

INTRODUCTION

BACKGROUND OF STUDY: Cancer is a chronic and life-changing illness, as patients experience depression, anxiety, exhaustion, cognitive changes, pain, sleep disruption and financial concerns among other psychosocial side effects. While these symptoms may arise on their own, they regularly co-occur. Not only the patients, but also their relatives, coworkers, and associates are affected by these symptoms. Only if the treatment side effects and complications associated with a cancer diagnosis are treated and controlled, in addition to the disease itself, can cancer treatment be deemed effective.

Different authors and researchers have defined cancer and differently, but the World Health Organization (WHO) defines it as a group of diseases characterized by irregular cellular growth. Similarly, cancer is view as unrestrained

the stigma associated with cancer diagnosis and social isolation (Weis, 2003). The focus of psychosocial support for cancer patients is generally on specific clinical issues such as anxiety, depression, exhaustion, health-related quality of life, and pain.

Typically, these interventions aim to provide effective psychosocial supports that are brief, goal-oriented, and targeted at specific clinical outcomes. Psychosocial interventions may help cancer patients, according to a meta-analysis of controlled outcome research (Rehse & Purkrop, 2003). Other research has found that psychosocial interventions using a cognitive-behavioral therapy (CBT) approach are effective in reducing depressive and anxiety

From Table 4.1 as well, more of the respondents 52 (51.5%) indicated to be HND/ University degree holders, 22 (21.8%) were NCE/OND holders, 18 (17.8%) were postgraduate certificate holders, while the other 9 (8.9%) were SSCE holders. Finally, frequency of visitation revealed that more of the respondents 37 (36.6%) visits the hospital between 5 and 9 times, 27 (26.7%) visits the hospital between 10 and 14 times, 17 (16.8%) visits the hospital less than 5 times, 12 (11.9%) visits the hospital more than 20 times, while the other 8 (7.9%) visits the hospital between 15 and 19 times.

INTER-CORRELATION BETWEEN VARIABLES OF THE STUDY:

Table 2 presents results on the relationship between variables of the study. It is shown on Table 2 that attitude towards genetic counselling had no significant relationship with cancer risk perception ($r = -.06; P > .05$), educational qualification ($r = -.01; P > .05$), number of visit ($r = -.16; P > .05$) and age ($r = -.16; P > .05$). Also, cancer risk perception

had no significant relationship with educational qualification ($r = -.04; P > .05$), number of visits ($r = -.04; P > .05$) and age ($r = -.01; P > .05$). However, educational qualification had significant positive relationship with number of visits ($r = .33; P < .01$) and age ($r = .42; P < .01$). Finally, there exists significant positive relationship between number of visits to hospital and age ($r = .49; P < .01$).

HYPOTHESES TESTING

Hypothesis one stated that attitude towards genetic counselling and cancer risk perception will be highest after treatment than before treatment among relatives of persons living with cancer in Ibadan. This was tested using one-sample t-test and the result is presented on Table 3.

The result in table 3 above shows that exposure to psycho-education boosted the level of attitude towards genetic counselling favourably ($t(43) = 47.84; p < .001$). Attitude to genetic counselling increased significantly after exposure to

Table 2.

Zero-Order Correlation Matrix Table Showing the Relationship between Attitude to Genetic Counseling, Cancer Risk Perception, and Demographic Factors.

SN	Variable	Meancy ic0
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