

ORIGINAL ARTICLE

The Effect of Group Counselling based on Constructive Couple Communication on Perceived Spousal Support in Uterine and Cervical Cancer Survivors: A Randomized Control Trial

Fatemeh Azimi¹, MS; Fatemeh Moghaddam-Tabrizi^{1,2}, PhD; Rahim Sharafkhani³, PhD

¹Department of Consultation on Midwifery, School of Nursing and Midwifery, Urmia University of Medical Sciences, Urmia, Iran;

²Maternal and Childhood Obesity Research Center, Urmia University of Medical Sciences, Urmia, Iran;

³Department of Public Health, School of Health, Khoy University of Medical Sciences, Khoy, Iran

Corresponding Author:

Fatemeh Moghaddam-Tabrizi, PhD; Maternal and Childhood Obesity Research Center, Urmia University of Medical Sciences, Pardis Nazlou, 11 Km of Nazlou Road, Postal Code: 57561-15335, Urmia, Iran

Tel: +98 44 32754960-3; Fax: +98 44 32754921; Email: moghaddam.f@umsu.ac.ir

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ABSTRACT

Background: Uterine and Cervical cancer survivors face challenges like the disruption of emotional and sexual relationships, struggle to maintain sexual life and intimacy, and the possibility of divorce. The study aimed to determine the effect of group counseling based on couples' constructive communication on perceived spousal support in uterine and cervical cancer survivors.

Methods: A randomized controlled trial on 40 women who survived uterine and cervical cancer were recruited using convenience sampling and then randomly allocated to a couple-based constructive communication intervention group and a routine cancer center care control group from June 2019 to March 2020 in Motahhari and Imam Khomeini hospitals in Urmia. The intervention group was involved in a group counseling session weekly for 5 weeks, regarding constructive couple communication skills. Perceived spouse support was assessed using the sources of social support scale which has 4 subscales informational, instrumental, emotional, and negative support before and one week after the end of the intervention in both groups. Data analysis was performed using SPSS version 24 through Independent and paired t-tests, Mann-Whitney U test, Wilcoxon, chi-square, and ANCOVA. P value<0.05 was considered statistically significant.

Results: The effect of the intervention was statistically significant in reducing negative support in the intervention group (2.70±0.80) in comparison with the control group (3.40±1.04) (P=0.03). It was also statistically significant in increasing informational support (3.45±0.71 vs. 2.15±0.80, P<0.001), instrumental support (3.15±0.58 vs. 2.85±0.74, P<0.001), and emotional support (19.40±1.60 vs. 16.10±2.10, P<0.001).

Conclusion: Group counseling based on couple constructive communication increased perceived spousal support in uterine and cervical cancer survivors

Trial Registration Number: IRCT20150125020778N22.

Keywords: Cancer, Cervix, Counseling, Family Support, Randomized Controlled Trial, Uterine

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INTRODUCTION

In 2020, it was estimated that about 4,700 women would develop gynecological cancer and about 2,500 women would die from gynecological cancer in Iran. Lack of organized screening strategies for early detection of developed gynecological cancers and low cancer awareness in the general population leads to late diagnosis and lower success rate in treatment, which may explain the continued rise in mortality rates.¹

Cancer patients often report disease- and treatment-related side effects, including fatigue, pain, and cognitive impairment.² Emotional distress is also common, manifesting as depression, anxiety, fear of disease progression, and death.³ For many patients who are married or are in a committed relationship, cancer also affects their partner. Partners' relationship satisfaction may also decrease over time following a patient's cancer treatment.⁴ Uncertainty about the effectiveness of treatment and the course of the cancer causes psychological distress for both patients and spouses.⁵ The couple faces new challenges (e.g. lack of knowledge about the disease, financial burden), changing roles (e.g. sole breadwinner, family roles), and worries about their future together.⁶

Accumulating evidence suggests that the ability of couples to communicate effectively plays an important role in the adjustment of both patients and partners to the illness experience.⁷ Specifically, communication behaviors associated with better adjustment include open discussion of cancer-related concerns (often referred to as disclosure) and the ability to listen and respond supportively to one's partner. Maladaptive communication behaviors include withholding of disclosure, avoiding, or avoiding response.⁸

The three elements that make up constructive communication behaviors are mutual discussion (both members try to discuss the problem), mutual expression (both members express their feelings to each other), and mutual negotiation (both members suggest possible solutions and compromises).

In contrast, mutual blame (both members blame, accuse, and criticize each other), mutual threat (both members threaten each other with negative consequences), verbal aggression (the man calls the woman names, swears at her, or attacks her character), and verbal aggression (the woman calls the man names, swears at him, or attacks his character) are the four items of destructive communication behaviors.⁹

Constructive communication about cancer-related concerns has been associated with less distress and greater relationship satisfaction in both early breast cancer patients and their spouses. Although spousal communication patterns can be conceptualized in various ways, studies involving cancer patients and their partners have mainly examined mutual constructive communication and demand-withdrawal communication patterns. Open and constructive discussions between spouses about a cancer-related concern appear to be associated with greater marital satisfaction and less distress. In contrast, when one member of the dyad exerts pressure to talk about a problem while the other member withdraws or becomes defensive, lower levels of relationship intimacy and marital satisfaction and increased levels of psychological distress are reported.¹⁰⁻¹²

Spousal support helps to promote active disclosure of cancer patients' life events and crises to their partners; this encourages cognitive reappraisal of the traumatic event of cancer diagnosis, thus promoting meaning-making from the cancer experience and ultimately leading to positive psychological changes resulting from struggling with highly challenging life crises or traumatic events, which can lead to a better appreciation of life, improved interpersonal relationships, greater spiritual development, increased life opportunities and enhancement of patients' personal strengths.^{13, 14}

Studies conducted in Iran have shown that women with uterine and cervical cancer face challenges such as lack of awareness and misconceptions about the disease, attempts to

seek financial and also medical support, physical and psychological problems, disruption of emotional and sexual relationships, worry about losing their place in marital life, struggle to maintain sexual life with their husbands, deterioration of intimacy, and the possibility of divorce and separation.^{15, 16}

Cancer is considered a stigma in the culture of the present study.¹⁷ On the other hand, the challenges caused by uterine and cervical cancer, especially sexual issues, are presented as taboo;¹⁸ in the same way, attention to women's needs is not a priority in the patriarchal culture. In other words, some women were not concerned with their marital satisfaction and declared that only their husband's satisfaction was important.¹⁹ Therefore, this study aimed to determine the effect of group counseling based on constructive communication between the couples on perceived spousal support in uterine and cervical cancer survivors.

MATERIALS AND METHODS

A randomized controlled trial was conducted on women who survived uterine and cervical cancers from June 2019 to March 2020 in Urmia located in Northwest of Iran. Due to the lack of similar internal and external studies (based on a study group search), we conducted a pilot study on 20 affected women (10 individuals in each intervention and control group). Constructive communication patterns and perceived feelings of spousal support were assessed in two groups to calculate the sample size. Considering the alpha of 0.05 and the power of 90% of the test, 40 women, in total, were estimated.

$$N = \frac{(z_{1-\alpha/2} + z_{1-\beta})^2 * [(s_1^2 + s_2^2)]}{(x_1 - x_2)^2}$$

$$20 = \frac{(1.96 + 1.28)^2 * [(9.49^2 + 10.02^2)]}{(47.16 - 36.94)^2}$$

Sampling initiated after obtaining the ethical approval code from the Ethics Committee of Urmia University of Medical Sciences and registering the study information

on the Iranian Registry of Clinical Trials. To conduct the study, the researcher screened 40 eligible participants out of 65 uterine and cervical cancer survivors in Motahari (22 women) and Imam Khomeiny hospitals (18 women) (Figure 1). Because these hospitals are located in the center of the province, patients from all over the province are treated in these two governmental centers.

Inclusion criteria were women who had been diagnosed with uterine and cervical cancer in stages I, II, and III according to medical records, had undergone total or radical hysterectomy and were receiving radiotherapy or chemotherapy, had no history of any other form of cancer, were able to read and write, were married and lived with their spouses, did not use drugs or alcohol, had no history of admission to psychiatric wards, and were not taking antidepressants. Exclusion criteria were unwillingness to continue or failure to attend two sessions of the intervention program and recent stressful events for the participants, such as cancer or death in first-degree family members during the study.

Eligible participants were assigned using concealed randomized allocation to group counseling based on constructive communication between couples (intervention group) and routine cancer center care (control group).

This was done by writing the letters A (intervention) and B (control) on 40 cards. Each patient then randomly selected one of the cards and was allocated to the intervention or control group based on the letter written on the card. This part was done by a person who was not involved in the trial. The consenting women in each group were then asked to sign the informed consent form. In the intervention group, participants received the intervention program as well as routine cancer center care. The participants in the intervention group were divided into three groups, each containing 6 to 8. According to the schedule given to the participants, they were asked to attend the sessions. Based on the participants' request, the husbands also participated in

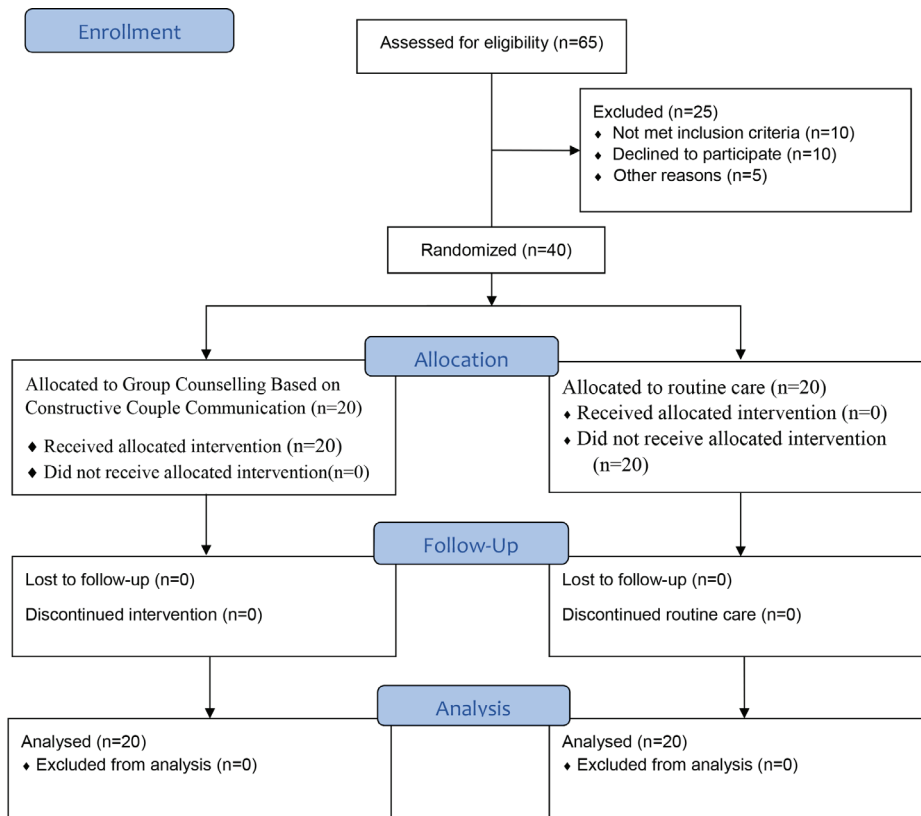


Figure 1: CONSORT flow chart of the study

the group counseling sessions. Nearly, they participated in the most sessions

The intervention group was involved in a group counseling session weekly for 5 weeks, each 45-60 minutes each session regarding constructive couple communication skills and related tasks, according to skills for constructive couple communication in uterine and cervical cancer survivors and their partners. In the control group, only routine cancer center counseling was conducted with the subjects regarding self-care in cancer treatment through the booklet. To comply with research ethics, participants in the control group had access to the intervention program after completing the questionnaires in the form of booklets.

The entire content of the intervention program was developed using the existing literature^{10, 20-23} and then confirmed for content validity by ten faculty members with psychology and oncology specialties. The content of the couple's constructive communication program is presented in Table 1.

To conduct the sessions, the researcher

followed the specific instructions designed by the research team, considering all the steps of the program. In this line, each session began with a challenging question about the participants' lived experience of couple communication patterns and new life challenges with uterine and cervical cancer diagnosis, and the participants' answers were collected in the form of brainstorming. Participants were encouraged to submit additional responses. This process continued until recurring statements emerged from the collective lived experience. The responses were then categorized based on the similarity of subjects by the researcher. For each challenging issue, the necessary consultation was then provided in the group and, if necessary, privately. During the week, the participants were encouraged to write their experiences in the form of daily notes as weekly assignments and share them with the group members in next sessions. The detailed implementation of the consultations and the process of answering questions was constantly monitored for necessary revisions.

Table 1: The content of the mutual couple constructive communication program

<p>First session:</p> <p>Objectives:</p> <ol style="list-style-type: none">1. To introduce the researcher and the research aims and procedures to the couples,2. To describe the steps of the constructive couple communication pattern. <p>Activities:</p> <ol style="list-style-type: none">1. The first session was to introduce the intervention program, plan the intervention (specifying the time, place, length, number of sessions and respecting the rules of the program and other participants).2. The main purpose of this session was to emphasize the importance of the supportive role of the spouse in improving the quality of management in critical condition, based on the results of scientific studies.3. Attempt to build a relationship of trust4. Establish a favorable relationship with the participants5. Group discussion and brainstorming on constructive couple communication6. Clarifying the researcher's expectations of the study phases7. Presentation of tips to improve couple communication8. Suggestion to pay attention to communication allergies and annoying behaviors9. Commitment to follow the emotional relationship and to be extremely careful of one's own behavior throughout the married life.10. Recommendation to pay attention to and understand the inevitable personality differences in couples, and to consider that accepting and avoiding disagreements and fully respecting these differences is essential.11. Obtaining a telephone number for communication if necessary and mentioning the goals and how to communicate.
<p>Second session:</p> <p>One week after the first session</p> <p>Objectives:</p> <p>Mutual self-disclosure and partner responsiveness</p> <p>Activities:</p> <p>For self-disclosure</p> <ol style="list-style-type: none">1- Disclosure of own and partner's preferences and experiences by answering a series of questions (including about cancer).2- Express own vulnerable feelings3- Improve the couple's ability to comfortably share their thoughts and feelings about cancer4- Encourage the couple to individually express their own perceptions of the patient's situation5- Patients list their cancer-related concerns and disclose their own cancer-related events and feelings in as much detail as possible;6- Express cancer-related experiences, cognitions and emotions;7- Patients and partners separately express their own facilitators and barriers to communication.8- Disclose cancer-related experiences and sources of distress and make a list of cancer-related concerns;9- Express support needs.10- Share thoughts and feelings about a range of cancer-related issues.11- Express experiences, thoughts and feelings honestly about a cancer-related topic.12- Discuss fears or concerns about disease progression or death13- Concerns about the quality of medical care <p>Partner responsiveness</p> <ol style="list-style-type: none">1- Review and discuss own approaching and withdrawing behaviors2- Listening patiently to partner's disclosures3- Improving mutual understanding4- Listen supportively to partner's disclosure and gain new insights into their experience5- Respond with empathy and affirmation6- Accept and validate partner's feelings and perspectives7- Listen reflectively to the partner's emotional disclosure, accepting the partner's feelings and avoiding premature advice.

Third session

One week after the second session

Objectives: Relationship commitment

Activities:

- 1- Accepting differences of opinion in different dimensions of life including: separating personal issues from common issues, seeing your partner as a set of good and bad, paying attention and focusing on common points, not trying to change your partner, not comparing yourself with others and highlighting individual and relationship strengths and sharing them.
- 2- Watch related videos to learn how to share your concerns and understand your partner's perspective.
- 3- Set up a text line with your partner and send each other constructive messages about your goals for life after cancer and discuss the facilitators for achieving them
- 4- Communicate supportively to understand issues
- 5- Identify and highlight support received in the intimate relationship
- 6- Review supportive communication skills and discuss transition to survivorship
- 7- Improve constructive communication about cancer-related concerns, mutual support and emotional intimacy
- 8- Practice skills learned in session and as homework
- 9- Discuss bridges and barriers as a couple
- 10- Learn the problem-solving model, apply it to challenging issues and share your experiences with other couples.
- 11- Practice purposeful speaking and active listening about a cancer issue during the session exercise and home assignment, and share lived experiences as a scenario.
- 12- Use inspirational phrases and positive affirmations, not comparing your life with others.
- 13- Creating a sense of security and self-esteem
- 14- Not to blame and to avoid rigidity, to move and to do physical activities.
- 15- Recognizing and believing in your partner's talents
- 16- Encourage compliments and praise each other
- 17- Strengthening the sense of responsibility and cooperation
- 18- Trying to make a decision about cancer-related issues through constructive couple communication skills and sharing the experience with couples in the group
- 19- Review progress in communication skills during the intervention
- 20- Predicting future probable cancer-related issues that may affect couple communication and discussing how to overcome them
- 21- Practice communication skills in each session
- 22- Write and read the thank-you letter to each other, review progress and discuss coping strategies for future cancer-related communication problems.
- 23- Maintaining a sex life
- 24- Dealing with financial concerns
- 25- Seeking support from friends and family
- 26- Carrying out household tasks
- 27- Carrying out daily activities
- 28- Dealing with changes in partner's appearance

Fourth Session

One week after the third session

Objectives: Relationship-compromising behaviors

Activities:

- 1- To point out the couple's inappropriate communication behavior;
 - 1.1. Accepting differences of opinion in different areas of life
 - 1.2. Separating personal issues from common issues, seeing your spouse as a set of good and bad,
 - 1.3. Paying attention and focusing on common points
 - 1.4. Not trying to change your spouse's personality
 - 1.5. Not comparing your life to others
 - 1.6. Not blaming and avoiding rigidity
- 2- Identifying unhelpful partner reactions
 - 2.1. Avoid unnecessary words and talk, talk about important issues, speak carefully, listen actively.
 - 2.2. Advice to accept the other person as they are.
 - 2.3. Not to try to change your spouse and make his or her characteristics and behavior similar to your ideal.

2.4. True love, and the love that all family psychologists agree on today, is to accept and respect the other person's differences.

2.5. Recommendation for reconciliation after mental preparation and calmness of each party,

2.6. To be fully mentally prepared and then to move forward. You give yourself up and despite all your negative emotions that somehow prevent you from doing so, you still go to your other side and continue the relationship. This will make him regret what he has done and you will feel better.

2.7. Remembering to remain interested in your wife despite differences of opinion and feelings

3- Block negative behavior

3.1. Recommendation to avoid violence as a punishment to the other party to prevent the deepening of the cloud.

3.2. Seeking help from professionals and not interfering with close family members in solving problems

3.3. Not to put the wife in a difficult situation by using pressure levers such as dowry.

Fifth session

One week after the fourth session

Objectives: Intervention feedback

Activities:

1. Reviewing and evaluating the skills acquired in terms of communication patterns

2. Carrying out the post-test

To assess the active participation of the subjects in the sessions, the researcher checked the quality and quantity of the answers received in the sessions. Participants were encouraged to recognize the causes of fears, beliefs, disgust, shame and negative attitudes as threatening obstacles to having control over the critical situation; also, they were motivated to identify the destructive factors of the couple's daily cooperation and intimacy. Then, they were persuaded to set goals to achieve optimism, and practice sharing feelings and emotions. In this way, they were trying to distinguish the barriers to accepting a positive body image, following self-regulated goals to appreciate the skills for stress management, and other skills, as mentioned in Table 1.

Participants were required to take daily notes and submit them to the trained researcher in the session. If necessary, additional responses and individual counseling could be provided through private counseling. They also had the opportunity to express their daily experiences, their most avoided emotions, barriers to having a firm opinion, factors that made them disorganized, a list of daily obstacles to having constructive couple communication, facilitators or barriers to being able to avoid uncertain situations, strategies to overcome loneliness, skills to promote self-esteem, mediators to overcome being vulnerable, unhappy or sad, strategies to establish positive beliefs, and creation of a sense of calmness

and hopefulness. They were given access to individual and group counseling based on their willingness to protect the safety and privacy of the subject. The content of the intervention program was provided in the form of written texts, video clips, images, lectures and recorded voices and booklets, and the main strategy for conducting the sessions was expressive and supportive focus group discussion, in addition to the help of counseling skills. All the contents of the intervention program and the conduct of the sessions were under the guidance of an expert psychiatrist who is a faculty member of the university. A Master of Counselling in Midwifery student attended the couples counseling workshops in addition to the relevant subjects in her academic curriculum, so she was qualified to conduct the intervention.

Demographic characteristics were collected and perceived spousal support were assessed from both groups before the intervention and one week after the end of the intervention. Perceived partner support was assessed using 10 items intended to measure diverse aspects of support. The items, termed the Sources of Social Support Scale (SSSS), drew on the existing evidence and theory to cast a wide net for potential ways of expressing support or nonsupport. Items assess aspects of informational, instrumental, emotional, and negative support. All items were rated on a scale ranging from not at all (1) to a lot

(5), so the total score ranges from 10 to 50. High scores on all scales reflect high levels of perceived support. Cronbach's α ranging from 0.81 to 0.95 in domains of scale exhibited good internal consistencies.²⁴

Validation of the Malay version of the SSSS among Malaysian cancer patients indicated that the SSSS total score (Cronbach's $\alpha=0.70$, intraclass correlation coefficient (ICC)=0.72) and its domains (Cronbach's α ranging from 0.70 to 0.83, intraclass correlation coefficient ranging from 0.6 to 0.76) exhibited good internal consistencies and good test-retest reliability.²⁵

In the present study, the Persian version of the questionnaire was examined for face and content validity in the Iranian society. The relative coefficient of content validity (CVR) was 72.37% and the content validity index (CVI) was 82.12% for this instrument, which is an acceptable level.

The clinical and demographic characteristics of the two groups were compared using chi-square test and independent samples t-test. To assess the difference of the mean scores of the participants' perceived spousal support between and within groups, we

used independent and paired t-test, Mann-Whitney test, Wilcoxon test, and ANCOVA. P value < 0.05 was considered significant, and all statistical analyses were performed using IBM SPSS Statistics 24.

This study obtained the approval from the Research Ethics Committee of Urmia University of Medical Sciences, Iran (approval No. IR.UMSU.REC.1398.031). All the participants signed written informed consent for their participation in the study. Confidentiality of the participants' information was considered. The right to withdraw from participation without penalty was preserved for all participants. Confidentiality of the participants' information was considered.

RESULTS

The women's mean age was 48.6±7.95 year. 29 (72.5%) subjects had cervical cancer and 11 (27.5%) had uterine cancer. There was no significant difference between the intervention and control groups in terms of the socio-demographic characteristics and some uterine and cervical cancer-related information of the participants (P>0.05) (Table 2).

Table 2: Comparison of socio-demographic characteristics and some clinical issues of participants between the control and intervention groups

Characteristics		Control (N=20) Mean±SD	Intervention (N=20) Mean±SD	P value
Age		49.65±8.11	47.55±7.86	*0.41
Husbands' age		53.75±9.10	53.50±8.56	*0.92
Number of children		3.50±1.67	2.34±1.82	**0.89
Duration of cancer diagnosed (months)		16.70±10.87	23.80±19.47	**0.30
		N (%)	N (%)	
Home ownership	Rental	5 (25)	8 (40)	***0.31
	Owner	15 (75)	12 (60)	
Participants' educational level	Under diploma	19 (95)	19 (95)	***1
	Diploma	1 (5)	1 (5)	
Husbands' educational level	Under diploma	17 (85)	20 (100)	***0.231
	Diploma	3 (15)	0 (0)	
Economic status	Insufficient	13 (65)	19 (95)	***0.44
	Enough	7 (35)	1 (5)	
Cancer type	Uterus	5 (25)	6 (30)	***0.723
	Cervix	15 (75)	14 (70)	
Treatment type	Chemotherapy	14 (70)	15 (75)	***0.72
	Radiotherapy	6 (30)	5 (25)	

*Independent Samples Test; **Mann-Whitney; ***Pearson Chi-Square

Table 3: Comparison of mean scores of sources of social support scale dimensions before and one week after the end of the intervention in intervention and control groups

Dimensions of support	Groups	Before intervention Mean±SD	One week after intervention Mean±SD	P value*
Information	Intervention	1.60±0.60	3.45±0.71	<0.001
	Control	2.00±0.72	2.15±0.80	0.06
	P value**	0.17	<0.001	
Instrument	Intervention	2.15±0.74	3.15±0.58	<0.001
	Control	2.65±0.81	2.85±0.74	0.24
	P value**	0.21	<0.001	
Emotional	Intervention	15.85±1.78	19.40±1.60	<0.001
	Control	16.05±2.16	16.10±2.10	0.24
	P value***	0.16	<0.001	
Negative	Intervention	5.95±1.53	2.70±0.80	0.03****
	Control	3.35±1.22	3.40±1.04	0.33*
	P value**	0.001	0.03	

*Wilcoxon signed-rank test; **Mann-Whitney; ***Independent Samples Test; ****Quade ANCOVA

The means of the SSSS dimensions were compared before and after the intervention in two groups (Table 3). In the intervention group, a significant decrease was observed for negative support ($P=0.03$), while informational ($P<0.001$), instrumental ($P<0.001$), and emotional support ($P<0.001$) increased significantly after the intervention. In the control group, on the other hand, none of the dimensions was significantly different after the intervention ($P>0.05$).

DISCUSSION

The findings of the current study confirmed the effects of group counselling based on constructive couple communication on improving perceived spousal support in women who survived uterine and cervical cancer. The results are in line with the view that the constructive communication pattern of couples affects the feeling of spousal support. Consistent with the results of the present study, other findings from various studies have shown that open and constructive communication, more social support, and supportive dyadic coping are associated with higher levels of marital adjustment. Other variables such as self-efficacy, sexual functioning, and psychological adjustment were also positively associated with marital adjustment.²⁶

As to information support, the results

showed a statistically significant increase after the intervention in the intervention group, indicating the effectiveness of the intervention on the constructive communication pattern of the couples with uterine and cervical cancer. Consistent with our study, the results of a qualitative study indicated that after cancer detection, spouses focused on problem solving under stress by preparing the patient for the doctor's explanation of the diagnosis, supporting her to adjust to the shock, and helping her to cope with the treatment advice; during the therapy period, the spouse focused on functional compensation to emphasize the patient's ignored self-care and family care capacities; after treatment, the spouse focused on role recovery by coping with changes in the patient and preparing her to change the family and society.²⁷

The instrumental support score, which is another dimension of couple support, increased after the intervention. In a systematic review, couple-based communication interventions reported improvements in relationship functioning (including mutual communication, intimacy, and relationship satisfaction) and individual functioning (including reductions in anxiety, depression, and cancer-related distress, and increases in psychological adjustment and quality of life).²³

The results of the present research on emotional support showed that a significant

difference was observed in the intervention group after the intervention compared to the control group; in other words, the intervention group received more emotional support. Together with the present study, the results of a qualitative study showed that the dimensions of psychosocial support, dyadic coping, communication, and intimacy are related and define the construct of relationship quality, thus influencing the couples' adjustment to breast cancer diagnosis and the disease trajectory.¹² A study highlighted the positive association between mutual constructive communication (i.e., discussing and expressing feelings about cancer-related concerns), active engagement (i.e., discussing cancer-related problems together), and cancer-related communication and psychological well-being in patients and spouses.²⁸

The results of the present research on negative support showed that after the intervention a significant difference was observed in the intervention group compared to the control group; in other words, the intervention group received less negative support. In terms of confirming the results, it can be said that negative support in the results of the qualitative analysis of dyadic interviews showed that when spouses did not take their wives' stress and alternative coping attempts or advice from spouses seriously, the patients perceived this as triggering pressure. Similarly, spouses reported conflict and feelings of rejection when some of their support efforts were perceived by patients as exaggerated and unhelpful; verbal arguments and failure to consider the other's point of view are mentioned as types of negative dyadic coping.²⁹ In this issue, a systematic review showed that a lack of communication, expressed through behaviors such as concealment, avoidance and protective buffering, is negatively associated with patients' and/or spouses' own psychological well-being, higher levels of depression, anxiety and general distress, and lower reported physical well-being.¹⁰

Consistent with the findings of the present

research, the results of the studies conducted in Iran showed that the spouse was one of the most important sources of adjustment with cancer for Iranian women.^{27,30} Perceived spousal support is known to be a cornerstone role in coping with cancer during periods of illness.³¹ Divorced people are more likely than married people to suffer from diseases such as cancer, cardiovascular disease, pneumonia, and high blood pressure. Some researchers believe that the reason for this problem is the loss of the greatest source of social support, the family.³² Consistent with the current study, also it has been found that support resources make a person feel loved, respected, valuable, and able to withstand stressful situations.³³

In the present study, the intervention program gave couples the opportunity to interact with each other, express their problems and challenges caused by cancer, their inner worries and hidden fears, improve their communication skills, and understand that their problem is not unique. The group created by the intervention program created a friendly atmosphere that helped the participants to express their lived experiences through brainstorming; they gained self-confidence and found supportive and genuine friends, and their husbands also became more aware of their wives' concerns.

The Couples Constructive Communication Counselling Program created an opportunity for the participants to express all their fears about the future life; silent tolerated worries about all aspects of anatomical and physiological changes; negative feelings about the destroyed mental body image; their worries about their responsibilities as a trustworthy mother for their young children at the time of the greatest need for a mother's supporting role; insecurities about the possibility of continuing appropriate marital relations; doubts about managing their job while the condition requires more income among other economic problems of family members, suppressed anger for fatalistic attitude because of misunderstanding of religious advice and not finding trustworthy source of support. In

the present study, counselling with couples was an attempt to create an empathic and trusting atmosphere for them to spend their time together; the experience might not have been perceived before because of the full-time involvement in daily routine. The intervention program tried to enable the participants to turn the sessions into an opportunity to create supportive and expressive sessions; in other words, the participants could feel a sense of belonging to the group and make it a social support group. The researcher tried to give the participants confidence that overcoming cancer and enduring this exhausting journey without the companionship of a spouse is an overwhelming task; she tried to motivate them to establish constructive communication in couples and reassured them that acquiring this skill by sharing experiences and practicing these skills through active participation in the group is achievable.

One of the strengths of the present study was that the counselling was group or individual, depending on the participants' willingness. The main strength was that the uterine and cervical cancer survivors attended the sessions with their husbands. It seems that it was an opportunity to reveal their hidden feelings and the unspoken words that they could not reveal before because they were involved in routine daily life, especially in a patriarchal couple relationship. In other words, as they stated in their feedback, they renewed their love, especially at the time when they felt hopeless and in need of help. The participation of the husbands led to practicing all the trained skills together, and it was a motivating factor for the researcher to ensure that the content of the sessions was practiced at home. Another issue was that the sessions were eagerly awaited by the participants so that we did not have any attrition.

Because cancer psychological counselling programs are not routine in cancer care in the study culture, if someone wanted to have access to this kind of counselling program, it would be available in a private setting, which is expensive, and most women could not afford

it. Thus, as some of the participants said, our program was a light of hope in the darkness.

As a limitation of the present study, sexual issues are considered taboo in the culture of the study, so the couples refused to discuss these issues in the group; we invited them to attend individual counseling to realize the barriers to sexual issues.

CONCLUSION

Group counselling based on couple constructive communication increased perceived spousal support in uterine and cervical cancer survivors. Healthcare providers are recommended to assist spouses in providing support following the changing needs of patients with uterine and cervical cancer and emphasize the importance of their empathy in modifying the psychosocial effects of stressors to facilitate the adjustment to cancer.

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