

JOURNAL CLUB

Sexuality and Intimacy Issues Facing Women With Breast Cancer

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This article has been chosen as being particularly suitable for reading and discussion in a Journal Club format. The following questions are posed to stimulate thoughtful critique and exchange of opinions, possibly leading to changes on your unit. Formulate your answers as you read the article. Photocopying of this article for group discussion purposes is permitted.

1. How does the information reviewed in this article match our experience with our own patients?
2. What is an example of a way in which we have addressed sexuality or intimacy issues with one of our patients?
3. What are some of the ways in which we assess sexuality and intimacy issues with our patients regardless of their diagnoses?
4. In what ways can we improve those assessment techniques?
5. What resources are available to assist patients when we uncover sexuality and intimacy concerns?
6. What are some things we might do to preempt the occurrence of such problems or to prepare patients for the possibility that they might occur?

At the end of the session, take time to recap the discussion and make plans to follow through with suggested strategies.

Purpose/Objectives: To explore the sexuality and intimacy experiences facing women with breast cancer.

Data Sources: Published articles; OVID, PsycINFO, and Florida Atlantic University databases; Web sites; and books.

Data Synthesis: Patient perceptions and knowledge of mastectomy and chemotherapy-induced menopause in regard to lifelong sexual experiences are lacking. Healthcare providers must institute much-needed education and open lines of communication.

Conclusions: The physical and psychological results of breast cancer diagnosis and treatment alter human sexuality. Breast cancer's survival rate is at an all-time high, increasing the number of people who will be living with such issues on a daily basis and shifting the focus from acute care concerns to chronic disease concerns.

Implications for Nursing: Healthcare providers should assess individual patients for potential issues they may face. By identifying problems, they can challenge health care to focus on the long-term problems associated with sexuality and intimacy issues facing patients.

Close your eyes, and think of the seven most important women in your life. At least one of them will be faced with the diagnosis of breast cancer in her lifetime (American Cancer Society, 2005). The physical and psychological results of a breast cancer diagnosis can result in many changes in quality of life. Altered sexual functioning, feelings of sexual inadequacy, and loss of sexual intimacy with a partner all are possible after a diagnosis of breast cancer. Defining human sexuality is a complex task that extends far beyond the reach of physical sexual function, and human sexuality is conceptualized uniquely by each individual as a lived experi-

Key Points . . .

- Postoperative expectations for breast reconstruction following surgery for breast cancer should be addressed preoperatively.
- Strong partner support aids in good sexual functioning.
- Long-term issues after diagnosis and treatment of breast cancer, including early menopause, should be assessed and addressed.

ence that affects the mind, body, and spirit (Hordern, 2000). Oncology nurses are positioned to identify symptoms related to changes in sexual function that often are neglected by other healthcare providers who may avoid the discussion of treatments and outcomes associated with breast cancer diagnosis. The purpose of this article is to explore sexuality and intimacy issues facing women with breast cancer and the management of such issues by healthcare providers.

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Background and Significance

The devastating diagnosis of breast cancer will become reality for about 211,000 American women in 2006 (Susan G. Komen Breast Cancer Foundation, 2005). The ravages that ensue from diagnosis and treatment present tremendous challenges for women and their partners. Sexuality and intimacy are significant issues in the lives of patients with breast cancer (Hordern, 2000; Katz, 2005; Kneece, 2003, 2004; Rogers & Kristjanson, 2002; Wilmoth, Coleman, Smith, & Davis, 2004). Western society reveres female breasts as central to female sexual identity. The total or partial loss of a female breast may lead to altered self-image and interfere in the sexual lives of the women affected (Rogers & Kristjanson, 2002; Wilmoth et al.). In addition, fatigue, early menopause, hot flashes, dyspareunia, mood swings, lowered libido, and vaginal dryness can diminish normal sexual responses and alter women's perceptions of intimacy (Hordern; Kneece, 2003; Wilmoth et al.).

Healthcare providers often forget or avoid discussion of sexuality in relation to cancer treatment. In a study of 126 women who had surgical intervention with adjuvant chemotherapy, 87% claimed that they were not educated about possible sexual alteration after treatment (Kneece, 2003). In addition, all of the women in that study had sexuality issues, but only about one-third of them queried their healthcare providers regarding the issues. Those who did communicate about the sexual side effects of treatment with their healthcare providers rated the handling of that discussion as inadequate. The results of the study show that healthcare providers need to better understand the sexuality and intimacy needs of women with breast cancer and their partners. To open the lines of communication, healthcare providers must have an understanding of the importance of discussing the sexuality issues of patients with breast cancer (Hordern, 2000; Katz, 2005; Kneece, 2003; Schnipper, 2003).

Sexual dysfunction in patients with breast cancer has emotional and physical variables, and each woman experiences sexual dysfunction in her own unique way. Women may become distraught over the physical disfigurement of mastectomy because it alters self-image and the ability to enjoy sexual stimulation after the loss of nipple sensation. Others may be affected by chemotherapy that can change hormonal balances by inducing menopause and causing infertility. The temporary effects of chemotherapy-induced alopecia, nausea, vomiting, and fatigue often contribute to inhibited sexual desire. In addition, painful radiation-induced dermatitis, along with the fatigue experienced during radiation therapy, can affect desire for intimacy (Kneece, 2003, 2004).

For patients with breast cancer and their partners, changes in sexual and intimate relationships can be significant and life altering (Kneece, 2003). The purpose of this literature review is to explore sexuality and intimacy issues that affect the lives of patients with breast cancer and the healthcare response to those patients' needs. Five important research studies will be examined and described to discover more about sexuality and intimacy in patients with breast cancer. By using the results of the research, healthcare providers can become better informed about the communication challenges.

Literature Review

The authors conducted a search for relevant recent research studies on the topic of sexuality in patients with

breast cancer. They used search terms such as sexuality, intimacy, breast cancer, and human sexuality. Search parameters included English-only, qualitative or quantitative research articles from 2000–2005. The search identified five important studies.

Study 1

Wimberly, Carver, Laurenceau, Harris, and Antoni (2005) combined the results of a cross-sectional study (examining women with partners during a single time point during the first year after surgery) with a second, longitudinal study (examining women after the first year of surgery). Scores from the two samples were obtained using several multi-item scales.

The first sample yielded 170 and the second sample 48 subjects, all of whom were postsurgical female patients with stage 0–II breast cancer from Miami, FL. Both samples were asked about their beliefs about their partners' reactions to the diagnosis and treatment and the influence of those beliefs on their psychosexual adjustment, marital satisfaction, and emotional distress. Partners' reactions were indirectly assessed through the women's perceptions of how their partners reacted to them as they tried to cope with the diagnosis of breast cancer and the partial or total loss of a breast.

The first sample described positive partner perceptions during the first sexual experience after surgery ($p = 0.05$). Researchers believed that this established the presence of adequate psychosexual adjustment in the couples. Female participants who felt that their partners were not disturbed by their surgical scars during the first sexual experience after surgery reported greater feelings of femininity and attractiveness. Emotional distress was noted to be greater in the women who perceived their partners to be less emotionally involved. Study results showed that women feeling that their partners were emotionally involved was directly correlated to higher levels of marital satisfaction, better psychosexual adjustment, and less emotional distress.

Wimberly et al. (2005) also interviewed women ($N = 48$) over a one-year period after breast cancer diagnosis. Emotional involvement on the part of partners did not correlate to the frequency of sexual interaction in the study. It did, however, relate to the women's perceptions of their partners' willingness to initiate sex ($r = 0.75$). The study confirmed that women's well-being was associated with a perception of partners' encouraging emotional support.

The researchers reached several conclusions based on the women's perception of their partners' beliefs. The results clearly indicated that a partner's emotional involvement was a strong predictor for a woman's sexual, marital, and emotional adjustment after breast cancer. Another finding associated with the study was that age negatively affected sexual frequency. In addition, the women reported less perceived negativity by their partners related to surgical scars, as well as an increase in partner-initiated sexual activity for patients who had undergone lumpectomy versus mastectomy (Wimberly et al., 2005).

The study findings refine the belief that women's ability to adjust psychosexually after breast cancer diagnosis and treatment is affected by their partners' perceived acceptance. Based on the data, healthcare providers should be involved in discussing and counseling women and their partners about sexuality and referring them for therapy if needed.

Study 2

Yurek, Farrar, and Anderson (2000) studied patients with stage II or III breast cancer postoperatively and prior to adjuvant therapy. They compared groups in relation to postoperative sexuality and body-change stress. Body-change stress is stress as a result of changes in body structure and includes situational stress and self-image disturbance. The study had a sample of 190 women; 78 underwent breast-conserving therapy or lumpectomy with lymph node biopsy, 29 had modified radical mastectomies with reconstruction, 79 had modified radical mastectomies, and 4 had bilateral mastectomies; 122 reported being preoperatively sexually active.

Significant findings suggested that patients who underwent modified radical mastectomy with reconstruction had poorer rates of sexual activity and responsiveness postoperatively than those who received breast-conserving therapy or modified radical mastectomy. Data were analyzed using multivariate statistics, analysis of covariance, and regression analyses. Analyses for approach and avoidance of sexual behavior and activities indicated that the frequency of current sexual behavior was significantly lower for the women who received modified radical mastectomy with reconstruction ($\bar{X} = 12.71$) than the frequency of behavior of women who received either lumpectomy (breast-conserving therapy, $\bar{X} = 18.06$) or modified radical mastectomy ($\bar{X} = 16.57$). The breast-conserving therapy and modified radical mastectomy groups showed statistical equivalent for sexual outcomes, including postoperative sexual activity levels ($F = 3.34$, $p < 0.05$), orgasm and resolution ($F = 5.62$, $p < 0.01$), and sexual satisfaction levels ($F = 4.37$, $p < 0.05$), which indicates that women treated with breast-conservation therapy reported significantly greater arousal throughout sexual activity than did women treated with modified radical mastectomy; orgasm and resolution and general satisfaction results showed that women who received breast-conserving therapy or modified radical mastectomy had significantly more indications of orgasm and feelings of sexual satisfaction during their current sexual activities than did women who received modified radical mastectomy with reconstruction (Yurek et al., 2000).

Based on sexuality patterns of women diagnosed and surgically treated for breast cancer (breast-conserving therapy, modified radical mastectomy, and modified radical mastectomy with reconstruction), the study supports that postoperative sexual behavior is disturbed in patients who undergo reconstruction. This leads to the conclusion that reconstruction offers no decrease in body-change stress in the early postoperative period. In addition, the women who underwent modified radical mastectomy with or without reconstruction reported stress changes that were, in some cases, double the rate for those who underwent breast-conserving therapy. The changes included situational distress and avoidance behaviors. Those who experienced negative self-image reported diminished sexual responsiveness and increased body-change stress, including sexual embarrassment and diminished arousability, ultimately altering coping skills and causing disruption of sexual relations and intercourse. The authors noted that other factors contribute to the disruption of sexual intimacy, including the diagnosis of cancer itself, hospitalization, and the surgical recovery period. Further evaluation of body-change stress at later postoperative periods may yield more information. The addition of baseline evaluations to assess patient

perceptions of postsurgical expectations and body self-image preoperatively may further enlighten the research.

Yurek et al. (2000) identified a need for evaluation of sexual and body-change stress in patients who are considering reconstructive surgery. Assessment should include the reasons for the choice of reconstruction and postoperative expectations. Yurek et al. laid the foundation for healthcare providers to discuss the benefits and risks for women considering reconstructive surgery. For women who want to feel whole again, want clothes to fit better, and want to feel that their outward appearances are important, further education may be warranted to give complete informed consent. Patients who are at higher risk for postoperative sexual stress should be identified and made aware of educational initiatives and perhaps receive intense preoperative and postoperative counseling.

Study 3

Wilmoth (2001) conducted a qualitative, grounded theory study to uncover the feelings and emotions surrounding sexuality in women after receiving treatment for breast cancer. She studied the experiences of patients with breast cancer for six months, 10 years after diagnosis. The sample consisted of 18 women, most of whom had received adjuvant therapy; 39% had received breast-conserving therapy and 61% had undergone mastectomy.

The study focused on four areas of altered sexuality, including missing parts, loss of bleeding/becoming old, loss of sexual sensations, and loss of womanhood. Wilmoth's (2001) focus in the study was how the adjustment of living with a diagnosis of breast cancer brought to the surface an altered sexual self. The results yielded the identification of "losses" that lead to an altered sexual self. The loss of body parts included the breast and alopecia. Many of the women felt that loss of a breast related to a maternal loss because their breasts nourished their children and defined them as women. Loss of sexual sensations, including breast sensation, led to changes in desire and orgasm and dyspareunia. Loss of womanhood was a theme that dealt with women's inner feelings, believing that they were less of a woman and that loss of bleeding translated into growing old. Many women had positive changes regarding their sexuality when their partners provided reassurance that they still were sexually desirable.

Practice implications as noted by Wilmoth (2001) included the need to increase the level of emotional support offered by healthcare providers. This was especially true when reflecting on chemotherapy-induced menopausal changes, vaginal dryness, dyspareunia, heart disease, and osteoporosis. Wilmoth stated that her results revealed legal and ethical obligations to open lines of communication, especially related to sexual health, with women after breast cancer treatment. Wilmoth described that an altered sexual self is not an experience unique to women with breast cancer but that all women experience it after menopause. However, the problems are more evident in women with breast cancer because of the abrupt onset, morbidity, and mortality of cancer diagnosis and the physical disfigurement of treatment.

Study 4

Holmberg, Scott, Alexy, and Fife (2001) undertook a qualitative pilot study with a sample of 15 men and women to examine the relationships and roles of women in regard to interaction with their partners, families, friends, and colleagues. The two foci of the study were intimacy and relationships

with families, friends, and colleagues, but only intimacy will be examined in this article.

The study focused on the couples' views on the physicality of intimate relationships and sexual functioning as they relate to postoperative and treatment-related changes. Body image and self-esteem issues included changes in physical features and, less importantly, sexual function. The male partners expressed the most concern, not about loss of sexual relations but about fear of potential mortality of the disease process. Partnered women cited that they had consistent support from their partners. The findings between partnered and unpartnered women were contrasting. Unpartnered women were more emotionally angered and saddened, receiving little emotional support from former partners. This often included verbalization of a lack of sexual desirability expressed by former partners, which resulted in fear of similar responses by future partners. Holmberg et al. (2001) discussed that negativity in such relationships may be related to the fact that the relationships had previous problems. Women in both groups cited diminished sexual responses, decreased desire, fatigue, menopausal symptoms, and depression as reasons for changes in sexual activity.

In the study, the partnered women's perceptions of their mates' responses were unchanged from their previous sexual encounters; however, when the men were queried, they indicated that they indeed had a decrease in sexual desire. The men unanimously believed that in the acute stages of diagnosis and treatment, sex was a frivolous issue in comparison to the potential mortality of their partners.

Holmberg et al. (2001) provided evidence that the diagnosis of breast cancer actually may strengthen partnered relationships. Changes that affected relationships included the inability to discuss issues of loss, mortality, and morbidity; how conflicts were handled; and how femininity was viewed. Unpartnered women faced greater challenges. Important findings included the necessity of open lines of communication, encouragement of positive feminine attributes despite physical changes, encouragement of partner support, and the need to identify the special needs of unpartnered women.

Study 5

A comparison study by Broeckel, Thors, Jacobsen, Small, and Cox (2002) compared sexual functioning in long-term patients with breast cancer to women with no history of cancer. The sample included 119 women: 58 with breast cancer and 61 who had not been diagnosed. Subjects were evaluated using the Multidimensional Fatigue Symptom Inventory, Center for Epidemiologic Studies–Depression Scale, Menopausal Symptom Checklist, and Medical Outcomes Study.

The breast cancer survivors reported poorer sexual functioning ($p \leq 0.01$). Additional findings included diminished sexual interest, inability to relax and take pleasure in sex, difficulties with sexual arousal, and anorgasmia. The breast cancer survivors reported more fatigue ($p \leq 0.05$), greater depression, increases in severity of hot flashes and vaginal dryness, and poorer marital functioning in comparison to the noncancer group. In relation to the potential mediators and level of sexual functioning, the results demonstrated greater sexual dysfunction ($p \leq 0.05$), greater fatigue ($r = 0.31$), greater depression ($r = 0.27$), increased hot flashes ($r = 0.20$), greater vaginal dryness ($r = 0.36$), and poorer marital functioning ($r = -0.28$) as compared to women who did not have breast cancer.

The study results suggested that relieving vaginal dryness may assist breast cancer survivors in improving sexual functioning. In addition, discussions between healthcare providers and patients about sexuality and methods to improve arousal and orgasm would be beneficial to breast cancer survivors and their partners. Counseling to improve marital functioning may help strengthen relationships between breast cancer survivors and their partners.

Discussion

Research associated with sexuality and intimacy issues among patients with breast cancer clearly illustrates that women and their partners may experience lifelong sexual dysfunction after diagnosis. Breast cancer survivors now face the challenges associated with chronic disease (Mallinger, Griggs, & Shields, 2005).

Wimberly et al. (2005) revealed that when a sexual partner is emotionally involved, greater sexual, marital, and emotional adjustments occur. The finding was reinforced in that strong partner support aided in healthier sexual outcomes (Broeckel et al., 2002; Holmberg et al., 2001; Wilmoth, 2001). Holmberg et al. enhanced the theme by including the differences between partnered and unpartnered women, offering a strong correlation between a good relationship support system and a better outcome in sexual health. The research reinforces the findings of Wimberly et al. and Wilmoth, which stressed that positive partner support was strongly correlated with better relationships and sexual adjustment and may even strengthen such relationships. Furthermore, researchers concluded that unpartnered women faced greater challenges in current bad relationships, which may make strong sexual relationships with future partners difficult (Holmberg et al.).

The research identified that menopausal changes influenced sexual health. Depression, fatigue, vaginal dryness, lowered libido, anorgasmia, and hot flashes add to the list of issues that diminish sexual functioning. In addition, fears of mortality and diagnosis of cancer itself are on the minds of men and women. Total or partial breast loss and menopausal symptoms also can alter sexual functioning and pleasure (Broeckel et al., 2002; Holmberg et al., 2001; Wilmoth, 2001).

Surprising evidence illustrated that women who underwent modified radical mastectomy with reconstruction had poorer rates of sexual responsiveness and sexual activity, which produced greater sexual stress (Yurek et al., 2000). Future research is needed to confirm and explore such possibilities.

Nursing Implications

Sexuality and intimacy are significant factors in quality of life. Most treating physicians and clinicians do not address or are uncomfortable addressing patients about their sexual concerns after treatment. Healthcare providers often lack knowledge about post-treatment sexuality and sexual functioning. To open the lines of communication, healthcare professionals must develop an understanding of the importance of sexuality issues for patients with breast cancer (Hordern, 2000; Katz, 2005; Kneece, 2003; Mallinger et al., 2005; Schnipper, 2003). Healthcare providers must have appropriate understanding of the breast cancer treatments they will deliver, ways to assess individual patients with breast cancer,

methods to evaluate sexual relationships, and ways to open the lines of communication with their patients. Those tenets are the basis of the nursing process and of all patient education. Comfort can be achieved by becoming knowledgeable about the subjects at hand.

Mallinger et al. (2005) suggested that patients may be unable to verbalize their needs or understand medical information, especially during the diagnosis and treatment phases. Healthcare providers should openly discuss topics about sexuality at multiple points along the care trajectory.

The first step in managing sexual problems is to assess the problem adequately (Tan, Waldman, & Bostick, 2002). Patients with breast cancer and their partners need to receive appropriate pharmacologic interventions, counseling, support, and guidance regarding sexual changes. Educational materials such as pamphlets, compact disks, videotapes, and Web sites should be offered to aid such men and women. The American Cancer Society offers a useful resource at www.cancer.org/docroot/MBC/content/MBC_2_3x_Sexuality.asp. Treatment of sexual dysfunction must be individualized to the specific needs of each individual woman.

Conclusion

The purpose of this literature review was to examine the sexuality and intimacy problems among women after diag-

nosis and treatment of breast cancer. A diagnosis of breast cancer brings fears associated with morbidity and mortality. Survival rates are at an all-time high (American Cancer Society, 2005; Susan G. Komen Breast Cancer Foundation, 2005), but survivors now face greater challenges for the rest of their lives. Research clearly indicates that strong relationships help support and heal emotional wounds, while weaker relationships tend to continue to promote discord. In addition, patients lack knowledge about the sexual effects of cancer and treatment, so healthcare providers must provide much-needed education and open lines of communication (Hordern, 2000; Kneee, 2003; Wilmoth, 2001).

Healthcare providers should identify and assess individual patients for menopausal status, partnered relationships, sexual needs and desires, strength of interpersonal and intimate relationships, and postoperative and post-treatment expectations. They also should assess and counsel such patients from diagnosis and beyond. Breast cancer often alters the sexual functioning of women and their partners long after treatment is completed. Healthcare professionals must recognize the psychosocial and physical needs of patients to address and promote healthy sexual self-images and sexual lives for breast cancer survivors.

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