

# Gender role conflicts experienced by Indonesian women with gynecological cancer: A phenomenological study

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## Abstract

**Background:** Gynecological cancer and its treatments can lead to sexual problems, potentially disrupting the gender role performance of women. Sexuality and gender roles are context-specific, yet these issues remain unexplored in the Indonesian context.

**Objective:** This study aimed to explore the gender role conflicts experienced by Indonesian women having gynecological cancer.

**Method:** A qualitative design with a phenomenology approach was utilized in this study. Data were collected through individualized, face-to-face, in-depth interviews conducted from 1 April to 30 December 2022 with 22 women diagnosed with gynecological cancer who had undergone treatments at the Dharmais Cancer Hospital, Jakarta, Indonesia. Data were analyzed using thematic analysis.

**Results:** Three themes were developed: 1) challenges in fulfilling female gender roles after having cancer diagnosis and therapies, 2) emotional struggles related to gender role conflicts, and 3) efforts to cope with gender role conflicts.

**Conclusion:** The study sheds light on how sexual complications due to gynecological cancer and its treatments extend beyond physical issues. A deeper layer of problems around sexual dysfunctions among gynecological cancer survivors is often rooted in traditional gender-role expectations. Nurses should have a comprehensive and contextual understanding of the unique experiences of women living with gynecological cancer to facilitate a positive adaptation to their cancer journey.

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## Keywords

Indonesia; gender role; gynecology; female; neoplasms; qualitative research; sexuality; role conflict; cancer survivors

## Background

Gynecological cancer affects the women's reproductive organs, including the uterus, ovaries, and cervix (Han et al., 2022). Despite significant advancements in the detection and treatment of gynecological cancer, the psychological and social impacts brought by this cancer and its therapies remain a substantial concern (Sun et al., 2022). One of the impacts of gynecological cancer treatments that is crucial yet often overlooked is sexual dysfunction (Hosseini et al., 2022).

Gynecological cancer treatments, including surgery, chemotherapy, radiation therapy, and hormone therapy, commonly have direct effects on sexual organs (Carter et al., 2013; Heyne et al., 2021). As a result, the prevalence of sexual dysfunction in women with gynecological cancer is the highest compared to other cancer types, as shown in a meta-analysis (Hosseini et al., 2022).

Sexual dysfunction is closely associated with gender role conflict (Komlenac et al., 2019). Gender roles refer to the set of traits, behaviors, and values expected from individuals based on their sex and society's beliefs about gender (Blackstone, 2003). 'Gender' term is often confused with 'sex.' While sex is a biological concept based on individuals' primary sex characteristics, gender is a social term that includes the meanings, traits, and values prescribed by society to different sexes (Blackstone, 2003). The socially constructed gender concepts affect the behaviors and beliefs of individuals and the way they interact with others (Azmodou et al., 2016).

Traditional 'masculinity' and 'femininity' are the predominant gender role traits in most sociocultural contexts (Kachel et al., 2016). Feminine gender roles mainly relate to the reproductive capacity of women, surrounding womanhood and motherhood (Poli, 2023). Traditional gender roles have often led women to feel responsible for fulfilling the sexual desires and needs of men (Impett & Peplau, 2002). In order to

take part in sexual relationships, women need to demonstrate 'feminine' behaviors, such as serving and supporting men and showing cooperative behaviors (Talbot, 2003).

While previous studies have shown that cancer patients commonly experienced role disruptions or conflicts during and after cancer treatments, those studies have primarily focused on men with prostate cancer (Keesing et al., 2018; Lennon et al., 2018; Uceda-Escobar et al., 2023). The issues of how gender role conflicts occur and are experienced by women with gynecological cancer are yet to be explored. An integrative review of the lived experiences of Nordic gynecological cancer survivors has shown that womanhood and sexual life are among the most salient concerns of these women (Sekse et al., 2019). Therefore, research to understand gender-related concerns of women living with gynecological cancer is warranted.

Studies on gender role conflicts among women diagnosed with gynecological cancer are highly relevant in the context of women's and family's well-being. Such studies may provide critical insights for nurses to support women not only to live through but also to thrive along their cancer trajectory. Moreover, insights are essential to garner support from the husbands/partners and family. Exploratory studies can help lay the foundation for further nursing studies to mitigate and manage gender role conflicts experienced by women with gynecological cancer. Development and implementation of effective nursing interventions to address gender-related concerns should be on the agenda of oncology nursing researchers, educators, and practitioners.

It is important to note that sexual and gender issues are context-specific and should be discussed within the framework of the predominant culture of the respective society (Kachel et al., 2016). Research on this subject is very limited in Asian society (Hosseini et al., 2022). To the best of our knowledge, no published study in Indonesia has explored the gender role issues faced by women with cancer. Thus, this study aimed to explore the gender role conflicts experienced by women diagnosed with gynecological cancer.

## Methods

### Study Design

In this study, the Heideggerian phenomenological approach (Heidegger, 1927, 1962) was employed. Phenomenology, according to Heidegger, focuses on the meaning of being, as described in the central concept of "*Dasein*" (means *existence* in German) (Heidegger, 1962). *Dasein* is an entity, a "*living being*" that can be comprehended through average daily interactions of "*being there*" and "*being in the world*" (Horrigan-Kelly et al., 2016). Heidegger premised that human beings are deeply intertwined with their world; their subjective experiences are weaved in the social, cultural, and political contexts (Heidegger, 1962).

The Heideggerian approach was selected for this study as it provides a highly congruent and applicable standpoint to the aim of this study. The "*Dasein*" lens was used to understand the essence of the lived experiences of the women regarding their sexual life and gender roles following a diagnosis of gynecological cancer. Furthermore, the women's lived experiences were understood within the Indonesian sociocultural perspective.

### Participants

Participant recruitment was conducted at the Dharmais Cancer Hospital in Jakarta, Indonesia. Dharmais Hospital is a comprehensive cancer center serving cancer patients from all over Indonesia. A purposive sampling technique was used to select participants who met the eligibility criteria (being diagnosed with gynecological cancer of any type for a minimum of one year), were communicative, and were willing to share their personal experiences for this study. Patients with a stage four cancer diagnosis and those who were single, widowed, or divorced were excluded since we intended to understand the participants' gender-role disruptions, which were closely related to sexual life. In Indonesia, pre- and extramarital sex are against the sociocultural norm and even law. Therefore, the participant's marital status was referred to check their eligibility to participate in this study. Data saturation was reached at 22 participants, marked by no new information from the interviews.

### Data Collection

Data from the participants were collected using semi-structured, in-depth interviews. The face-to-face individual interviews were conducted in a meeting room at the outpatient unit of the Dharmais Cancer Hospital at a mutually agreed time. Privacy was maintained in the interview setting. The entire data collection process occurred from 1 April to 30 December 2022. The Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007) were used to report this study. Before the study, there was no relationship between the researcher and the participants. Rapport was developed from the start of the research to the end of the interview.

An interview guide, developed based on the study objective, was used in the interviews. The guide includes the following key questions: 1) please tell me about your experiences performing your roles after the cancer diagnosis; 2) could you please describe the changes? 3) how did you cope with them? All questions in the interview guide went through an expert review and were piloted in two participants. No participants were excluded during the data collection process.

Unlike Husserl's phenomenological approach, which explicitly brackets researchers' assumptions, Heidegger posited that suspending researchers' assumptions and experiences related to the studied phenomenon is impossible. Prior understanding presumes hermeneutics. This principle guided the conduct of this study.

The interview was performed by the first author (ARM), a female Ph.D. candidate who is a maternity nurse specialist and educator with considerable training and experience in qualitative research and oncology nursing. The first author carried out the pilot interviews under expert supervision (the second author). The second author (YA) is a Professor with expertise in oncology nursing, women's health nursing, and qualitative studies. The third and fourth authors (WJ and IR) are cross-disciplinary research team members. WJ is a computer science professor with over a decade of experience working with nursing experts on various projects, including in the women's health field. IR is a sociologist in the field of family, gender, social transformation, and sexual violence. The fifth author, AM, has experience in research and policy-making

in cancer nursing, women's health, and human resources of health.

All interviews were conducted in Bahasa Indonesia. The most salient quotes were translated into English for the purpose of an international publication. The interviews lasted 50-60 minutes for each participant. No repeated interview was needed. Follow-up telephone interviews were also conducted to clarify or expand the participants' responses after analysis. The follow-up was sufficiently done via telephone since there were only a few materials for clarification, and the telephone was deemed more convenient by the participants. Interviews were audio-recorded using a tape recorder and a mobile phone as a backup. Field notes were also taken during each interview. The moment of data saturation was determined when no new information was observed.

### Data Analysis

Initially, all interviews were transcribed verbatim to represent the participants' responses accurately. Afterward, a thematic analysis approach was carried out in accordance with the methods proposed by Braun and Clarke (2019). This approach entailed identifying recurring patterns, themes, and subthemes within the transcribed data. Six iterative phases were conducted, i.e., 1) familiarization with the data through active reading and re-reading of the verbatim transcripts, 2) producing initial coding of the data, 3) generating potential themes, 4) reviewing the themes, 5) refining themes and exploring their relationships, and 6) synthesizing the final report (Braun et al., 2019).

The thematic analysis was selected as it allows flexibility in exploring the data to obtain a thorough and compelling interpretation of the participants' experiences and perspectives. The Heideggerian phenomenological standpoint to inquire about the meaning of "*being in a world*" for women with gynecological cancer in relation to their gender roles was encapsulated in the thematic analysis process.

Data analysis was undertaken primarily by the first author (ARM) and supervised by the second author (YA). Intensive discussions were also carried out among the first, the second, and the fifth authors to refine the themes and their relationships. Subsequently, the results of the analysis were verified by the third and fourth authors as well as by the selected participants.

The data were analyzed using NVivo version 12. Data were stored in password-protected personal computers of the research team until five years after the study completion. Data management and other crucial study information were provided to the participants in the information sheet, accompanied by an oral thorough explanation to seek participants' consent.

### Rigor

Four components of rigor, i.e., credibility, transferability, confirmability, and dependability, as outlined by (Lincoln & Guba, 1985), were applied in this study. Credibility was enhanced through member checking, triangulation, and prolonged engagement. For member checking, five participant representatives recognized and validated the research findings that the researchers shared with them. Credibility was

also established by triangulation, i.e., having multiple researchers in the research team with qualitative solid and women's health backgrounds involved in the data analysis. The first author/interviewer also had a long engagement with the participants for around six months at the research site. Furthermore, a detailed description of the study participants and themes identified in this study was provided to improve the transferability of the findings beyond the examined group. NVivo software was used to enhance dependability to allow for an audit trail. Finally, confirmability was enhanced by keeping a reflexive journal.

### Ethical Considerations

The ethical approval for this study was obtained from the Institutional Review Boards of the Faculty of Nursing Universitas Indonesia (no: KET-199/UN2.FI2.DI.2.I/PPM.00.02/2023) and Dharmais Hospital (no: 090/KEPK/IV/2022). Formal permission from the hospital and the respective unit (gynecology outpatient unit) was also obtained prior to conducting the study.

Participants were given a full explanation regarding the study's aim, procedures, potential risks, and benefits, as well as how to minimize or manage the risks if they occurred. As for potential risks, the information sheet stated that this study posed no significant risk to the participants. Emotional distress might occur, however, so the interviewers put extra sensitivity into their diction and the participants' nonverbal and verbal cues. The interviews were well managed without participants demonstrating or expressing emotional distress. In addition, after receiving the information sheet and informed consent form, they were also provided adequate time and space to consider their decisions and ask questions before providing written informed consent to participate in the study. The confidentiality of the participants was maintained throughout the research process. Participants were coded by their interview sequence (e.g., P1 for Participant 1 was the first to interview).

It is also noted that this study was part of a larger study on the development of a smartphone-based sexual health intervention for gynecological cancer survivors and their spouses.

## Results

### Participant Characteristics

Twenty-two women aged 32 to 58 years (mean age = 46.09 years) who were diagnosed with various types of gynecological cancer participated in the study. Most of them had the diagnosis of cervical cancer (59.09%). While the rest were diagnosed with ovarian cancer (22.72%) and endometrial cancer (18.18%). According to cancer stage, almost half of the participants (45.45%) had stage I cancer, 18.18% had stage II cancer, and the rest of them had stage III cancer. All participants (100%) had undergone surgery, 90.90% had chemotherapy, and 59.09% received radiotherapy. Regarding marriage years, the longest was 30 years, while the shortest was four years. Finally, the majority of participants (72.27%) had two children (Table 1).

**Table 1** Socio-demographic characteristics of the participants

Participant	Age (years)	Education	Religion	Employment	Cancer Type	Cancer Stage	Therapy	Years of marriage	Number of Children
P1	40	Senior high school	Christianity	Housewife	Cervical	I	Surgery	18	1
P2	55	Senior high school	Islam	Housewife	Cervical	II	Surgery, chemotherapy, radiotherapy	17	2
P3	53	Senior high school	Islam	Housewife	Cervical	III	Surgery, chemotherapy, radiotherapy	18	2
P4	43	Senior high school	Islam	Employee (private sector)	Ovary	II	Surgery, chemotherapy	18	2
P5	58	Senior high school	Islam	Housewife	Ovary	III	Surgery, chemotherapy	28	2
P6	32	Senior high school	Christianity	Employee (private sector)	Endometrial	I	Surgery, chemotherapy, radiotherapy	4	0
P7	36	Senior high school	Islam	Employee (private sector)	Cervical	III	Surgery, chemotherapy, radiotherapy	3 <sup>rd</sup> marriage: 4 years	2
P8	58	Senior high school	Christianity	Retired	Cervical	I	Surgery, chemotherapy, radiotherapy	26	0
P9	42	Senior high school	Islam	Entrepreneur	Endometrial	I	Surgery, chemotherapy	26	2
P10	42	Senior high school	Islam	Employee (private sector)	Cervical	II	Surgery, chemotherapy, radiotherapy	4 <sup>th</sup> marriage, 4 years	3
P11	37	Senior high school	Islam	Housewife	Ovary	I	Surgery, chemotherapy	18	2
P12	42	S1	Islam	Civil servant	Cervical	III	Surgery, chemotherapy, radiotherapy	18	2
P13	40	Senior high school	Islam	Entrepreneur	Endometrial	I	Surgery, chemotherapy	2 <sup>nd</sup> marriage, 4 years	0
P14	43	Senior high school	Islam	Housewife	Ovary	III	Surgery, chemotherapy	26	2
P15	55	University	Christianity	Housewife	Endometrial	I	Surgery, chemotherapy, radiotherapy	30	2
P16	58	Junior high school	Islam	Housewife	Cervical	III	Surgery, chemotherapy, radiotherapy	28	2
P17	58	Senior high school	Islam	Housewife	Cervical	I	Surgery, chemotherapy, radiotherapy	26	2
P18	58	Senior high school	Christianity	Housewife	Cervical	III	Surgery, chemotherapy, radiotherapy	30	2
P19	33	Senior high school	Islam	Housewife	Ovary	I	Surgery, chemotherapy	6	2
P20	42	Senior high school	Islam	Entrepreneur	Cervical	III	Surgery, chemotherapy, radiotherapy	18	2
P21	42	Senior high school	Islam	Housewife	Cervical	II	Surgery, chemotherapy, radiotherapy	3 <sup>rd</sup> marriage, 4 years	2
P22	47	Senior high school	Christianity	Seller	Cervical	I	Surgery	18	1

### Thematic Findings

Our thematic analysis resulted in three themes that portray the gender-role-related experiences of Indonesian women diagnosed with gynecological cancer. The themes include the

challenges of the participants in fulfilling their female gender roles after having cancer diagnosis and therapies, their emotional struggles related to the gender role conflicts, and finally, their efforts to cope with the role conflicts ([Table 2](#)).

**Table 2** Themes, subthemes, and codes of the study

Themes	Subthemes	Codes
Challenges in fulfilling female gender roles	Challenges in fulfilling the role of a wife	<ul style="list-style-type: none"> <li>Physical problems arising from cancer</li> <li>Psychological problems arising from cancer</li> <li>Body image disturbance</li> </ul>
	Challenges in balancing motherhood roles	<ul style="list-style-type: none"> <li>Motivation to recover was increased by remembering children</li> <li>Disrupted roles as a mother due to the cancer diagnosis</li> <li>The desire to be a good mother was hindered because of cancer</li> </ul>
Emotional struggles arising from gender role discrepancies	Self-reflection of emotions	<ul style="list-style-type: none"> <li>Feelings of sadness</li> <li>Feeling very weak</li> <li>Feeling guilty</li> </ul>
	Feelings toward husbands and children	<ul style="list-style-type: none"> <li>Inability to have sex due to weakness and fatigue</li> <li>Inability to have husband and wife relations due to illness</li> <li>Feeling proud of children becoming more independent</li> </ul>
Role conflict resolutions	Adhering to gender role expectation	<ul style="list-style-type: none"> <li>Offering husband to have sexual relations</li> <li>Trying the best possible efforts to satisfy husband so that he does not have an affair</li> <li>Learning to have sex after cancer treatment</li> <li>Finding the husband's understanding</li> </ul>
	Compromising gender role expectations	<ul style="list-style-type: none"> <li>Apologizing to husband for inability to fulfill obligations</li> <li>Developing a loving relationship without always having to have sexual intercourse</li> <li>Thanking God for increasing spiritually</li> </ul>
	Mitigating through avoidance	<ul style="list-style-type: none"> <li>Avoiding sexual intercourse because of pain</li> <li>Avoid sexual intercourse due to the trauma of bleeding</li> <li>Surrender your husband will do anything</li> </ul>

**Theme 1: Challenges in Fulfilling Female Gender Roles**

**Subtheme 1.1: Challenges in fulfilling the roles of a wife**

The participants described their difficulty in performing their perceived main role as a wife, that is, fulfilling the sexual needs of their husband. This role disruption was due to the direct impact of cancer on their reproductive organs, which was even more exacerbated by cancer treatments such as chemotherapy and surgery, as illustrated by a 43-year-old participant who was diagnosed with stage 2 ovarian cancer in the following quote.

*“Before the surgery, it was still enjoyable; I still had sexual desire with my husband. The challenges were probably because of the enlarged abdomen that made me feel bloated like I was pregnant. However, after the chemotherapy, my sexual desire decreased. Then, after the hysterectomy, it also became dry down there, just like my friend who had her uterus removed said. She told me it would affect the marital relationship, and I feel it, too. Before the illness, even a little touch from my husband would ignite passion, but now, not anymore.” (P4)*

Many other participants specifically mentioned the sexual relationship as a “duty” of a wife towards her husband. Failing to do the duty leaves the women with deep regret so that they would apologize to their husband, as described by P1, a woman diagnosed with cervical cancer who had been married for 18 years. Some women also felt a big hollow in their sense of womanhood beyond their control, so they chose the diction “surrender” (in P2’s quote) to convey their resignation to the Divine Will in dealing with this matter.

*“I sometimes feel sorry for my husband, but I’m also scared. I sometimes apologize. I’m sorry I can’t fulfill my duty, but my husband says my recovery is important. He even reminds me to*

*take medicine every day. Thank God, my husband is so caring.” (P1)*

*“I surrender because I can’t fulfill my duty (a sexual relationship). But my husband is understanding; he doesn’t leave me.” (P2)*

**Subtheme 1.2: Challenges in balancing motherhood roles**

Being diagnosed with cancer has significantly altered how the participants perceive their role as mothers. A cancer diagnosis creates tension between the mother’s identity and the roles of ill people in seeking a cure. In the following quote, a 47-year-old woman with cervical cancer pursued cancer therapies so she could survive as a mother to their children, especially the youngest one.

*“I always remember my children; my third child is still young. I am motivated to undergo treatment because I think of my child. I want to accompany and take care of them. I feel my role as a mother has changed since I was diagnosed with the illness.” (P22)*

However, the participants also found themselves grappling with the harsh reality of battling gynecological cancer. The following quote was expressed by a woman with stage 1 endometrial cancer. She had undergone surgery and chemoradiation to treat her cancer. The quote illustrates how her bodily condition as a cancer patient left the participant struggling to perform everyday tasks, illuminating the ongoing battle she faced to maintain her expected roles as a mother and a wife.

*“I want to be a strong mother and partner, but my condition after gynecological cancer often makes me unable to perform daily tasks. This is a real struggle.” (P15)*

Not only the physical impacts of cancer and its therapies but also the repeated hospital visits that made the participant

unable to tend to her household and child, as mentioned by a cervical cancer patient below:

*"I'm sad because my husband takes care of everything at home, and my child is often left alone. Because I keep going back and forth to the hospital." (P17)*

## Theme 2: Emotional Struggles Arising from Gender Role Discrepancies

### Subtheme 2.1: Self-reflection of emotions

The participants experienced emotional struggles, torn between their roles as a wife, a mother, and a patient. The role discrepancy brings negative feelings among participants, ranging from sadness, guilt, powerlessness, and hopelessness. The majority of participants in this study were housewives, and they shared such personal feelings in the quotes below. These quotes are poignant reflections of the emotional challenges the participants faced as a mother and a wife battling a serious and long-term illness like cancer.

*"I feel sad because I often leave my husband and child to manage everything at home. Due to frequent hospital visits." (P17)*

*"I feel extremely weak after undergoing gynecological cancer treatment. Being unable to fulfill the roles of a mother and wife properly makes me feel guilty." (P20)*

*"So, my complaint isn't about pain but fatigue. Even doing sexual intimacy requires energy, but I feel so weak." (P3)*

*"Every time my husband tried to engage, it was really painful. I can't engage anymore; I was still in pain until now. I have given up." (P2)*

### Subtheme 2.2: Feelings toward husbands and children

Apart from feelings toward themselves, the participants also shared the feelings they experienced toward their significant others who were affected by their cancer and therapies. As an example, in the following quote, a 40-year-old participant expressed how she felt pity for her husband due to her apprehension towards sexual intimacy after cancer. Her expression showcases the tension between the compassion she feels for her husband for missing the sexual relationship and her own fears and uncertainty coming from her illness.

*"Well, after experiencing cancer, I became hesitant when it came to intimacy. Even my husband is cautious. So, we haven't had sexual intimacy till now. Sometimes, I pity my husband, but I'm also scared." (P1)*

Despite the struggles, some participants brought up some positive emotions by witnessing the resilience of their significant others, especially children. Participant 21, as illustrated in the following excerpt, saw the silver lining in the emotional battle against cancer and its treatments. Seeing her children's ability to cope and become more independent, even in her absence due to cancer treatments, brought a sort of compensation for her role discrepancy as a mother.

*"My children have become independent, learning to handle many things on their own because I'm not always physically present. Despite the challenges, I see them growing stronger." (P21)*

## Theme 3: Role Conflict Resolutions

When sharing their experiences dealing with the role conflict, the participants mostly highlighted their role as a wife

regarding their intimate relationship with their husbands. The traditional role of a wife was mostly disrupted by cancer and its treatments. The participants tried various ways; some tended to apply one approach only, and others used several approaches. Their strategies can be classified into three, as described in the following subthemes:

### Subtheme 3.1: Adhering to gender role expectations

Some participants emphasized the importance of women making an effort to satisfy their husbands despite the challenges caused by cancer and its therapies. While the husbands usually understood the wife's conditions and adjusted their demands of a sexual relationship, many women still held firmly to their belief system that fulfilling the husband's needs, including sexual needs, was the primary duty of a wife.

One participant mentioned in the following quote that she experienced no significant sexual issues at some point during her therapy and that she was eager to perform her "duty." And yet, her husband was considerate about her health condition and checked with the doctor about the safety of performing sexual relationships given his wife's condition.

*"I felt no issues with sexual functions after my third round of chemotherapy. I 'offered' myself to my husband, but he wanted to be sure and asked the doctor. His priority was that I should recover first." (P14)*

Another participant, for example, a 40-year-old woman diagnosed with stage II ovarian cancer (participant 4), also added that even though her physique was being restricted, she made efforts to perform her traditional role as a wife to keep her marriage. She implied her worry that her husband might find another woman to fulfill his sexual needs.

*"As women, we should do our best to satisfy our husbands. We shouldn't let them seek satisfaction elsewhere. So, we need to be resourceful, even if some things are restricted due to our health. My husband understands my condition, but I also need to make some effort." (P4)*

A 53-year-old participant with stage III cervical cancer who had undergone surgery and chemoradiation talked about the need to relearn intimate relationships with her husband after undergoing cancer therapies in the following quote:

*"We both had to relearn how to have intimate relations after the treatment. It's a significant change in our relationship" (P3)*

Furthermore, a 42-year-old participant diagnosed with stage III cervical cancer candidly described her efforts to conform to her gender role while adapting to her physical condition. She explored various alternative methods, including using hands and mouth or introducing variations, addressing the changing preferences of modern husbands.

*"My husband understands my situation, but I also have to take some action. Well... (laughing), I have to be resourceful too. I can't do it from behind (anal) because it's against our religion (Islam). At least using my mouth and hands are options. And, well, using my (vaginal) 'hole' is also not as tight as before because of weakened muscles, so I have to introduce variations. Nowadays, men are into blue movies, or they prefer ejaculating on the breast. They seem to like that more... well, modern-day husbands." (P20)*

### Subtheme 3.2: Compromising gender role expectations

On the other hand, some participants perceived that they had compromised their marital duties and felt guilty about it. In the following quote, a 58-year-old participant described that despite her attempt to redefine sexual relationships and her husband's understanding, she still bore the burden of 'failure to serve' her husband.

*"I apologize to my husband for being unable to fulfill my duties, and he understands. He even pities me. As we age, direct physical intimacy decreases. But love, cuddling, and sleeping together are also forms of sexual connection. I often pray, 'Oh God, please give me tremendous help.' I feel like I'm burdening my husband. I said to him, I'm sorry for constantly bothering him. Then he said, 'Don't say that. It's human nature to help each other.' Oh God, I see how loyal my husband is. I say, Alhamdulillah (Thank God)." (P5)*

### Subtheme 3.3: Mitigating through avoidance

Nevertheless, a few participants described a different approach to coping with the role conflict; they avoided the role. The participants who chose this approach usually experienced a heightened level of physical and psychosexual issues. For example, participant 5, aged 58 years old and diagnosed with stage III ovarian cancer, expressed her long-standing fear of engaging in sexual intercourse due to the pain she experienced. This fear led to a prolonged period of sexual abstinence, as she found it incredibly painful. Her story highlighted another end of a spectrum of gender role conflict resolution cancer, which was caused by unresolved sexual issues.

*"I was scared for so long to have sexual intercourse—the husband-wife relationship. I just couldn't do it; I couldn't have sex at all. It hurt incredibly for a long time. I didn't have any sexual contact with my husband because it hurt so much—really painful for so long" (P5)*

## Discussion

This study, to our best knowledge, was the first to explore the experiences of Indonesian women regarding their gender-role conflicts after being diagnosed and treated for gynecological cancer. Our research has illuminated how deeply ingrained the traditional female gender role, particularly as a wife, is within the belief system of Indonesian women. From their point of view, female roles are mainly perceived as duties or obligations, primarily about satisfying their husband's sexual needs. Consequently, the sexual complications resulting from cancer treatments have significantly hindered women's ability to fulfill their primary roles as wives, leading to a range of psychological distress. Such distressing impacts necessitate coping processes to address the disruptions.

Our study findings confirm and expand on the previous study results on sexual and intimacy problems experienced by Indonesian cervical cancer survivors (Afiyanti & Milanti, 2013; Arianti et al., 2020). While prior studies mostly explored women's sexual issues physically and psychologically, our study saw through the women's lens of socially constructed gender roles. The findings suggest that the sexual problems experienced by women with gynecological cancer, which may manifest as various physical and sexual issues, often run deeper, with more burdening and multifaceted consequences.

Gender role expectations compound these consequences. The gender role expectations as a wife are what makes women struggle to maintain sexual life with their husband despite the women's reluctance or even fear of sexual activity due to diminished desire and enjoyment for having sex, pain or vaginal dryness, fatigue, and the fear of cancer recurrence (Alinejad Mofrad et al., 2021; Uceda-Escobar et al., 2023).

All Indonesian women with gynecological cancer in this study strongly held onto traditional female gender roles. Within Indonesian socio-cultural and religious contexts, the traditional gender roles of the wives are to serve and provide for their husbands, including the husbands' sexual needs. The Indonesian women in our study prioritized their perceived duty towards their husbands over their own rights within the gender role construct. This is consistent with previous research that indicates traditional gender roles often dictate that women are responsible for satisfying men's sexual desires and needs (Impett & Peplau, 2002).

Gender orders are commonly internalized since early childhood, developing into self-concepts throughout adolescence and adulthood (Steffens & Viladot, 2015). In the Indonesian context, gender orders are seen as 'adat' (the term for custom in Bahasa), and they underpin an individual's engagement in various aspects of social life (Ramadhani, 2023). Notably, 'adat' or customs in Indonesia are strongly rooted in religious traditions, particularly Islam, Christianity, and other religions such as Hinduism and Buddhism (Robinson, 2008). In addition, government policies, especially during the 32-year ruling regime in Indonesia, reinforced the female gender roles as mothers and wives (Tickamyar & Kusujarti, 2012). In the mainstream gender role construction in Indonesia, marriage and motherhood are seen as the ultimate destiny of Indonesian women (Tickamyar & Kusujarti, 2012).

These strong gender role expectations for women may put significant pressure on women with gynecological cancer. Women may employ strategies to navigate role disruptions while adhering to their beliefs about the feminine gender role. Most women in our study managed to adapt or negotiate their role performance, especially in their relationships with their husbands. A previous study also suggested that unpleasant sexual life due to cancer treatment is mostly transitory and may improve over time along with the adaptation and adjustment process (Uceda-Escobar et al., 2023).

### Implications for Nursing Practice

Accumulating number of studies have highlighted the vital role of healthcare professionals, including nurses, in assisting women and their partners in successfully resuming their sexual roles after cancer treatment (Afiyanti et al., 2020; Keesing et al., 2018; Uceda-Escobar et al., 2023). Therefore, nurses should equip themselves with awareness, knowledge, and understanding of the issues surrounding gender roles and sexuality within the religious and sociocultural context of women. Nurses should initiate discussions about gender roles and sexual issues with patients and their spouses. Patients commonly feel reluctant to do so because sexual problems are viewed as taboo and private matters (Afiyanti & Milanti, 2013; Sekse et al., 2019). The study findings provide insights to help nurses, especially Indonesian nurses, understand and navigate the challenges faced by gynecological cancer

survivors related to gender role performance. The participants' stories presented in this article can serve as compelling evidence to validate the patients' experiences, support them in optimizing their gender role performance, and gain support from their spouses. Globally speaking, the findings can open the doors for further nursing studies to manage gynecological cancer survivors' gender role conflicts. Moreover, first-hand stories can also be powerful means for improving practice and advocating policy for the better well-being of women with gynecological cancer. Future studies to advance knowledge, practice, and policy regarding the gender role performance of women diagnosed with gynecological cancer are warranted.

### Limitations

As in every study, this study has some limitations. The first limitation was that, despite the varied participants' characteristics, the maximum variation approach from the different ethnic backgrounds was not used to enrich the study findings. In fact, Indonesia has over 1,300 ethnicities, of which the majority (40.22%) live on Java island (Statistical Bureau of Indonesia, 2023). Future studies should identify and include more varied Indonesian ethnicities. The second limitation was that the participants were limited to those who were married to better fit the scope and context of the study. As a consequence, some particular groups of women with gynecological cancer, such as those who were single or had no sexual partners or spouses, were overlooked. Future studies can explore this population niche.

### Conclusion

This study provides a comprehensive exploration of the multifaceted experiences of Indonesian women facing gynecological cancer diagnoses and treatments within the context of their gender roles. This research shed light on the profound challenges faced by these women as they strived to meet the socially constructed gender roles as a wife, a mother, and a cancer patient. Coping with these conflicting roles is a complex process that requires adjusting to the traditional gender role norms and embarking on a learning journey. The study underlines the need for a comprehensive and contextual understanding of the unique experiences of women living with gynecological cancer and the intricate interplay between gender roles, psychological adaptation, and the well-being of the patients and their spouses.

### Declaration of Conflicting Interest

The authors have no conflicts of interest to disclose.

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### Authors' Contributions

All authors contributed equally to this study according to ICMJE authorship criteria.

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### Data Availability

The data generated and analyzed in this article are available from the corresponding author.

### Declaration of Use of AI in Scientific Writing

There is nothing to declare.

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