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Constructions of sexuality and intimacy after cancer: Patient and health professional perspectives

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Abstract

With an increasing emphasis on the provision of psychosocial support for patients in cancer and palliative care, an emerging body of literature has highlighted the importance of providing the opportunity for patients to discuss issues of intimacy and sexuality with their health professionals. Very little is known about why health professionals struggle with this level of communication in clinical practice. The aim of this paper is to discuss constructions of intimacy and sexuality in cancer and palliative care from patient and health professional perspectives. A three stage reflexive inquiry was used to systematically and critically analyse data from semi-structured interviews ($n = 82$), a textual analysis of 33 national and international clinical practice guidelines and participant feedback at 15 forums where preliminary research findings were presented to patients and health professionals in cancer and palliative care. The study was conducted across one public teaching hospital in Australia from 2002 to 2005. Data were further analysed drawing upon the work of Giddens on reflexivity, intimacy and sexuality, to reveal that the majority of health professionals embraced a less reflexive, more medicalised approach about patient issues of intimacy and sexuality after cancer. This was in stark contrast to the expectations of patients. Cancer had interrupted their sense of self, including how they experienced changes to intimate and sexual aspects of their lives, irrespective of their age, gender, culture, type of cancer or partnership status. Key findings from this project reveal incongruence between the way patients and health professionals constructed sexuality and intimacy. Structures which govern cancer and palliative care settings perpetrated the disparity and made it difficult for health professionals to regard patients as people with sexual and intimate needs or to express their own vulnerability when communicating about these issues in the clinical practice setting. A degree of reflexivity about personal and professional constructions of sexuality and intimacy was required for health professionals to confidently challenge these dominant forces and engage in the type of communication patients were seeking.

Keywords: Communication; Reflexivity; Australia; Sexuality; Intimacy; Cancer; Palliative care

Introduction

Background

Health care is now practised in contemporary western societies saturated with images of sexuality and intimacy to advertise and market products using every conceivable form of media and communication

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technology available. Health consumers are confronted with provocative messages of sexuality on billboards across street corners, buildings and bus stops, whilst lurid text messages scroll across the screen of mobile phones or computers as we collect our electronic mail. These marketing strategies are overwhelmingly superficial, with a fixation on wrinkle-free, glamorous and penetrative sex, from which the frail, ugly, sick, elderly or debilitated are generally excluded. Deeply embedded in many of these images are statements about contemporary sexuality and modern day intimacy that leave their mark on health care consumers. As a consequence, many relationships between patients and health professionals have also undergone a radical transformation, so that the basic tenets of traditional communication between patients and health professionals have frequently been challenged (Butler, Banfield, Terry, & Allen, 1998; Hordern & Currow, 2003; Kissane, White, Cooper, & Vitetta, 2004; Stead, Brown, Fallowfield, & Selby, 2003). Today's patients face a myriad of choices as they navigate their way through complex health systems. They make choices as to whether they will enter the private or public health system or whether they receive their care in a hospital, as an outpatient or in their home. Added to these decisions, patients are increasingly provided with the option of receiving their cancer treatment from a medical specialist, a specialist nurse, a general practitioner or a 'specialist' in natural therapies. Patients are also encouraged to seek second medical opinions, formulate a list of questions and bring a partner or support person to promote self comfort and confidence throughout the consultation (National Breast Cancer Centre, 2004; National Breast Cancer Centre and National Cancer Control Initiative, 2003).

Giddens (1993), captures some of these modern changes when he writes about reflexivity, intimacy and sexuality, citing reflexivity as the defining feature of late modernity. Reflexivity becomes the 'self confrontation' of all that we are forced to make choices about, and in this 'destabilising' capacity, where more traditional rules and structures have been eroded by individual choice, reflexivity represents increasing independence of agency from structure (Giddens, 1993; Lash, 2003). Stated in another way, modern day living presumes the existence of non-linear systems and it is "the 'chaos' or noise of the unintended consequences that leads to system dis-equilibrium" (Lash, 2003, p. 50). In a less reflexive era, a patient would go to a doctor and wait to be told what to do next (Frank, 1995).

This type of "de-normalisation" of everyday events (Lash, 2003, p. 53), highlights the capacity of the individual to question their relationship with their health, their body, emotions and social world—and the ways in which they have accounted for their experiences (Giddens, 1992). Examples of modern day reflexivity liberate expressions of sexuality and intimacy from a pre-determined relationship with reproduction. Non-fixed gender roles, relationships and technological developments in contraception and abortion have all contributed to the remodelling of intimacy and sexuality across a life span and in response to individual desires and life experiences (Giddens, 1992). Captured in the term 'plastic sexuality' (Giddens, 1992; Giddens & Pierson, 1998), the malleable nature of relationships, sexuality and intimacy in contemporary western society has impacted on individual and social constructions of sexuality and intimacy, stretching or slicing through traditional age, gender, religious, culture and partnership boundaries. Health care settings are not immune to the effects of plastic sexuality. Increasingly, health care professionals are exhorted to move beyond a focus on survival and recognise and address the ongoing biopsychosocial needs of the people living with and affected by cancer.

In 2003, for the first time in Australia, the national psychosocial guidelines for the care of people with cancer provided key indicators and health promoting strategies for adults experiencing alteration in sexual function after a cancer diagnosis (National Breast Cancer Centre and National Cancer Control Initiative, 2003). An emerging body of literature (Butler et al., 1998; Chamberlain Wilmoth, 2001; Holmberg, Scott, Alexy, & Fife, 2001; Kissane et al., 2004; Lemieux, Kaiser, Pereira, & Meadows, 2004; Schover, 2005; Stead, Brown, Fallowfield, & Selby, 2002; Watkins, Bruner, & Boyd, 1998) further supports the importance of discussing issues of intimacy and sexuality with patients in cancer and palliative care. Although these writers agree with the need to address sexuality, and in some cases provide strategies to do this, to date there has been no clear acknowledgement about the place of reflexivity and plastic sexuality in these health care debates. Nor have the implications of changing socio-cultural expectations been explored for patients and health professionals attempting to communicate on these topics in cancer and palliative care contexts.