, A. K., ... Balboni, T. A. (2012). The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. *The Journal of Supportive Oncology*, *10*(2), 81–87. <https://doi.org/10.1016/j.suponc.2011.09.003>
- van Ryn, M., Sanders, S., & Kahn, K. (2011). Objective burden, resources and other stressors among informal cancer caregivers. *Psychooncology*, *20*, 44–52.
- von Scheve, C. (2012). Emotion Regulation and Emotion Work: Two Sides of the Same Coin? *Frontiers in Psychology*, *3*. <https://doi.org/10.3389/fpsyg.2012.00496>
- Wakui, T., Saito, T., Agree, E. M., & Kai, I. (2012). Effects of home, outside leisure, social, and peer activity on psychological health among Japanese family caregivers. *Aging & Mental Health*, *16*(4), 500–506. <https://doi.org/10.1080/13607863.2011.644263>
- Ware, J., Kosinski, M., & Keller, S. (1993). *SF-36 Physical and mental health summary scales: A user's manual*. Boston, Massachusetts: The Health Institute.
- Waterhouse, P., Hill, A. G., & Hinde, A. (2017). Combining work and child care: The experiences of mothers in Accra, Ghana. *Development Southern Africa*, *0*(0), 1–16.
<https://doi.org/10.1080/0376835X.2017.1323627>

- Waugh, A., & Grant, A. (2001). *Rose and Wilson Anatomy and Physiology in Health and Illness* (9th Ed.). London: Harcourt Publishers Limited.
- Wiredu, E. K., & Armah, H. B. (2006). Cancer mortality patterns in Ghana: a 10-year review of autopsies and hospital mortality. *BMC Public Health*, *6*, 159.
<https://doi.org/10.1186/1471-2458-6-159>
- Woloski-Wruble, A., & Kadmon, I. (2002). Breast cancer: reactions of Israeli men to their wives' diagnosis. *European Journal of Oncology Nursing: The Official Journal of European Oncology Nursing Society*, *6*(2), 93–99.
- Yamoah, K., Beecham, K., Hegarty, S. F., Hyslop, T., Showalter, T., & Yarney, J. (2013). Early results of prostate cancer radiation therapy: an analysis with emphasis on research strategies to improve treatment delivery and outcomes. *BMC Cancer*, *13*(1), 1.
<https://doi.org/10.1186/1471-2407-13-23>
- Yeh, P.-M., Wierenga, M. E., & Yuan, S.-C. (2009). Influences of psychological well-being, quality of caregiver-patient relationship, and family support on the health of family caregivers for cancer patients in Taiwan. *Asian Nursing Research*, *3*(4), 154–166.
[https://doi.org/10.1016/S1976-1317\(09\)60027-X](https://doi.org/10.1016/S1976-1317(09)60027-X)
- Yesilbalkan, O. U., & Okgun, A. (2010). Patients' self reports and caregivers' perception of symptoms in Turkish cancer patients. *European Journal of Oncology Nursing*, *14*, 119–124. <https://doi.org/DOI: http://dx.doi.org/10.1016/j.ejon.2009.08.002>
- Zhang, Z., & Hayward, M. D. (2006). Gender, the Marital Life Course, and Cardiovascular Disease in Late Midlife. *Journal of Marriage and Family*. *68*, 639–657.
- Ziersch, A. M., & Baum, E. E. (2004). "Involvement in civic society groups: is it good for your health?" *Journal of Epidemiology and Community Health*, *58*(6), 493–500.
- Zwahlen, R. A., Dannemann, C., Grätz, K. W., Studer, G., Zwahlen, D., Moergeli, H., ... Jenewein, J. (2008). Quality of Life and psychiatric morbidity in patients successfully treated for oral cavity squamous cell cancer and their wives. *Journal of Oral and Maxillofacial Surgery*, *66*(6), 1125–1132. <https://doi.org/10.1016/j.joms.2007.09.003>

APPENDICES

Appendix A: Background Information of Participants

Serial number	Pseudonym	Age	Number of years of marriage	Number of children	Home town	Religion	Nationality	Employment
1	S1	63	36	8	Axim	Christian	Ghanaian	Used clothing seller
2	S2	60	40	1	Kwawu	Christian	Ghanaian	Corn seller
3	S3	50	25	2	Saviokope	Christian	Ghanaian	Petty trader
4	S4	63	36	3	Kwawu	Christian	Ghanaian	Retired teacher
5	S5	58	11	2	Keta	Christian	Ghanaian	No work
6	S6	62	42	6	Agbozome	Christian	Ghanaian	Petty trader
7	S7	58	32	3	Angloga	Christian	Ghanaian	Seamstress
8	S8	68	53	7	Gomoa	Christian	Ghanaian	Plastic bag seller
9	S9	68	47	4	Leklebi	Christian	Ghanaian	Petty trader
10	S10	50	20	4	Ga	Muslim	Ghanaian	Trader
11	S11	54	30	4	Fante	Christian	Ghanaian	Food staff seller
12	S12	58	40	2	Breman	Christian	Ghanaian	Shop owner
13	S13	56	30	3	Ashanti	Christian	Ghanaian	System operator

Appendix B: Interview Guide

Data Collection Instruments

Interview guide

A. Demographic information

Identification (ID) Code.....:

1. Age
2. Number of years in marriage
3. Occupation
4. Religion
5. Tribe
6. Language(s) spoken
7. Number of children
8. Nationality

B. Guiding Questions:

1. Madam, please tell me about your husband's condition
2. What do you do for him on daily bases? Cooking, washing, feeding, etc.
3. How do you think your caring role has affected you physically?

Probes:

- Sleep
- Eating pattern
- Tiredness

4. Madam, please tell me how you think your care of your husband has affected you psychologically?

Probes:



- Fears
- Sad moments
- Source of strength

5. Kindly tell me how you combine your caring role with your social life

Probes:

- Time with friends
- Time for leisure activities

6. In what way has your caring role affected your work?

Probe:

- Attendance
- Customer relation
- performance

7. What about your finances?

Probe:

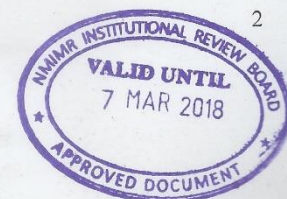
- Loan
- Support
- Selling items, etc

8. Please tell me what brings you and your husband closer to each other

Probes:

- Communication/isolation
- Sex/affection

9. What keeps you focused in your caring role?



10. Please tell me about how you think your husband's condition has affected your spiritual life?
11. What is the meaning of the situation to you?
12. What are your doubts in this situation?
13. How do you see God in the entire situation?
14. What is your hope at this moment?
15. How do you cope with caring for him?
16. What else would you like to tell me?



Appendix C: Consent Form from NMIMR

NMIMR-IRB CONSENT FORM TEMPLATE

Title: Experiences of Spouses of Men with Advanced Prostate Cancer in the Accra Metropolis

Principal Investigator: Margaret Ofori

Address: School of Nursing, College of Health Sciences, University of Ghana.

General Information about Research

This study will seek information from you concerning your wellbeing in your caring role for your husband. The study involves a research on the experiences of spouses of husbands with advanced prostate cancer in the Accra City. You will be interviewed and our conversation will last between 45 minutes to 60 minutes. Our conversation will focus on your bodily, social, emotional and spiritual wellbeing as a caregiver. The interview will be recorded on audio tape recorder with your permission. Dr. Samuel Atindanbila will take you through counselling where necessary at no cost. He can be contacted on 0277532705.

Possible Risks and Discomforts

The study involves minimal risks. It is expected that during the interview, questions asked may touch on your emotional wellbeing as a caregiver. However, Dr. Samuel Atindanbila will take you through counselling where necessary at no cost. He can be contacted on 0277532705.

Possible Benefits

You may not have direct benefit at this time. However, your participation in this study will give awareness to nurses, other health workers and the public on exactly what spouses go through in the care of men with prostate cancer. It will encourage health workers to care for the women as well; instead of paying attention to only the man suffering from the disease so that the spouses can easily adjust to the situation. In addition, it will be resourceful to the stakeholders of health in policy formulation. Finally, your participation will give reasons for the establishment of prostate cancer support group in Ghana.

Confidentiality

Even though our conversation will be recorded, under no circumstances will your name be mentioned in any part of this research. However, you will be given a false name that will be attached to all the information concerning you during this interview. My two supervisors are the only other people who can have access to your information. You are assured that all information you give will be protected to the best of our ability. The audio-tape will strictly be put under lock and kept for five years in my custody.

Compensation

There is no compensation for this study; but you will be given snack after the interview.

Voluntary Participation and Right to Leave the Research

Your participation in this study is voluntary. Therefore you have the right to withdraw at any point in time in the course of the study without giving me any notice or explanation.

Contacts for Additional Information

Please contact the following people in case you need additional information:

Margaret Ofori

Phone number: +233-207356449/ +233-249440355

Dr. Lydia Aziato

Phone number: +233-208552719/ +233-244719686

Dr. Mathew Kwame Yeboah Kyei

Phone number: +233-244653186



Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title (*Experiences of Spouses of Men with Advanced Prostate Cancer in the Accra Metropolis*) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

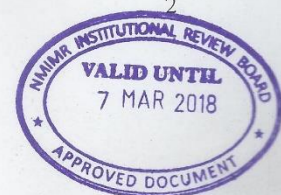
Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained Consent



Appendix D: Ethical Clearance

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979A Constituent of the College of Health Sciences

University of Ghana

INSTITUTIONAL REVIEW BOARD

Phone: +233-302-916438 (Direct)
-233-289-522574
Fax: +233-302-502182/513202
E-mail: hirb@noguchi.ug.edu.gh
Telex No: 2556 UGL GH



Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

8th March, 2017

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

IRB 00001276

NMIMR-IRB CPN 076/16-17

IORC 0000908

On 8th March, 2017, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Experiences of Spouses of Men with Advanced Prostate Cancer in the Accra Metropolis**

PRINCIPAL INVESTIGATOR : **Margaret Ofori, MPhil Cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 7th March, 2018. You are to submit annual reports for continuing review.

Signature of Chair:

Mrs. Chris Dadzie
(NMIMR IRB, Chair)

Appendix E: Introductory Letter



UNIVERSITY OF GHANA
SCHOOL OF NURSING

SON/E.11

March 15, 2017

Ref. No.:

The Deputy Director of Nursing Services
Korle Bu Teaching Hospital
Accra

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Margaret Ofori, an M.Phil student of the School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Legon. She is seeking your permission to collect data for her research on the topic **"Experiences of Spouses of Men with advanced Prostate Cancer in the Accra Metropolis."**

I should be most grateful if you could kindly assist her with the information that she may require.

Thank you.

Yours faithfully,

A handwritten signature in blue ink, appearing to read 'Lydia Aziato'.

Dr. Lydia Aziato
Senior Lecturer

COLLEGE OF HEALTH SCIENCES

P.O. Box 1043, Legon, Accra, Ghana.
• Tel: +233 (0) 302 513 290 / 0259 531 213 • Email: son@nurs.ug.edu.gh • Website: www.nursing.ug.edu.gh

Appendix F: Correspondent from Professor Betty Ferrell

Permission to use your model

Inbox x



MARGARET OFORI <maggofori@gmail.com> 3/22/15

to bferrell

Dear Professor Ferrell,

My name is Margaret Ofori, an M Phil Nursing student of the University of Ghana, Legon.

I am conducting a qualitative research on the topic "Experiences of spouses of men with advanced prostate cancer in the Accra Metropolis, Ghana"

I have read on your Quality of Life Model and it is suitable for me to use as the conceptual framework for my thesis. I cannot use what belongs to you without your consent.

Hope to hear from you soon.

Thank you.



Ferrell, Betty <BFerrell@coh.org> 3/22/15

to me

You are welcome to use our tools and models. They are on our website

[Http://prc.coh.org](http://prc.coh.org) in the QOL section.

Betty Ferrell

Sent from my iPhone

Completion of Thesis

Inbox x



MARGARET OFORI <maggofori@gmail.com> Jul 24

to bferrell

Dear Professor Ferrell,
It has been a success using your model on Quality of life applied to family caregivers per your permission. It was interesting and fulfilling.
I am grateful for your assistance.

Thank you.



Ferrell, Betty <BFerrell@coh.org> Jul 24

to me

Congratulations. I'm so glad it was helpful to you.
Betty Ferrell

Sent from my iPhone

The philosophy of Quality of Life Model Applied to Family Caregivers.

Inbox x



MARGARET OFORI <maggofori@gmail.com> Aug 4 (6 days ago)

to bferrell

Dear Professor Ferrell,-----
Completion of Thesis

Inbox x



MARGARET OFORI <maggofori@gmail.com> Jul 24

to bferrell

Dear Professor Ferrell,
It has been a success using your model on Quality of life applied to family caregivers per your permission. It was interesting and fulfilling.
I am grateful for your assistance.

Thank you.



Ferrell, Betty <BFerrell@coh.org> Jul 24

to me

Congratulations. I'm so glad it was helpful to you.
Betty Ferrell

Sent from my iPhone

Model on Quality of Life Model Applied to Family Caregivers. However, I keep asking myself lots of questions on the why, what and how of research studies.
I wish to use your Model again for a more matured writing as I am being mentored by my mentors in research.

Prof. I wish you could educate me on what pushed or inspired you to develop such a wonderful model.

I would be expecting your prompt response as usual.
Thank you.



Ferrell, Betty <BFerrell@coh.org> Aug 4 (6 days ago)

to me

Betty Ferrell - Ph.D, RN, FAAN. FPCN, CHPN

Director & Professor

City of Hope

Nursing Research & Education

1500 East Duarte Road, Duarte CA 91010

Population Sciences Bldg #173

Direct: (626) 218-2825

Fax: (626) 218-8941

bferrell@coh.org