WOMEN'S SEXUAL HEALTH

Sexual Health, Mental Health, and Beliefs About Cancer Treatments Among Women Attending a Gynecologic Oncology Clinic

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ABSTRACT

Introduction: Sexual health is an important, yet overlooked, aspect of quality of life for gynecologic oncologic patients. Although patients with gynecologic cancer frequently report sexual health concerns, there are limited efforts to address these problems. A comprehensive understanding of the relationship between mental health and sexual health needs to be prioritized.

Aim: To examine multiple components of sexual health in patients with gynecologic cancer.

Methods: For the present study, sexual health concerns (ie, sexual frequency, desire, response, and satisfaction; orgasm; and pain during sex; independent variables), beliefs about cancer treatments affecting sexual health (dependent variable), and mental health (ie, anxiety and depressive symptoms; dependent variables) of patients at a US gynecologic oncology clinic were assessed.

Main Outcome Measures: Demographics; cancer diagnosis; positive screening results for cancer; sexual health histories including sexual frequency, desire, pain, orgasm, responsiveness, and satisfaction; and mental health including depression and anxiety symptoms.

Results: Most women reported experiencing at least one sexual health concern, and half the women screened positive for experiencing symptoms of depression and anxiety. Forty-nine percent of participants reported having no or very little sexual desire or interest in the past 6 months. Further, in mediation analyses, pain during sex was significantly and positively correlated with depressive symptoms ($r = 0.42$, $P < .001$), and this relationship was fully mediated by believing that cancer treatments affected one's sexual health ($B = 0.16$, 95% confidence interval $= 0.01-0.48$, $P < .05$).

Conclusion: Findings emphasize the need to further address and incorporate sexual and mental health into standard care for patients attending gynecologic oncology clinics. Screening women for whether and to what extent they perceive cancer treatments affecting their sexual health could provide a brief, easily administrable, screener for sexual health concerns and the need for further intervention. Intervention development for patients with gynecologic cancer must include mental health components and addressing perceptions of how cancer treatments affect sexual health functioning. **Eaton L, Kueck A, Maksut J, et al. Sexual Health, Mental Health, and Beliefs About Cancer Treatments Among Women Attending a Gynecologic Oncology Clinic. Sex Med 2017;5:e175–e183.**

Key Words: Sexual Health; Mental Health; Gynecologic Oncology; Cancer Treatment

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INTRODUCTION

Although the topic of sexual health for gynecologic oncologic patients has garnered more interest in recent years, intervention work to address this aspect of quality of life often remains overlooked and not incorporated into standard of care.[1–3] Sexual health is an area of interest and concern for many women who are currently undergoing, or who have undergone, gynecologic oncology treatments. According to Abbott-Anderson and

Kwekkeboom,[4] most survivors of gynecologic cancer experience physical sexual dysfunction. However, intervention resources for women with sexual health needs are limited.[4–6] In addition to the social and emotional effects of coping with a cancer diagnosis and managing intensive cancer treatment regimens, gynecologic cancer treatments can—and often do—directly affect a patient's physical and emotional capacity to engage in sexual activity.[7,8] As a result of these realities, sexual health research in these patients and intervention development must be prioritized.

Sex health morbidities in patients with gynecologic cancer are common and can persist for years after their treatment has completed.[6,9–14] Reports of dyspareunia (ie, pain during intercourse), lack of interest in sexual activity, and difficulties with arousal and orgasm are common in women during and after treatment, regardless of the amount of time since diagnosis. For example, Lindau et al[15] found that, although long-term vaginal and cervical cancer survivors engage in sexual behaviors at rates similar to the general population, they are more than twice as likely to experience sexual health problems. Further, they report that their sexual health care is significantly poorer than their overall cancer treatment care.

One area of sexual health that deserves further attention is its relation to psychological well-being.[16,17] Sexual health has a history of being treated as a separate entity, not understood within a larger social-ecologic framework. In Abbott-Anderson and Kwekkeboom's[4] review of sexual health concerns in gynecologic cancer survivors, they noted many studies addressing physical changes and needs, but not addressing psychological- and social-related concerns regarding sexual health. Levin et al[18] found that sexual health concerns are a robust and reliable predictor of psychological adjustment in gynecologic cancer survivors. Interestingly, this study noted a lack of association between disease diagnosis or treatment type and psychological adjustment. This finding suggests that understanding how treatments affect sexual health is more complicated than simply assessing the direct impact of the treatment-derived physical changes.

The beliefs one holds regarding whether cancer treatment will affect one's sexual health could be a critical component to assess when evaluating the short- and long-term effects of cancer treatments. This notion is directly in line with the Integrated Theory of Health Behavior Change (ITHBC).[19] The ITHBC is a framework that depicts health behavior change as the result of three main tenets: increased knowledge and health beliefs, self-regulation skills and abilities, and enhanced social facilitation. This theoretical approach posits that knowledge about treatments affects beliefs and behaviors in response to treatments. Fostering positive health beliefs directly affects the self-regulation skills and abilities of the individual; this includes the management of emotional responses related to symptoms of depression and anxiety. Similarly, social and emotional support provided by loved ones and health professionals is essential to the development of positive short- and long-term outcomes of the patient's health.[19] The ITHBC demonstrates the strong association that exists between health beliefs and treatment outcomes specifically related to sexual health outcomes.

STUDY OBJECTIVES

The present study examined multiple components of sexual health in patients with gynecologic cancer. There were three main study objectives: (i) describe areas of sexual health including sexual desire, response, and satisfaction; orgasm; and pain during sex; (ii) assess the associations between sexual health and mental health (ie, depressive and anxiety symptoms); and (iii) evaluate the relations among sexual health concerns, cancer treatment and sexual health beliefs, and mental health symptoms.

METHODS

Participants and Setting

Patients attending appointments at a gynecologic cancer treatment center in the Northeastern United States from April 2014 through August 2014 were approached to participate in this study. Women in need of treatment for cervical, uterine, ovarian, and other cancers related to female reproductive health attend the clinic. All patients were eligible for the study regardless of diagnosis or treatment status, with the exception of patients too physically sick or emotionally distraught as determined by medical staff. Participants were approached in clinic examination rooms by a female researcher and were informed that the study would take approximately 10 minutes to complete, that it was anonymous, and that it was in no way linked to any care that they might or might not receive. Further, participants were told that the survey would ask about their health screenings and diagnoses, mental health, and sexual health. Research staff provided the participant with informed consent, and verbal consent was obtained before survey administration. The assessment was conducted by Audio Computer Assisted Self Interviewing (ACASI), which is often used to allow participants to answer survey questions related to sensitive personal material. The ACASI was delivered by electronic tablet. A research staff member provided instruction on using the ACASI assessment and was available to the participant to answer any questions throughout the study. The participant completed the survey in a private office at the clinic. Approximately 85% of women approached agreed to participate. All study procedures were approved by the institutional review board at the University of Connecticut Health Center.

MAIN OUTCOMES MEASURES

The assessment included measures of demographics; cancer diagnosis; positive screenings for cancer; sexual health histories including sexual frequency, desire, pain, orgasm, responsiveness, and satisfaction; and mental health including depression and anxiety symptoms.

Demographics

Participants were asked to answer questions regarding their age, educational level, ethnicity, marital or partner status, and income level.