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Communication on sexual health with patients suffering from cancer: A multi-method study

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Keywords: Sexual health; Cancer; Multi-methods; Patient-centred communication; Healthcare.

Abstract

Introduction: Healthcare professionals, nurses and doctors often face the challenge that patients suffering from cancer experience decreased sexual health. The communication about sexual health is suboptimal.

Objective: The objective of this study was to explore healthcare professionals' attitudes, perceptions, and communication about sexual health issues among patients who have cancer. In addition, the intent was to identify and describe facilitators and barriers to this communication.

Methods: The multi-method approach used included a survey and interviews. In total, 128 (38%) responded to a validated questionnaire, and four participated in individual interviews.

Results: Quantitatively, healthcare professionals reported a lack of comfort, competence, readiness, training and education in addressing sexual health in their communication with patients.

Qualitatively, six themes were identified: Prioritising conversations about sexual health, initiation of discussions about sexual health, competences towards sexual health, personal assessment, the collegial cooperation regarding sexual health, and the structural framework.

Conclusion: This study indicates that while half of the healthcare professionals in the survey felt comfortable discussing sexuality with patients who have cancer, the interviewers revealed a reluctance to communicate about this issue in clinical practice. This could be due to concerns about patients' readiness to discuss sexuality. Healthcare professionals' inadequate competencies in sexology, lack of support among colleagues, and perceived time constraints contributed to the healthcare professionals' neglect of addressing sexual health among patients who have cancer.

Introduction

Healthcare professionals (HCPs) often face the challenge that patients suffering from cancer experience decreased sexual health [1,2]. A cancer diagnosis and cancer treatment often affect bio-psychosocial aspects of sexual health [1,3,4,5]. These aspects frequently include sexual dysfunctions such as a decrease in intimate relationships and quality of life [1,5-7]. It is evident that patients with cancer express the need for communicating with HCPs about their sexual health [6,8-10] (Traumer et al., 2018) and want the HCPs to initiate conversations addressing sexual health [4,11] (Traumer et al., 2018). HCPs' communication about sexual health can strengthen and increase patients' quality of life, highlighting the importance of HCPs addressing this issue [12-14]. However, HCPs' suboptimal communication about sexual health [12,15-18] seems to leave patients with unidentified and untreated sexual problems [18]. Common barriers to communicating about sexual issues are a lack of education, knowledge, training, and communication skills [16,19-20], as well as embarrassment, and the view that sexual health is not part of HCPs' professional responsibility [19,21]. Further, sociocultural norms, lack of routine, priority, time, and organisational support are demonstrated barriers [16,19,20]. Sexual health is a sensitive topic, which can be characterised by a two-way taboo [22] (Traumer et al., 2018), where negative experiences of professional inadequacy and lack of institutional policy hinder HCPs from integrating sexual health issues into their professional capacity [19]. HCPs' attitudes and capacity towards addressing sexual health affect how they interact with patients [20,23], as do those healthcare providers who have more proximity with cancer patients than others (Putty et al., 2024). They make up most of the informants in this study. Therefore, this study aims to explore HCPs' attitudes, perceptions, and communication about sexual health issues among patients who have cancer. In addition, the intent is to identify and describe facilitators and barriers to this communication.

Methods

Design: This study applies a multi-method approach [24], including a quantitative survey and qualitative interviews, to respond to the research aim.

Survey

Participants and recruitment: Respondents of the survey were HCPs (registered nurses (RNs) (85,9%), healthcare assistants (1,6%), physicians (10,9%) and others (1,6%)) from six medical and surgical oncology inpatient and outpatient wards at a Danish university hospital. The HCPs received an email with a link to an online version of the questionnaire: Professionals' Attitudes Towards Addressing Sexual Health (PA-SH-D) [25], created in SurveyXact (Ramboll Management Consulting, Aarhus, Denmark). Furthermore, the PA-SH-D was available at the wards as a paper edition to increase the response rate. To optimise the response rate, the HCPs were reminded once.

PA-SH-D: The PA-SH-D is validated and adapted to HCPs from the SA-SH-D [13,20], which is a questionnaire targeted at healthcare students and translated and adapted to Danish from the original Swedish questionnaire, SA-SH [26]. Validation of the PA-SH-D showed an acceptable face validity, internal consistency and floor and ceiling effects [25], indicating PA-SH-D's usefulness in measuring HCPs' attitudes towards addressing sexual health. PA-SH-D consists of 22 items divided into four domains comprising: feelings of comfortableness (items 1–9), fear of negative influence on patient relations (items 10-15), working environment (items 16-18), and educational needs (items 19-22) [25]. The 22 items are answered on a Likert scale with five options: strongly agree, agree, partly agree, partly disagree, and disagree [25]. Demographic data regarding gender, age, health profession, seniority, current working department, and years of employment in the current working department were added to the PA-SH-D. The adapted PA-SH-D is available in Appendix X.

Statistical analysis

Data were analysed using descriptive statistics, and presented in numbers and percentages for gender, profession, year of completed education, current working department and years employed in the current working department. Age is presented in mean and SD. Horizontal bar charts present each item of the PA-SH-D in percentage. Data analysis was performed using STATA 16.1.

Interviews

Informants and recruitment: The informants were RNs, and a physician recruited from responders of the survey, where they had provided their contact information as an expression of interest in participating in an individual interview. The informants were conveniently sampled to explore in more depth their attitudes and perceptions, as well as facilitators and barriers for communicating about sexual health issues. Semi-structured interviews were conducted based on an interview guide that included domains from the questionnaire and reviewed literature. The interview guide was pilot tested before SRD, MDH, and CM conducted the interviews. Due to the COVID-19 restrictions, the four interviews were held by phone (one) or virtually (three).

Analysis: The interviews were audio-recorded and transcribed verbatim using InqScribe version 2.5. Following Braun and Clark [27] a thematic analysis consisting of six phases was used to identify patterns and themes: first, familiarity with the data and content; second, generation of codes and meaningful patterns; third, generation of themes; fourth, a review of the generated themes concerning the entire data material; fifth, naming and identifying the essence of the themes; and sixth, final analysis and report.

Ethical considerations

Ethical considerations followed the directions of the Helsinki Declaration (The Danish Data Protection Agency, 2023). The respondents gave written informed consent to participate in the study after having received oral and written information about the study.

Results

Survey: 337 HCPs were invited to participate in the survey (Figure 1). The overall response rate was 38 % (128 HCPs).

The mean age of the responders was 42.7 years (SD 12.1, range 24-69) (Table 1). Among the respondents, most were RNs (86%), followed by physicians (11%), health assistants (2%) and other professions such as radiographers (2%).

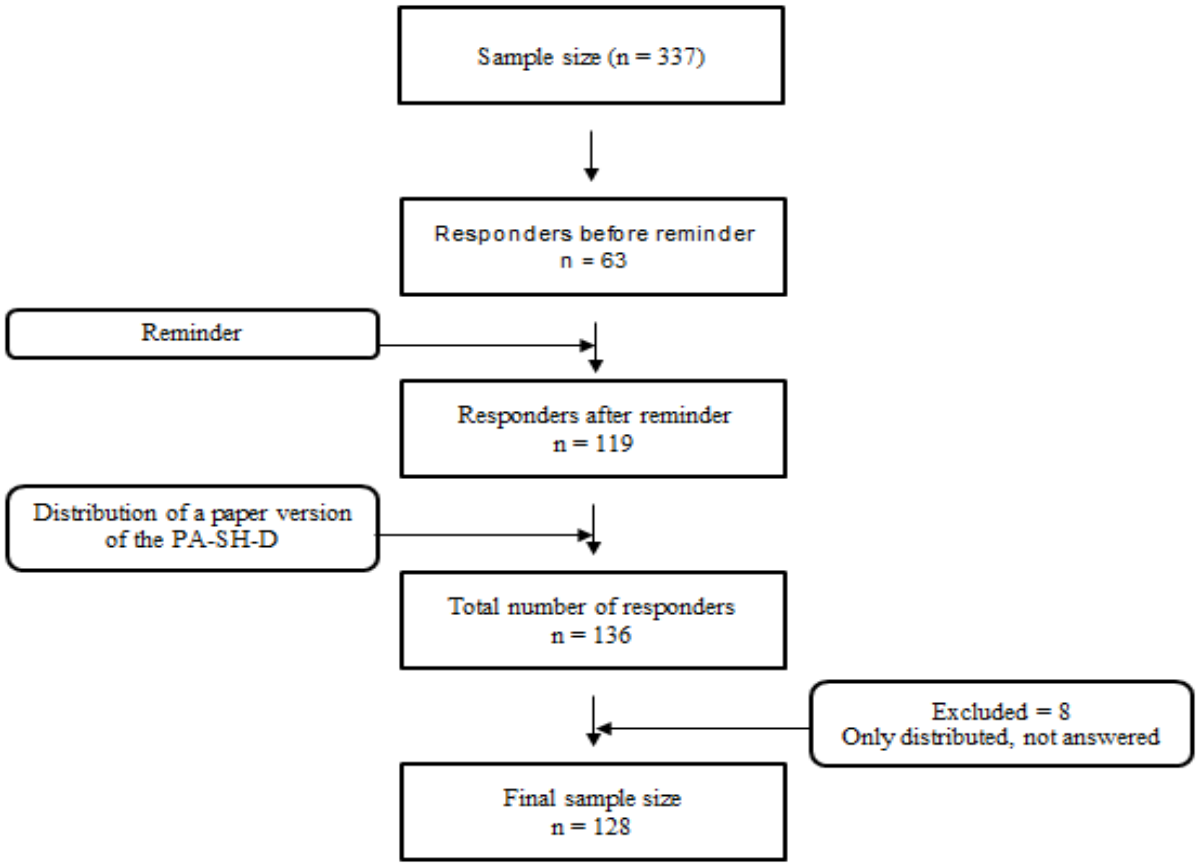

Figure 1: Flowchart of survey responses.

Table 1: Demographic characteristics.

		Education			
Demographic variable	**Total number of respondents (n=128)**	**Nurses n=110 (85.9%)**	**Physicians n=14 (10.9%)**	**Social and health assistants n=2 (1.6%)**	**Other professions n=2 (1.6%)**
Female, n (%)	117 (91)	107 (91)	6 (5)	2 (2)	2 (2)
Male, n (%)	11 (9)	3 (27)	8 (73)	0 (0)	0 (0)
Age, mean ± SD, min, max	42.7 ± 12.1 min: 24, max: 69	42.8 ± 1.2 min: 24, max: 69	42.4 ± 2.9 min: 30, max: 68	55.5 ± 4.5 min: 51, max: 60	26.5 ± 2.5 min: 24, max: 29

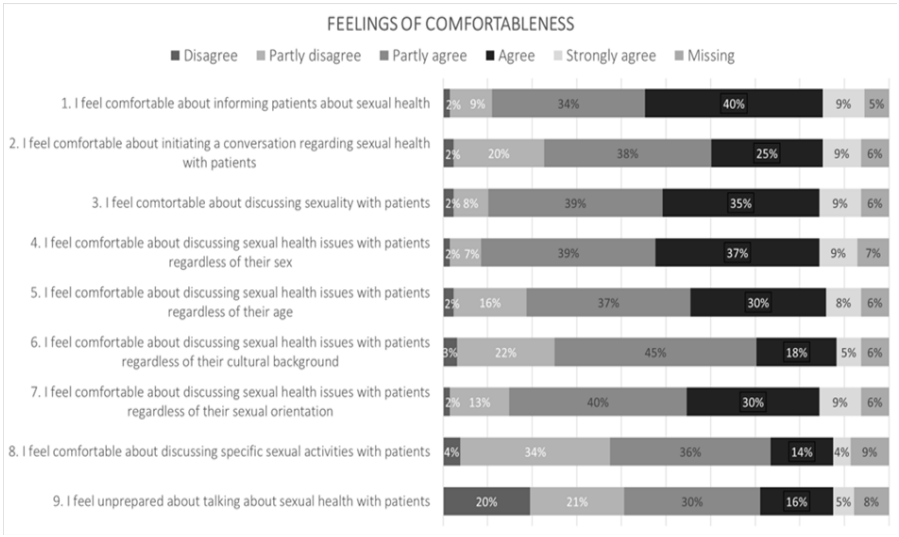

Figure 2: Reported feelings of comfortableness with addressing sexual health (N=128).

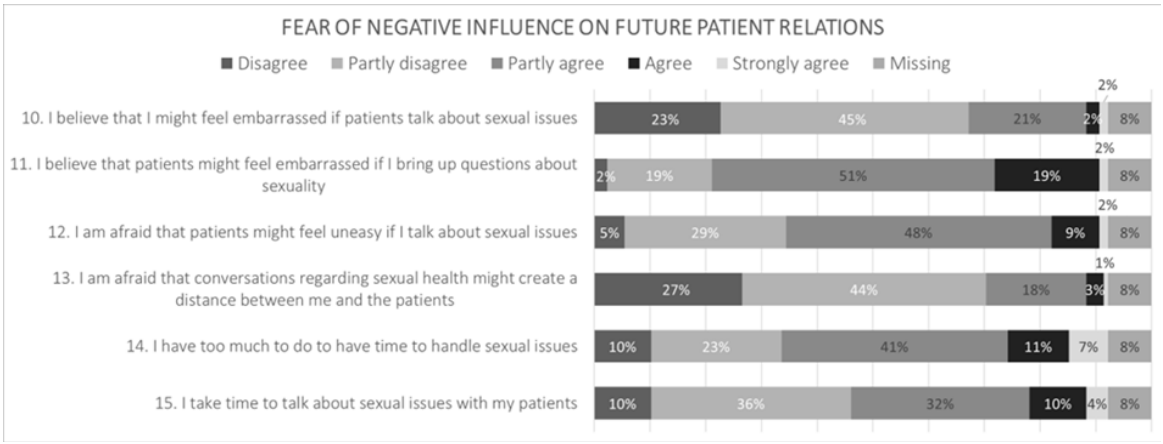

Figure 3: Reported fear of negative influence on patient relations when addressing sexual health (N=128).

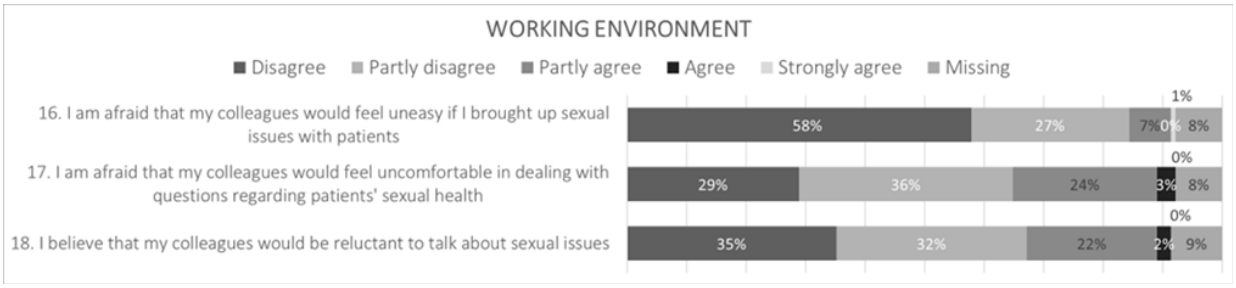

Figure 4: Working environment (N=128).

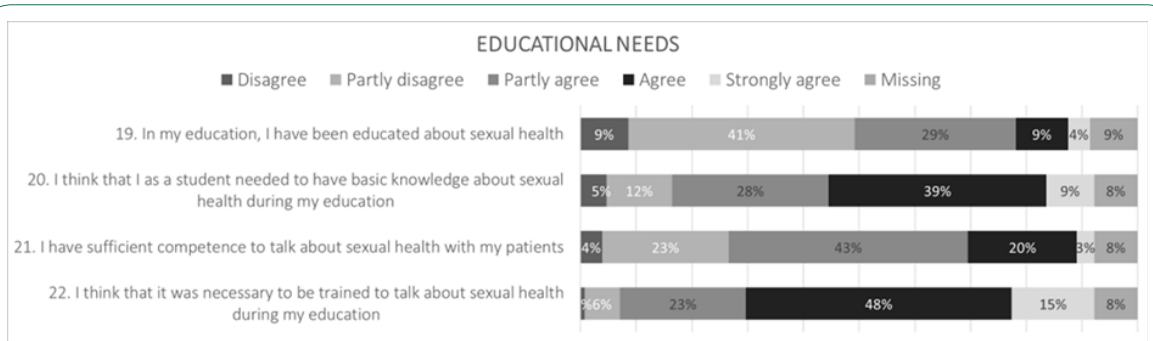

Figure 5: Educational needs regarding sexual health (N=128).

Table 2: Themes identified in the qualitative study.

Prioritizing conversations about sexual health	Initiation of conversations about sexual health	HCPs' competences towards sexual health	HCPs' personal assessment	The collegial cooperation regarding sexual health	The structural framework

Approximately half of the HCPs reported that they felt comfortable about informing patients about sexual health (Figure 2). Fewer of the HCPs reported that they felt comfortable about initiating a conversation about sexual health and about discussing sexual health with patients regardless of their sex, age, cultural background, or sexual orientation. A smaller proportion of the HCPs felt comfortable about discussing specific sexual activities with patients and disagreed that they felt unprepared to talk about sexual health with patients.

Approximately two-thirds of HCPs disagreed that they would feel embarrassed if patients talked about sexual issues. In contrast, a few disagreed that patients might feel embarrassed if they, as professionals, raised the subject (Figure 3). A quarter of the HCPs were not afraid that patients might feel uneasy if they, as professionals, talked about sexual issues. In addition, most HCPs were not afraid that conversations regarding sexual health could create a distance in the relationship between the patients and themselves as professionals. One-third of the HCPs did not believe that they had too much work to have time to handle sexual issues, while a small proportion of the HCPs prioritised talking about sexual issues with patients.

Most HCPs were not afraid that their colleagues would feel uneasy if they brought up sexual issues with patients (Figure 4). Approximately two-thirds of HCPs were not afraid that their colleagues would feel uncomfortable in dealing with questions regarding patients' sexual health, and they did not believe that their colleagues would be reluctant to talk about sexual issues.

Few of the HCPs had been educated in sexual health, and few had sufficient competencies to talk about sexual health with patients (Figure 5). Approximately half of the HCPs reported that they needed basic knowledge about sexual health during their education. In contrast, most reported that training in talking about sexual health during their education is needed.

Interviews

The analysis identified six themes: (1) prioritising conversations about sexual health, (2) initiation of conversations about sexual health, (3) HCPs' competences towards sexual health, (4) HCPs' assessment, (5) the collegial cooperation regarding sexual health, and (6) the structural framework. The themes are presented in the following section, illustrated by interview quotations.

Prioritising conversations about sexual health: HCPs do not talk about sexual health with patients because they experience that patients are not ready for such conversations:

"When the patients come to me, they have just been told that they have cancer and that they must have radiation and maybe surgery. So, I find the treatment and the possibility of getting well important, which we are discussing (...). I find that they are in a crisis because they have just been told they have cancer" (Nurse, I1).

HCPs do not prioritise communication about sexual health as they assume that other issues related to the diagnosis and the treatment are more important for patients. Furthermore, HCPs express an uncertainty about who is responsible for communicating about sexual issues:

"I do not think there are some who have the responsibility towards it [sexual health]. So, I do think that people have delegated and said, 'This [sexual health] is your responsibility to talk about or provide for. ' There are so many other responsibilities that are handed out, but I do not think that [sexual health] .... It is not handed out" (Physician, I2).

The above illustrates that the responsibility for addressing sexual health issues is unclear and does not seem to be part of HCPs' clinical practice. This may have the consequence that no one addresses issues regarding sexuality among patients with cancer.

Initiation of conversations about sexual health: Some HCPs perceive that they are not ready to initiate a conversation about sexual health with patients:

"(...) I must be honest; I think it is difficult to start these conversations. But if I have a patient that brings it up [sexual health], then I quickly take the conversation further" (Nurse, I4).

The HCPs do not initiate communication about sexual health. However, if patients start talking about this issue, they take up the conversation. Thus, HCPs await patients' initiative to talk about sexual health, because they are concerned about the patient's reaction if they bring up the topic:

"So, I must work on approaching it so that I feel that I am not crossing anyone's boundaries (..). It should not just be something I throw on the table, which will take people by surprise. I imagine it will surprise people" (Nurse, I1).

The HCPs are concerned about exceeding the patients' boundaries and making the patient worried by addressing a private and sensitive topic such as sexual health:

"If I think about it, putting thoughts in their heads can be dangerous. Because, if it is not how they see it, I can suddenly start something where they can think: 'God yes, that is also true. What if it turns out that way? Does she think that I will soon feel like this?' Then I will bring up many thoughts" (Nurse, I4).

The HCPs consider that communicating about sexual health can be worrying for the patients and cause concerns that patients may not have thought about.

HCPs' competences towards sexual health: The HCPs do not feel professionally competent in conversations about certain aspects of sexual health. Some HCPs find it easier to talk about physical aspects of sexual health, while others find it easier to talk about social or psychological aspects of sexual health. Furthermore, HCPs feel like they need a solid base of knowledge and the right competences before they initiate communication about sexual health, as they may feel inadequate if they cnnot respond to questions and make suggestions to solve the problems:

"Then you do not feel like a very good nurse either, if they finally open a topic and have a problem, and then you sit there and say: 'Yeah, well, now you have to see, I will see if I can find a pamphlet'" (Nurse, I3).

The HCPs have expectations of themselves and may not want to expose their weaknesses. They may feel like their professional identity is at stake if they must discuss a topic that they do not feel competent to handle:

"But there is also someone [HCPs] who got the courage to ask all the right questions. Moreover, maybe I am not quite there yet. She [one of the nurses] could also handle a failure if they [the patients] said 'no, I do not want to talk about it', then she would say 'that is fine, I would just check in with you'" (Nurse, I3).

The HCPs consider it a failure if the patient rejects talking about sexual health. This rejection can make HCPs feel incompetent because it may indicate they cannot understand the patients' signals and needs. Some HCPs feel that increased knowledge and education will make them more able to support patients with sexual problems. However, other HCPs suggest that increased knowledge and education do not necessarily prompt conversations about sexual health:

"It is probably a matter of interest and recognising that the patient needs it, or at least that it is important to the patient. Some physicians probably have the approach that they have not spent twenty years becoming surgeons to talk about feelings with the patient, right?" (Physician, I2).

It seems like not only the level of knowledge and education influences the HCPs' decisions about talking about sexual health, but also their attitudes or values are important for whether conversations about sexual health will be initiated.

HCPs' Assessment: HCPs find it difficult to assess who should be offered conversations about sexual health:

"We have so many different people in the ward. Is it (sexual health) something you must talk to everyone about? (…). It is difficult to find out, because I do not want to ask everyone" (Nurse, I3).

"This is a man from North Jutland, and he will not even talk about whether he is in pain. Why should he then talk about his

relationship with his wife? Am I making him embarrassed? Am I affecting another conversation we could have had?" (Nurse, I4).

HCPs find it challenging to identify who they need to communicate with about sexual health. Conversations are often based on HCPs' personal preferences or patient characteristics, such as age, gender, or which part of the country the patient lives in. Thus, personal preferences or patient characteristics can constitute barriers to initiating conversations about sexual health. In addition, HCPs are concerned about negatively affecting the patient relationship with certain patients in the short and long term.

The collegial cooperation regarding sexual health: Some HCPs experience sexual health as taboo or stigma in their ward:

"I simply think that it is too big a taboo. (…). The fact (that sexual health is not discussed among colleagues) means that it is not something you talk to your patients about either" (Nurse, I3).

When sexual health is a taboo topic among HCPs, the risk of avoiding communicating with patients about this issue increases, thereby decreasing the ability to help patients with potential sexual problems or challenges. Several HCPs express a desire for sexual health to become a topic that can be discussed equally with other parts of nursing. Openness about sexual health among colleagues, as well as the opportunity to get professional support and guidance, creates a basis of security for HCPs about initiating conversations about sexual health with patients:

"I want to be able to turn it around with someone. I want to be able to come out and say "She (a patient) is feeling like this, and it is damn hard". And then I would like to have a colleague who says: "Yes, I understand that, maybe you can try this and that", because I can do that with all the other aspects of nursing, and you just cannot do that with this (sexual health)" (Nurse I4).

Lack of openness and legitimisation of talking about sexual health among colleagues are present, and a negative attitude among colleagues can hold back other colleagues who find sexual health relevant. In this way, the colleagues can create a vicious circle which maintains or strengthens sexual health as a taboo focus area. HCPs find it positive to have a facilitator on the ward who focuses on and legitimises sexual health:

"Well, it is nice, both because you can ask her if there is anything you need, and she also sometimes uninvitedly expresses, 'I have just read this article, or I have just spoken to some others. 'She is like someone who gives us information when she knows something new" (Nurse I1).

A facilitator who is specialised in sexual health may encourage HCPs to address sexual health and update their knowledge regarding sexual health.

The structural framework: HCPs express that the structural framework at the hospital comes into play when they talk to the patients about sexual health. For example, lack of time is highlighted as a significant barrier, as HCPs often perceive that the available time is spent on conversations about the cancer diagnosis and the treatment plan. However, it is also mentioned that the limited time is approached differently:

"We can plan our way out of many things. In other words, I agree that when a patient comes tomorrow, I will leave for half an hour and talk to him and his wife. We can plan out of at, so I could do that if I wanted" (Nurse I1).

It seems like there may be a difference in whether the HCPs experience a lack of time as a barrier or whether care activities, such as addressing sexual health, are planned. The HCPs express that the hospital design with multiple bedrooms has an impact on whether sexual health is discussed. Conversations about sexual health are more superficial when other patients are present in the same room:

"If you must ask about something very intimate, you hold back because a patient or two sitting next to you may be in a completely different place in their life. I often think that the physical setting is not really for it (conversations about sexual health)" (Nurse I3).

The HCPs seem to be concerned about patients' feelings of confidentiality, which often results in opting out of conversations about sexual health. This concerns both the patient, whom the HCP must consult in advance, and the other patients in the room:

"I wonder what the person next to the patient thinks about it [conversations about sexual health]? Moreover, when I leave the room, they must still be there. So, I can leave the room with my awkwardness, but he [the patient] must stay in there with his awkwardness" (Nurse I4). The HCPs reflect on the patient's reaction to the conversation and the thoughts the patient will leave with. Thus, it suggests that the relationship between the patients in the ward is considered when the HCP considers whether they should initiate conversations about sexual health.

Discussion

In this multi-method study, the survey revealed low readiness and competence among HCPs to address sexual health issues. In the qualitative study, six themes were identified, including prioritising conversations about sexual health, initiation of conversations about sexual health, HCPs' competences towards sexual health, HCPs' assessment, the collegial cooperation regarding sexual health, and the structural framework. This discussion integrates and discusses both quantitative and qualitative results.

Although, cancer is a major, increasing, public health problem worldwide, where approximately 80% of patients diagnosed with and treated for cancer experience sexual dysfunctions highlighting the importance of HCPs' attention [28,29], sexuality is constituted as an overlooked subject within the healthcare system, as HCPs' communication about sexuality appears to be difficult and taboo [30]. In our study, the HCPs also stated that sexuality is taboo in their ward. A so-called 'two-way taboo' exists, as neither HCPs nor patients initiate conversations about patient sexuality, resulting in conversations about patient sexuality being deficient or non-existent [31], because most HCPs fail to discuss patients' sexual concerns [32]. Frequent reasons among HCPs are identified as barriers, including lack of basic education, knowledge, competences, training, communication tools, time, and priority, as well as embarrassment [33,34] (Åling et al., 2021).

A consequence of HCPs' silence may be that sexuality is not mentioned amongst patients, who may experience shame and guilt about their sexual concerns [35]. To embrace sensitive issues, HCPs must focus on patient-centred communication [36,37]. It has been documented that support from management is essential to ensure and encourage communication

training for HCPs in a sensitive subject such as sexuality [38]. Communication training enhances HCPs' sense of self-efficacy to meet patients' needs where sensitive topics are part of the conversation [39]. Communication requires skills in addressing the patient's perspective, the agenda for communication, shared decision making, and feedback [37,40]. Furthermore, training an entire group of HCPs reduces the stigma of addressing sensitive issues and creates space for curiosity towards the patients' perspectives [41].

In our interview study, HCPs perceived difficulties in addressing sexuality with patients. Communication with patients about sensitive topics requires sensitivity. HCPs should consider patients' ability to perceive information in their own time, speed, and communication timing (Sævareid et al., 2018). Compassionate communication using motivational interviewing is a possible tool to address sensitive subjects such as sexuality [37]. Despite face to face encounters with the patients are preferable literature state that video consultation with the patients in their own homes may make the patients feel safe being in their own environment at home when discussion vulnerable topics such as their own sexuality [42]. Further, recent studies indicate that personal narratives can help HCPs talk about sensitive topics and ease the patient's mental and physical suffering [43,44]. Furthermore, the presence of a facilitator does not necessarily mean that HCPs and patients talk about sexual health. The fact that the HCPs can be updated on knowledge is not sufficient for facilitating HCPs' conversations about sexual health.

The healthcare system is complex and demanding of patients, as at a minimum, they must navigate healthcare facilities, comprehend written material, articulate symptoms, e.g., sexual dysfunction, answer questions, and understand and follow care instructions. However, it can be even more complex when communication about sexual health issues is taboo, as demonstrated in our study. Communication about sexual health requires health literacy, defined as the "knowledge, motivation, and competences to access, understand, appraise, and apply health information in order to make judgements and decisions in everyday life concerning healthcare, disease prevention and health promotion, to maintain or improve quality of life." (Sørensen et al., 2012). HCPS must identify patients' health literacy and communicate about sexual health. Otherwise, patients may not benefit from communicating about sexual health. Our findings indicate that organisational factors, such as a lack of time, are perceived as barriers to communicating about sexual health/issues. Organisational health literacy is "an organisation that makes it easier for people to navigate, understand, and use information and services to care for their health" [45]. However, when a lack of time and competences are present, in addition to challenges in communicating about sensitive issues, it may increase the risk that patients' potential sexual problems are not addressed and thus affect patients' quality of life negatively. In our interview study, one HCP suggested that patients do not want to talk about their sexuality. This finding aligns with a previously shown mismatch in expectations between patients and HCPs, as well as unmet patient needs in communication about sexuality. Most patients with cancer need HCPs to address sexual changes. In contrast, many HCPs assumed that patients shared their focus only on combating the disease [46]. However, studies have shown that there is an agreement between patients and HCPs expecting that HCPs are competent and educated in the field of sexual health [47,48]; therefore, sexual health should be obligatory in HCPs' basic educational programs [48].

Despite some limitations in our study, such as a small sample of HCPs in the interview study, the incorporation of both quantitative and qualitative data strengthens the credibility of this study. The number of participants in the qualitative study aligns with the recommendations of sampling three to ten participants [49] (Stake, 2013). Additionally, a sample of 128 HCPs responding to a validated questionnaire, PA-SH-D [25], can improve the quality of the quantitative study (Terwee et al., 2006). Since the PA-SH-D was distributed via an open link in emails, there is a potential risk for selection bias if the HCPs who are potentially interested in sexual health tend to answer the questionnaire. However, an online open link questionnaire is simple to distribute via email, anonymous, the data collection can be followed, and after the data collection, the data are immediately available online and ready for analysis [48].

Conclusion

In this multi-method study, the survey showed that half of the HCPs felt comfortable about addressing sexuality among patients who have cancer. However, when it comes to accomplishing this in clinical practice, the interviews revealed that they do not address sexuality for the sake of the patients. The HCPs believe that the patients are not ready to discuss that topic, so the HCPs avoid creating unnecessary worry for the patients. In addition, the HCPs lack knowledge and competencies in sexology. Furthermore, the HCPs lack support among colleagues to address sexual health. Finally, the study also demonstrated that a lack of time is a barrier to addressing patients' sexual health; thus, patients' sexuality is downgraded based on the vast amount of other information that patients suffering from cancer must be provided.

Declarations

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Author contributions: The study design was created by Siw Rosenvinge Dalgaard, Mie Dahl Petersen, Camilla Mølgaard Hansen and Lone Jørgensen. Siw Rosenvinge Dalgaard, Mie Dahl Petersen, and Camilla Mølgaard Hansen recruited participants. Siw Rosenvinge Dalgaard, Mie Dahl Petersen, Camilla Mølgaard Hansen and Lone Jørgensen performed data analysis, interpretation of data and created themes. Helle Gerbild and Birgitte Schantz Laursen wrote the article's first draft, and Christina Louise Lindhardt and all authors critically commented on the previous version of the manuscript. All authors read and approved the final manuscript.

Ethical considerations: Ethical considerations followed the directions of the Helsinki Declaration (The Danish Data Protection Agency, 2023). Informed consent was both written and verbal.

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Data availability: Data are available by contacting the first author.

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