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RESEARCH ARTICLE

Clinical analysis of the care pathway among women who underwent mastectomy following breast cancer in Cameroon

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Abstract
This article examines the care trajectory and psychological experience of women who have undergone mastectomy following breast cancer in Cameroon, using a qualitative clinical and interpretative approach. Based on semi-structured clinical interviews with three women receiving follow-up care in an oncology department in the Western region of Cameroon, the study highlights how the care pathway extends beyond biomedical treatment and is shaped by sociocultural meanings, economic constraints, family dynamics, and spiritual interpretations. Findings reveal diagnostic delays, therapeutic wandering, and the frequent coexistence of biomedical medicine, traditional practices, and religious healing in patients' trajectories. Mastectomy emerges as a major embodied disruption affecting body image, self-esteem, sexuality, marital relationships, and feminine identity, often intensified by stigma and fear of social judgment. However, the study also identifies resilience processes supported by children, family bonds, faith, and opportunities for psychological verbalization. This research contributes to the literature by emphasizing mastectomy as a relational and meaning-making experience embedded in a plural medical and cultural context. Practical implications include the need for earlier diagnostic communication, improved health education, partner-sensitive counseling, and integrated psychosocial support throughout the care pathway.

Keywords: Breast cancer; Mastectomy; Care pathway; Psychological experience; Cameroon

INTRODUCTION

Breast cancer is currently a major public health issue worldwide. According to estimates from the GLOBOCAN 2020 program, it is the most frequently diagnosed cancer among women, with approximately 2.3 million new cases, representing 11.7% of all cancers and now surpassing lung cancer (Sung et al., 2021). This increase is part of a continuous upward trend linked to population aging, urbanization, and changes in lifestyles (Siegel et al., 2025).

In sub-Saharan Africa, the situation is particularly concerning due to late diagnosis, limited access to specialized care, and significant socio-economic inequalities. The cancer burden is expected to nearly double by 2040, reaching close to 1.5 million new cases annually across the continent (Sung et al., 2021). Survival rates remain significantly lower than those observed in high-income countries, with less than 30% recovery in some French-speaking African regions compared with more than 60% in Western countries (Jedy-Agba et al., 2016).

In Cameroon, breast cancer is the leading cancer among women and accounts for approximately one-third of female cancer diagnoses, with a substantial proportion of affected women under 40 years old (Essiben et al., 2013). Most cases are diagnosed at advanced stages, increasing the likelihood of mastectomy. These delays are explained by insufficient health information, financial barriers, limited insurance coverage, shortage of specialists, geographical inequalities, and sociocultural representations of illness (Joko-Fru et al., 2024).

Within the Cameroonian sociocultural context, serious illness is rarely interpreted exclusively through a biomedical framework (Tsala, 2009). It may also be understood as resulting from spiritual forces, witchcraft, moral transgression, or relational conflict (Salem & Daher-Nashif, 2020; Tsala, 2009). Such beliefs strongly influence healthcare-seeking behaviors and often lead to plural therapeutic trajectories combining self-medication, traditional medicine, and religious healing before biomedical consultation (Mwaka et al., 2016). These trajectories suggest that what is commonly called the "care pathway" should not be reduced to the formal medical system but should be conceptualized as a broader process integrating personal interpretations, social networks, cultural resources, and institutional constraints.

From a psychological perspective, breast cancer is widely described as a destabilizing experience that affects body image, identity, sexuality, and interpersonal relationships (Dong et al., 2023; Nkoyock, 2023). Mastectomy in particular can generate a profound

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disturbance in the sense of self. In psycho-clinical terms, it may be interpreted as an experience of narcissistic injury, meaning a threat to self-esteem and bodily integrity that disrupts personal identity representations. It can also be understood as a form of symbolic mutilation, referring not to a literal cultural ritual, but to the subjective experience of bodily loss as a rupture in the symbolic meaning of femininity and womanhood (Sebri et al., 2021; Knaul et al., 2012). These concepts require a clinical interpretative approach rather than a purely epidemiological or biomedical framework, especially in contexts where femininity, motherhood, and the breast are culturally invested as markers of value and social identity.

However, despite growing research on breast cancer in Africa, important gaps remain. Many studies in sub-Saharan Africa focus primarily on epidemiological factors, access to services, and medical outcomes, while fewer explore the embodied and subjective experience of mastectomy through in-depth clinical narratives. Furthermore, the intersection between cultural explanatory models, plural healthcare practices, and post-mastectomy psychological adjustment remains insufficiently documented in the Cameroonian context. This gap justifies the relevance of a qualitative clinical multiple-case study design, as it allows for a detailed exploration of personal meanings, relational dynamics, and cultural representations shaping illness experience.

Therefore, the objective of this study is to understand, through a qualitative clinical and interpretative approach, how Cameroonian women experience their care pathway and psychological adjustment after mastectomy, with particular attention to diagnostic delays, therapeutic plurality, identity disruption, and resilience resources.

MATERIALS AND METHODS

Study Design

This research adopts a qualitative approach with a clinical and interpretative orientation. This framework was chosen to explore in depth the subjective experience of women who underwent mastectomy following breast cancer, taking into account both psychological suffering and sociocultural meanings. A multiple-case study design was selected in order to provide detailed individual analyses while enabling cross-case comparison. This design is particularly relevant for understanding complex experiences of bodily transformation and identity disruption.

Study Setting and Period

The study was conducted at the Batsenla Catholic Hospital of Dschang, a referral healthcare facility located in the Western region of Cameroon. Data collection took place from 11 May to 30 May 2024, within the oncology follow-up context.

Sampling Strategy and Case Selection

Participants were recruited through a purposive sampling strategy, targeting women who had undergone mastectomy following a confirmed diagnosis of breast cancer and were receiving medical follow-up in the hospital. Three cases were selected to capture diversity in age, socio-educational background, and social trajectory. This selection aimed to identify both shared patterns and meaningful variations in post-mastectomy experiences.

Researcher Positionality

The interviews were conducted by a clinical psychologist, trained in clinical listening and qualitative interviewing. The researcher adopted a supportive and non-judgmental posture to facilitate emotional expression and narrative depth. Reflexive attention was maintained throughout the analysis process, acknowledging that interpretation is shaped by the interaction between participants' discourse and clinical hypotheses.

Participants and Sociodemographic/Clinical Characteristics

The sample included three women aged 30, 31, and 45 years who had undergone unilateral mastectomy after breast cancer. At the time of the study, all participants were receiving follow-up care and had been exposed to oncological treatments, including chemotherapy and radiotherapy.

Table 1. Sociodemographic and Clinical Profile of the Participants

Pseudonym	Tchakam	Malla	Mvondo
Age	31	45	30
Marital status	Married	Married	Partnered
Number of children	3	3	Not specified
Education level	Bachelor's degree (Licence)	Primary School Certificate (CEP)	High school diploma (Baccalauréat)
Occupation	Student	Housewife	Trader
Hospital setting	Batsenla Catholic Hospital of Dschang	Batsenla Catholic Hospital of Dschang	Batsenla Catholic Hospital of Dschang
Time since diagnosis	1 year 6 months	10 months	1 year 3 months
Time since mastectomy	11 months	6 months	11 months
Treatment received	Chemotherapy and radiotherapy	Chemotherapy and radiotherapy	Chemotherapy and radiotherapy

Data Collection Procedure

Data were collected through semi-structured clinical interviews. Each participant completed three interview sessions, each lasting approximately 30 minutes, for a total of about 90 minutes per participant. Interviews were conducted in a confidential room within the hospital to ensure privacy and facilitate trust.

An interview guide was developed to explore key domains: symptom discovery, pre-diagnostic trajectory, and diagnosis disclosure, psychological experience of mastectomy, marital and sexual impacts, social repercussions, and coping resources. All interviews were audio-recorded with consent and transcribed verbatim.

Data Analysis and Rigor

Data analysis followed a thematic content analysis approach inspired by Mucchielli (1991). The process included repeated reading of transcripts, identification of

meaning units, coding of emerging themes, development of thematic categories, and interpretative synthesis across cases.

To ensure rigor, the researcher maintained a systematic audit trail of analytic decisions and ensured that interpretations were grounded in participant quotations. Clinical notions such as emotional collapse, shame, or identity destabilization were formulated cautiously as interpretative hypotheses rather than psychiatric diagnoses.

Ethical Considerations

Ethical clearance was obtained from the Regional Ethics Committee of the Littoral Region (Douala, Cameroon). Participants provided informed consent before data collection. Confidentiality was ensured through pseudonyms and removal of identifying information.

Given the sensitive nature of the topic (sexuality, trauma, body image), protective measures were implemented. Participants were informed of their right to pause or stop the interviews at any time without consequences for medical care. In case of emotional distress, the clinical psychologist-researcher ensured immediate supportive listening and the possibility of referral to appropriate psychological care within the hospital system.

RESULTS OF STUDY

The results of this research are based on the in-depth clinical analysis of three case studies, making it possible to explore the complexity of the care trajectory and the psychological experience of mastectomy among Cameroonian women with breast cancer. This approach highlights both individual singularities and thematic convergences. The cross-analysis of the interviews reveals several central dimensions, including diagnostic delay and therapeutic wandering, the interweaving of biomedical, traditional, and religious registers in representations of the illness, the narcissistic and identity impact of mastectomy, as well as the marital, social, and spiritual repercussions of the experience. The cases presented below (those of Tchakam, Malla, and Mvondo) illustrate in a nuanced way how the somatic ordeal interacts with previous life history, pre-existing psychological vulnerabilities, and resilience resources mobilized in the face of illness.

Case of Tchakam

Presentation of the participant

Tchakam is a 31-year-old Cameroonian woman, married and mother of three children, from a conflict-ridden polygamous family background. Her history includes early ruptures (mother's death at birth, sibling conflicts, repeated relocations), suggesting a context of psychological vulnerability. She underwent unilateral mastectomy after a long and uncertain care pathway marked by delayed diagnosis and medical wandering.

Care trajectory before diagnosis and cultural meanings of illness

Tchakam initially minimized the symptoms, delaying recourse to biomedical care: "*I told myself it was just an abscess and it would go away.*" Her trajectory was marked by repeated consultations and ambiguous medical communication: "*The doctor did not directly tell me that I had cancer… he kept going around it.*" The delayed disclosure intensified anxiety and shock: "*That's when I cried all the tears in my body.*" Throughout the trajectory, she interpreted the illness through magico-religious beliefs: "*It's the work of the devil and witches… maybe my mother-in-law.*" She also reported traditional practices and sacrifices: "*I go to the village for sacrifices… when a part of your body is removed.*" This illustrates a plural care pathway combining biomedical, traditional, and religious registers.

Psychological experience of mastectomy and the wounded female body

Mastectomy was experienced as a profound narcissistic and identity rupture. She strongly associated femininity with the breast: "*A woman, a real woman, is her breasts.*" The loss triggered bodily estrangement: "*I have become a mask… my body no longer looks like anything.*" Shame and withdrawal were central: "*I don't talk to people… I prefer to stay alone.*" Concealment strategies created emotional exhaustion: "*All this exhausts me, I can't take it anymore.*" Her marital and sexual life was deeply disrupted, with perceived rejection: "*He no longer touches me… he says I'm no longer attractive.*" Sexuality became emotionally empty: "*I don't feel anything anymore… I'm already dry inside.*"

Psychological resources and resilience factors

Despite intense distress, she mobilized support through her children, sister, and verbalization in dialogue: "*When we talk, it allows me to feel joy and to free myself.*" These resources appear as key elements enabling partial coping and meaning-making.

Case of Malla

Presentation of the participant

Malla is a Cameroonian woman, married, mother of three children, from a modest socio-economic background. Her life history includes early bereavements (father, fiancé, first child) and limited schooling, creating vulnerability before illness. She underwent mastectomy after a long therapeutic journey combining traditional care, self-medication, and late biomedical consultation.

Care trajectory before diagnosis

Her first response was traditional medicine, guided by family: "*I had discharge from my left breast and pain; I first went to the healer with my mother.*" The illness was interpreted as mystical aggression: "*He told me it was night poison… someone in my neighborhood who hates me sucked my breasts at night.*" After failure of traditional treatments, biomedical consultations remained vague and reassuring: "*They did not tell me it was cancer… they only said it was an inflammation.*" The eventual disclosure of cancer was experienced as traumatic: "*When I heard the word cancer, I was shocked… I cried because I knew everything was over for me.*"

Clinical experience of mastectomy

Malla accepted surgery mainly due to exhaustion and pain: "*I wanted to recover… too much pain and too many expenses.*" After mastectomy, she described strong rejection of her altered body: "*I can't look at myself in the mirror… my body has changed a lot.*" Femininity was again directly linked to the breast: "*I have only one breast whereas a woman is her breasts.*"

Marital rejection intensified suffering: "*My husband… no longer touches me like before… he says the scar is disgusting.*" She expressed a global sense of loss: "*The mastectomy took everything from me: my life, my marriage, my pride and my dignity.*"

Cultural representations, religion, and psychological withdrawal

Malla named cancer as a total collapse: "*That's the name I gave to my illness because it took everything.*" She expressed spiritual rupture and disillusionment: "*I do not believe in the existence of a real God… I rely only on the power of my ancestors.*" Social withdrawal was pronounced: "*I left all my associations… I prefer to stay alone.*" Her trajectory highlights how stigma, taboo, and cultural beliefs shape both suffering and coping strategies.

Case of Mvondo

Presentation of the participant

Mvondo is a 30-year-old Cameroonian woman living in Bafoussam, in a relationship, with an active sexual life before illness. She underwent left unilateral mastectomy after breast cancer, which she described as "pre-cancer." Her discourse was emotionally intense, marked by persistent distress affecting relational, sexual, social, and spiritual functioning.

Care trajectory: diagnostic wandering and socio-economic constraints

Mvondo described early medical trivialization and symptomatic treatment: "*When they examined me they just told me to go home and take antibiotics… paracetamol… they said it could be a pregnancy.*" This contributed to prolonged wandering: "*I stayed without treatment… it was like that for one year and six months.*" She also used traditional remedies through her father: "*Sometimes my father prepares traditional remedies for me… always hoping I will be completely cured.*"

Diagnosis announcement: psychological shock and fear

The diagnosis was experienced as traumatic and overwhelming: "*We cried a lot… other patients thought we had lost someone.*" Cancer was immediately associated with death: "*In my head I was thinking about death.*"

Mastectomy and injury to feminine identity

Mastectomy was described as an amputation of the self: "*One side of me disappeared… a part of my life too.*" She expressed deep identity devaluation: "*I feel less like a woman without my two breasts.*" and "*Now I am half a woman.*" She also feared constant social judgment: "*When I walk in the street, all the eyes are on me.*"

Marital and sexual repercussions

Mvondo's sexuality became a major site of shame and rejection: "*He sometimes avoids the bedroom… he leaves me to sleep alone.*" and "*He no longer looks at me.*" She perceived the absence of affection as deeply painful: "*He does not even touch the breast that remains.*" Her body became a source of distress: "*I am ashamed of my body… even my own body annoys me.*" A later relational attempt ended in humiliation: "*He shouted: what is that! … and he left me alone.*"

Social isolation, family conflict, and spiritual crisis

Mvondo progressively withdrew from social and religious life: "*I no longer have friends… I don't even go to church anymore.*" Faith became a place of abandonment: "*When the Lord should have intervened for me, he abandoned me.*" She also expressed conflictual blame toward her mother: "*I hold her responsible… if she had not massaged my breasts… this would not have happened.*" This illustrates the intertwining of illness, relational tensions, and culturally shaped interpretations of causality.

Cross-Case Synthesis

Across the three cases, several shared patterns emerged. First, diagnostic delay was common and was reinforced by the initial trivialization of symptoms, financial limitations, and uncertainty in communication with health professionals. Second, all participants described plural therapeutic trajectories combining biomedical care with traditional remedies and religious practices. This plurality did not appear contradictory for participants but rather functioned as a strategy to increase hope and meaning in a threatening situation.

Psychologically, mastectomy was consistently experienced as an embodied rupture affecting self-esteem, body image, and perceived femininity. Shame and fear of social judgment contributed to isolation and concealment behaviors. Marital and sexual relationships emerged as central dimensions of suffering, especially when partner support was absent or inconsistent. Finally, despite distress, resilience processes were identified through children, supportive relatives, spiritual practices, and the possibility of speaking about the experience in a safe relational space.

Important variations were also observed. Tchakam's narrative emphasized family conflict and polygamous relational insecurity; Malla's trajectory highlighted cumulative losses and spiritual disillusionment; Mvondo's case showed strong sexual and relational trauma combined with intergenerational blame.

DISCUSSION

This study highlights the multidimensional complexity of care pathways for women undergoing mastectomy in Cameroon. It confirms that access to diagnosis and treatment is shaped not only by economic constraints but also by cultural explanatory models and relational dynamics. The diagnostic delays observed align with evidence in sub-Saharan Africa showing that breast cancer is often diagnosed at advanced stages due to low health literacy, limited screening programs, and high cost of care (Mwaka et al., 2016; Salem & Daher-Nashif, 2020).

However, the main contribution of this study lies in its clinical qualitative approach, which reveals mastectomy as an embodied, relational, and meaning-making experience. Rather than being experienced solely as a medical intervention, mastectomy is described as a rupture in identity continuity, affecting body image and self-esteem. The narratives illustrate how femininity is culturally invested through the breast, not only as a biological organ but also as a symbolic marker of motherhood, marital value, and social recognition. In this context, mastectomy generates vulnerability to shame and stigmatization, contributing to withdrawal and silence.

The study also illustrates the coexistence of biomedical medicine, traditional practices, and religious healing as a plural therapeutic logic. This confirms that therapeutic trajectories in Cameroon often integrate multiple systems, not as competing models but as complementary strategies

for survival and meaning (Tsala, 2009; Salem & Daher-Nashif, 2020). This plurality should be considered in health service planning, particularly in how diagnosis is communicated and how patient education is designed.

Marital relationships and sexuality appear as major determinants of psychological adjustment. Participants' narratives suggest that partner rejection or avoidance intensifies emotional suffering and identity insecurity. These findings support the importance of couple-oriented psychosocial interventions, including counseling on body image and sexuality. Practical service implications include training healthcare providers in sensitive diagnostic disclosure, implementing systematic psychological screening after surgery, and developing culturally adapted psychoeducation programs that address stigma and misconceptions.

Finally, resilience resources emerged as critical protective factors. Children, family support, spirituality, and verbalization opportunities functioned as coping mechanisms enabling patients to reconstruct meaning and maintain hope. This underscores the relevance of integrating psychosocial oncology services into breast cancer care pathways in Cameroon, even through low-cost models such as group support sessions, trained counselors, and referral networks.

Limitations

This study has several limitations. First, it is based on a small sample of three cases, which limits generalization. Second, the study relies on retrospective narratives, which may be influenced by memory reconstruction. Third, the cases were recruited from a single hospital setting, which may not reflect the diversity of experiences in rural areas or among women without access to oncology follow-up. Finally, interpretations are grounded in a clinical and cultural framework, and therefore should be understood as analytic hypotheses rather than psychiatric diagnoses.

CONCLUSION

This qualitative clinical study shows that the care pathway of Cameroonian women undergoing mastectomy cannot be reduced to a biomedical trajectory. It is a multidimensional experience shaped by diagnostic delays, economic barriers, and the coexistence of biomedical, traditional, and religious systems. Mastectomy emerges as a major embodied rupture affecting feminine identity, sexuality, marital relationships, and social belonging.

Despite intense distress, women may mobilize resilience resources through children, supportive relatives, spirituality, and opportunities for psychological expression. These findings support the need for integrated breast cancer care in Cameroon, combining medical treatment with culturally sensitive psychosocial support, improved diagnosis communication, and partner-inclusive counseling.

Future research should involve larger and more diverse samples, including rural contexts and longitudinal follow-up, to better understand long-term identity reconstruction and psychosocial adjustment after mastectomy.

DECLARATION

Ethics approval and consent to participate

Ethical clearance for this study was obtained from the Regional Ethics Committee of the Littoral Region (Douala, Cameroon). All participants were informed about the objectives, procedures, and voluntary nature of the study. Written informed consent was obtained prior to data collection. Participants were also informed that they could withdraw from the study at any time without any consequences for their medical care.

Consent for publication

All participants provided written consent for the use of anonymized data and quotations for publication purposes. Confidentiality was ensured through the use of pseudonyms and the removal of any identifying information.

Availability of data and materials

The datasets generated and analyzed during the current study are not publicly available due to confidentiality and ethical restrictions, as they contain sensitive personal narratives. However, anonymized excerpts may be made available from the corresponding author upon reasonable request and with ethical approval where necessary.

Conflicts of interest statement

The authors declare that they have no competing interests.

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Artificial Intelligence-Assisted Technology

Artificial intelligence-assisted tools were used solely for language editing, grammar correction, and improvement of academic writing clarity. No AI tool was used for data collection, transcription, coding, interpretation of qualitative findings, or generation of scientific conclusions. The authors remain fully responsible for the content, analysis, and integrity of the manuscript.

Authors' contributions

Alvy Gislaine Magne Fongang contributed to the conception and design of the study, conducted data collection, participated in data analysis and interpretation, and drafted the initial manuscript. **Martial Nguegno Fouadjo** contributed to the study design, supervised the methodological and clinical orientation, participated in thematic analysis and interpretation, critically revised the manuscript, and ensured final validation.

Both authors read and approved the final manuscript.

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