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ORIGINAL RESEARCH ARTICLE

Gynecological cancer survivors' experiences with sexual health communication in nurse-led follow-up consultations

Anita Paulsen[1,2] | Ingvild Vistad[3,4] | Liv Fegran[2]

[1]Department of Research, Sorlandet Hospital, Kristiansand, Norway

[2]Department of Health and Nursing Sciences, University of Agder, Kristiansand, Norway

[3]Department of Gynecology and Obstetrics, Sorlandet Hospital, Kristiansand, Norway

[4]Institute of Clinical Medicine, University of Oslo, Oslo, Norway

Correspondence
Anita Paulsen, Department of Research, Sorlandet Hospital, Egsvei 100, 4615 Kristiansand, Norway.
Email: anita.paulsen@sshf.no

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Abstract

Introduction: Gynecological cancer and its treatment may cause sexual difficulties in terms of physical and psychosocial health. Considering the essential role that nurses play in cancer care, they are well positioned to be ideal providers for addressing sexual health concerns in the follow-up phase of gynecological cancer. The aim of this study was to gain in-depth knowledge of how gynecological cancer survivors experience sexual health communication in nurse-led follow-up consultations.

Material and methods: Using a qualitative hermeneutic approach, we conducted individual semi-structured interviews with 17 women from five different hospitals in Norway between April 4, 2022, and June 2, 2022. The women participated in a large intervention study on cancer follow-up that included sexual health as one of several topics addressed by trained nurses in three consultations in the first year of follow-up. A five-stage Gadamerian-inspired research method was utilized for data collection and analysis.

Results: We identified three themes: (1) the importance of nurses listening to the women's own perceptions of sexuality, (2) post-treatment sexual challenges influence the women's need to communicate about sexual health, and (3) nursing communication can help women regain their sexual health.

Conclusions: Women who have undergone treatment for gynecological cancer find communication with trained nurses regarding sexual health beneficial. We recommend integration of trained nurses in the follow-up team. The nurses should adjust communication according to each gynecological cancer survivor's unique understanding of sexuality and inform women with sexual health concerns at that end of treatment, that sexual health can improve during follow-up.

KEYWORDS
communication, follow-up, gynecological cancer, nurse-led, sexual health, sexuality, survivorship

Abbreviations: GC, gynecological cancer; HCP, health care provider; SH, sexual health.

1 | INTRODUCTION

Gynecological cancer (GC) treatments negative impact on sexual health (SH) is well-documented.[1-3] Women treated for GC may encounter various physical and psychological challenges, such as dyspareunia, vaginal dryness, alterations in self-perception, reduced sexual interest, diminished feelings of attractiveness and anxiety related to sexual activity.[1] Furthermore, for women with partners, sexual desire of partners and communication within the relationship may also be influenced.[1]

Recent evidence suggests the positive impact of integrating sexual health (SH) communication into routine follow-up care after GC treatment.[4,5] In their study, Cleary and Hegarty[6] proposed a three-dimensional framework to understand sexuality in women with GC, encompassing sexual function, sexual self-concept and sexual relationships.[7] These dimensions align with the World Health Organization's (WHO) definition of sexuality.[8] Effective communication plays a pivotal role in this context, enabling patients to express their concerns, feel valued, and actively participate in their healthcare journey.[9,10]

Given the essential role of nurses in cancer care, they have the potential to serve as ideal providers for addressing SH concerns during the follow-up phase if they receive appropriate training.[11,12] The Lifestyle and Empowerment Techniques in Survivorship of Gynecologic Oncology (LETSGO) study seeks to enhance traditional follow-up after GC by involving dedicated nurses in follow-up consultations. The LETSGO nurses have been trained in coaching techniques, including patient-centered communication (PCC) in SH issues.[13,14] PCC emphasizes the recognition of patients' needs, perspective, and unique experience with the goal of enhancing patients.[10]

In a study by Afiyanti et al.[15] cervical cancer patients and their partners experienced positive outcomes in their sexual relationship after participating in a nurse-led intervention. A mixed method study showed that a nurse-led intervention helped GC survivors resume sexual activity after radiotherapy.[16] However, information on patients' experiences of nurse-led consultations with nurses that have been trained in SH communication across different gynecological cancer diagnoses in a routine follow-up setting, is lacking. The aim of this study was therefore to gain in-depth knowledge of how women treated for GC experience SH communication with trained nurses in a routine follow-up setting.

Key message

Sexuality is important in all stages of a woman's life, and gynecological cancer treatment can negatively affect sexual health. Nurse-led follow-up consultations can facilitate readjustment to sexuality after treatment for gynecological cancer.

2 | MATERIAL AND METHODS

2.1 | Design

We conducted a qualitative hermeneutic study based on the research process by Fleming et al.[17] grounded on Gadamer's philosophy. Gadamer believed that preunderstanding is fundamental for any kind of understanding, asserting that we all possess preunderstanding view owing to our unique life history.[18] He perceived interpretation as a fusion of horizons, an interaction between the preunderstandings of the interpreter and the meaning of the text.[19] The process of going back and forth between parts and the whole (the hermeneutic circle) leads to a new and richer understanding.[19] Due to the GC clinical experience of the first and second authors, Gadamer's emphasis on preunderstandings and the hermeneutic process posed both a challenge and an opportunity, enhancing discussions and reflections among the authors throughout the research process, particularly during data analysis. The process by Fleming et al.[17] aligns with the study's objective of gaining a deeper understanding of how women treated for GC experience communication about SH with nurses. Their five-stage method is systematic and ensures research rigor and trustworthiness. These stages include: (1) deciding upon the research question; (2) identifying preunderstanding; (3) gaining understanding through dialogue with the participants; (4) gaining understanding through dialogue with the text (containing four steps) and (5) establishing trustworthiness.[17]

The first stage, to decide upon a research question, was based on a review of the literature and developed in collaboration with all the authors. We sought to answer the following research question: How do women treated for GC experience SH communication in nurse-led follow-up consultations?

In the second stage, the preunderstanding of the authors was explored and further discussed throughout the research process.[17] All the authors were female. The first author kept a reflexive journal in which theoretical, methodological, and contextual reflections were described. Also, the situatedness and role of the first author, being a nurse and a sexologist, was discussed with her coauthors, who were experienced researchers in the fields of nursing science (RN, MScN, PhD) and gynecological oncology (MD, PhD).

The third stage, gaining understanding through dialogue with participants, will be described in the data collection section. The fourth stage, gaining understanding through dialogue with text consists of four steps and will be elaborated in the analyses section. The fifth stage, which is the establishment of trustworthiness,[17] pertains to assessing the level of confidence in data, interpretation, and methods employed to ensure the quality of a study.[20] This stage will be examined in the discussion section.

2.2 | Setting

Five hospitals that took part in the LETSGO study introduced a new follow-up model in which nurses replaced physicians in parts of the follow-up care.[13] The nurses conducted four consultations in the first year of follow-up and in three of them they routinely assessed if the participating women had any sexual concerns or problems.[13] The communication was adjusted to the women's diagnoses, treatment, and possible late effects.[14] The participanting women also had two consultations, including a gynecological examination, with a gynecologist in the first year of surveillance.[13]

2.3 | Study participants

We used purposive sampling as all informants were recruited from the LETSGO study.[13] The inclusion criteria for this present study were participation in the LETSGO study for a year. A total of 22 women were approached and 17 agreed to participate. The women who declined were not asked why they choose not to participate. The women were recruited by the nurses who conducted consultations in the LETSGO study and informed about the study's aim. They were also informed that the first author was a member of the LETSGO research team and that she was a nurse. After giving their informed consent, the participants were contacted by the first author and the date, time, and place for the interviews were set.

2.4 | Data collection

The interviews were conducted by the first author at locations chosen by the participants. A total of 11 interviews took place at undisturbed meeting rooms at hospitals, four at a university office, one in the home of the participant, and one over telephone.

Based on previous literature and interviews of the nurses in the LETSGO study,[14] we developed a semi-structured interview guide. The guide was tested in a pilot interview in which a patient representative treated for GC gave feedback on the guide. The semi-structured form has the advantage of allowing the researcher to be flexible and sensitive to specific topics that the participants bring up.[21]

The interviews started with the participating women briefly introducing themselves, followed by questions on how they understood sexuality. They were then asked to share their experiences with SH communication with the nurses they met in the LETSGO consultations. The women were encouraged to speak as openly as they were comfortable with. According to Fleming et al.,[17] at stage three, gaining understanding through dialogue with participants, it is important that the researcher understands the participant's meaning and find a common understanding. We utilized clarifying questions, such as "Can you please elaborate on …" to obtain a fusion of the two horizons, which is essential for Gadamer.[17,18] After each interview, the first author documented her general impressions and descriptions of the setting.

The 17 interviews were conducted by the first author between April 4, 2022, and June 2, 2022, and lasted between 33 and 64 min (a total of 11 h and 46 min). The interviews were audio-recorded and transcribed verbatim. The transcriptions encompassed approximately 150 pages.

2.5 | Data analyses

Gaining understanding through dialogue with text, the fourth stage in the approach by Fleming et al.[17] consists of four steps. The steps are systematic but do not necessarily occur in a particular order. In the first step, all the interviews were read several times to obtain an overall understanding of the interviews.[17] After the initial reading, the transcripts were imported into the qualitative data analysis software NVivo.[22] In the second step, every sentence and section was examined and divided into condensed meaning units that represented what the participants said.[17] In the third step, we connected the condensed meaning units with the whole text to broaden the meaning of the text. In hermeneutic interpretation, a mutual understanding is obtained by moving back and forth between the whole and its parts.[17] The condensed meaning units were discussed among all the authors and then interpreted by the latent meaning into subthemes. The initial subthemes were gradually synthesized into new, clearer subthemes. In the fourth and last steps, we grouped the subthemes into themes. Quotations from the participants were chosen to exemplify the findings.[17] The analysis process is exemplified in Table 1.

3 | RESULTS

The median age of the 17 participants was 55 (range, 36–77). Also, there were variations in terms of diagnosis and treatment modalities (Table 2). A total of 14 women were in a relationship with a male partner. Of the 14 women with a partner, 12 were sexually active with their partner before treatment. All 12 had resumed sexual activity when the interviews were conducted, either solitary through masturbation ($n=1$) or with their partner ($n=11$). Two of the three single participants were sexually active with a male sex-partner prior to the cancer diagnoses. Both had returned to being sexually active with a sex-partner at the time of the interviews, one had a new sex-partner. A total of 16 of the participants were from western countries. Three themes were identified: (1) the importance of nurses listening to the women's own perception of sexuality, (2) post-treatment sexual challenges influence the women's need to communicate about sexual health, and (3) nursing communication can help women regain their sexual health.

3.1 | The importance of nurses listening to the women's own perception of sexuality

The participants' understanding of sexuality influenced their need to communicate about SH in follow-up consultations. Because

TABLE 1 Examples of the analysis process (stage 4 of the approach by Fleming et al.) from raw data to sub- and main themes.

Raw data[a]	Condensed meaning units (second step)	Subthemes (third step)	Themes (fourth step)
For me, it is of course the physical part. But it is also how I feel about myself. If I am sort of … ready for sex and if I feel attractive and that sort of thing. (P8, 53 years)	The physical part and how I feel about myself	Sexuality has both a physical aspect and a psychological aspect	The importance of nurses' listening to the women's own perception of sexuality
To me, sexuality also has to do with … the physical contact between two individuals. It is not necessarily about penetration … it might as well be about touching each other, being kind to each other … and about making it enjoyable for both. (P17, 73 years)	Physical contact, but not just penetration, also being kind to each other		
Sex is something you may have with yourself, but you can also share it with others. It is something that keeps us together. I believe that physical contact, not necessarily penetration, keeps us connected. It strengthens our relationship. (P5, 36 years)	With yourself, but also sharing it and keeps us connected	Sexuality is part of being in a relationship and, at the same time, it is personal	
I would say that sexuality is a gem in a relationship. [Pause.] That is how I would put it. (P2, 77 years)	A gem in a relationship		
Oh, I do not know what I would have answered my grandchildren if they asked me what sexuality is. … [Pause.] I probably would say, "I think your mom can explain it better" [laughs]. (P7, 75 years)	I do not know what I would answer	Sexuality is influenced by taboos, age, and life phases	
I think sexuality should be talked about in cancer care. At the same time, it involves two persons, and it could just as well be uncomfortable and embarrassing for the partner [that the participating women talks to a nurse about sexuality]. (P2, 77 years)	It could also be embarrassing for the partner		
[For] quite a while, I felt less attractive. My body image changed, and [I] lost sense of who I was. … I felt that my body responded differently. (P14, 54 years)	Less attractive, changed body image and response	Late effects and sexual concerns may directly or indirectly affect sexuality	Post-treatment sexual challenges influence the women's need to communicate about sexual health
They did mention before surgery that I would move straight into menopause. And I had hot flashes and felt warm. But I did not know that my skin would change … it is so dry. And I look grayer. … Also, my vagina is dry … and I did not expect that either. (P10, 49 years)	Hot flashes, change skin, dry vagina was unexpected		
Gynecological cancer is kind of right in the core area of sexuality. (P15, 45 years)	The core of sexuality	Gynecological cancer occurs in the core of sexuality	
I think it would have been easier if it was in another part in the body … It is kind of like … I do not think it would have been that hard to talk about sexuality if it was. (P1, 55 years)	If it was in another part, it would not be that hard to talk about		
The intimacy with my husband was there also after the treatment. But not the sex. That simply was not the focus. Sex had to wait. Yes, we had to put it aside. I thought it was going to work out eventually. But it just needed to take the time it needed. Yes, that is what I thought. (P13, 62 years)	Intimacy was there but not sex, it needed time	Readjustment can take time	
My sex-life has gradually resumed after the treatment … it has gotten better and better. I actually feel that it is quite normal again. … Well, maybe not like it was before the treatment … but I feel that it is functioning as it should … (P16, 49 years)	Sex-life has resumed gradually, it is functioning as it should		
The nurse is appropriate because she has the time. When you are at the doctor's, you are going to get checked, and she has sort of got different things that need to be filled out and typed in and stuff. I feel that the time is more limited. The nurse is not going to do any examinations. So, I think a nurse can be responsible for that conversation. (P13, 62 years)	The nurse is appropriate, the doctors time is limited	Talking to the right person at the right time is necessary for sexual health communication	Nursing communication can help women regain their sexual health.
I do not think I had the capacity to receive information about sexual health in the treatment phase. There is a lot of information in general. For me, it was better to get information after treatment. (P11, 55 years)	Not under the treatment, but post treatment		
It is important that the nurse had been in the same situation several times. She must have talked to others who had been through the same treatment and received feedback on which sexual issues are most common. (P3, 69 years)	The nurse should have talked to others who have been through the same	Essential skills and knowledge for nurses when addressing sexuality	
First of all, you are tense, because you wonder if penetration will be painful or if your vagina will feel tighter. … So, it is important that the nurse know that and inform [you] that it might be a bit uncomfortable at the start. (P16, 49 years)	The nurse should know that penetration might be painful		

[a]The first step encompasses reading the interviews several times to obtain an overall understanding of the data.

TABLE 2 Demographics of the women participating in the study.

Participants (*n*)	**17**
Age (years)	
Mean	57.5
Median	55
Range	36–77
Marital status (*n*)	
Married/partner	14
Single	3
Diagnoses (*n*)	
Uterus	6
Ovaries/tubes	7
Cervix	3
Vulva	1
Treatment (*n*)	
Surgery	7
Surgery and chemotherapy	5
Surgery, chemotherapy and maintenance therapy	2
Chemotherapy and radiotherapy	3

sexuality was considered to be an intimate subject, they appreciated that the nurses initially explored how the individual participating women understood and experienced sexuality and adjusted the communication accordingly. In several interviews, the participants had an emotional response, with some even shedding tears as they openly conveyed the importance of good sexual health and their personal interpretation of their own sexuality.

> It [sexuality] can differ from person to person…It is a personal aspect of one's life, so you do not want to bring it up with someone who does not really care about you … it is a topic that requires a certain level of confidence and comfort. And it is important that the nurse genuinely cares and listen to your thoughts, feelings, how you understand your own sexuality and how important it is to you….
>
> (P13, 62 years)

Some participants acknowledged sexuality as limited to the physical aspect, such as sexual intercourse or achieving orgasm. However, the majority of participants offered detailed descriptions that highlighted their understanding of sexuality as encompassing psychological and relational dimensions, which included sexual interest, arousal, attraction, love, intimacy, and the feeling of emotional closeness with another person:

> For me, sexuality is everything from love to purer physical well-being.
>
> (P14, 54 years)

Sexuality was identified by some participants as an integral aspect of their personal identity or part of their femininity. A few participating women expressed feeling "healthy" and "normal" when experiencing sexual desire and joy because it formed an essential part of their being. At the same time, sexuality was understood as "a natural part of a relationship."

> Sexuality, for me, is about something that is a part of two people who love each other—something that is a natural aspect of a relationship. It has always been an important part of my life. It can make you playful. It should not be too serious, at least not in my world. Sexuality is not defined by gender. And, yes, sexuality can also be something you could practice without a partner…oh, yes, absolutely…oh my God, yes, what would I have done this year if I could not do it alone? (laughs).
>
> (P15, 45 years)

Taboo and embarrassment were mentioned by many as part of sexuality that could make communicating about sexuality challenging. The eldest women hesitated more and paused more frequently than the younger women during the interviews. Furthermore, they used metaphors when talking about sexuality more often than the younger women. For example, instead of orgasm when masturbating, they used terms such as "give yourself a high" or "having a peak." They explained that they were from a generation where sexuality had not been part of their vocabulary when they grew up. The absence of sexual education influenced how they understood and communicated about SH, both with health care providers (HCPs) and with a partner:

> Sexuality was never talked about. No, oh my God! In school, it was more about the flowers and the bees. And that lingers.
>
> (P6, 73 years)

Regardless of age, relationship status, diagnoses, and type of treatment, every participant expressed the view that sexuality holds greater significance for young women.

3.2 | Post-treatment sexual challenges influence the women's need to communicate about sexual health

The degree of post-treatment sexual concerns and problems affected the participants' need to communicate about SH. A few participants rarely mentioned sexual concerns during the interviews, and said that GC had not impacted on their SH. They still expressed a desire for HCPs to routinely talk about SH during follow-up consultations. More than half of the women described a wide range of sexual problems directly impacting their sexuality, including hormonal changes, vaginal dryness, dyspareunia, and reduced sexual desire. Indirectly, they also encountered challenges impacting SH, such as fatigue, neuropathic pain, and musculoskeletal pain.

Also, psychological challenges, such as fear of recurrence, had an indirect impact on the women. A prevalent issue that necessitated communication revolved around the profound influence of bodily changes on sexuality, with several participants referencing the concept of "the post-treatment body."

> My genitals do not work as they used to. My vagina is dry. I lack sex drive, and it takes a lot of work just to approach sexuality. It is pretty hard.…
>
> (P14, 54 years)

One participant (P4, 40 years) who had been through brachytherapy, said that GC had impacted "the core of sexuality" because the female reproductive organs were affected. She also said, "Gynecological cancer and sexuality are enemies." Having a diagnosis of GC was regarded as exceptional or unique concerning its impact on sexuality:

> I do not know how it is to be diagnosed with another cancer diagnosis. However, GC is in an intimate area. An area that also includes sexuality.…
>
> (P5, 36 years)

The younger women with cervical cancer who underwent comprehensive treatment including chemotherapy and radiotherapy (containing brachytherapy) exhibited an eagerness to openly engage in discussions regarding their concerns with the nurses. Additionally, this subgroup displayed a higher prevalence of late effects compared with those who exclusively underwent surgery. Moreover, these women faced additional challenges and ambivalence in managing their sexuality and daily life post-treatment because of the responsibility of caring for small children:

> And we have small children…and you do not really have the energy to spend so much time on it [sexuality]. Even though we both think it is important…And then you lose your desire…And then there is the added aspect of illness and concerns. It just piles up, you know. And then you have to press it [sex] in, too.…
>
> (P5, 36 years)

At the time of the interviews, 1 year after the completion of treatment, despite concerns and late effects and irrespective of age and diagnosis, most of the participating women who had experienced initial sexual concerns had adapted to their new circumstances:

> It sorts of just worked out. It was probably just the first time, yes, a little bit like…I think I was a bit anxious…Would it feel differently? And because of that, I was not able to relax. Later, we experienced that it was not that different.
>
> (P8, 53 years)

To navigate the challenges of sexuality after treatment, the participating women had to actively decide to return to being sexually active and employed pragmatic strategies to engage in sexual activity, as described by one participant:

> We put it [sex] in as an Outlook reminder (laughs). It can be hard when you get home from work and have tasks to do home and you should exercise and help your children with homework…But, yes, we try to make it fit in.…
>
> (P9, 44 years)

3.3 | Nursing communication can help women regain their sexual health

The opportunity to engage in SH communication with the same nurse throughout the follow-up period was considered crucial for facilitating adjustment.

> After surgery, it took a long time before I could even begin to think about sexuality. But when I talked to the nurse about it, she reassured me that it was not actually dangerous. It was comforting to hear that because I had this mindset that things were just the way they were and would stay that way. But when she brought it up and said that it is not dangerous, the only thing that could happen, she said, was that it might be different in the vagina, so to speak, but that I should go ahead and try it out for myself. So that is what I did. I tried it out for myself. So, she really helped me a lot.
>
> (P12, 68 years)

The women had different opinions on when sexuality should be addressed. SH communication was seen as less important during the treatment phase because their main focus was directed at being cured of the cancer. However, some women would have wanted information about what to expect regarding sexuality before and during treatment as well:

> To be prepared, you should already, from the start of the treatment, be given information about how sexuality can be different after treatment. It might not be different, but it is important that you know that things may change.
>
> (P5, 36 years)

As the follow-up phase ensued, a notable shift occurred, and all the participating women said that SH should be addressed during the follow-up phase.

To facilitate readjustment, the participants emphasized the significance of nurses having sufficient knowledge and proficient communication skills in relation to both SH and common sexual late

effects. In particular, the participants highlighted the importance of understanding the more intimate, interpersonal, and psychological aspects of sexuality. Counseling, advice, and suggestions on what they could do if faced with sexual difficulties were appreciated by the participants. Examples included suggestions on vaginal dilator therapy, topical estrogen, lubricants, and advice on how to be intimate with their partner.

The participants emphasized the significance of nurses meeting them with respect and care during discussions on sexuality by recognition and normalization of the new situation. The care provided by the nurses fostered a sense of comfort and trust, enabling the participating women to openly discuss and address their evolving SH concerns. Two participants were even moved when emphasizing the significance of their relationships with the nurses they encountered during consultations.

> I am unable to discuss sexuality with anyone. It will have to be someone that I feel confidence in … someone I have a connection with. Not like there is a wall between us. They have to be personally suitable.
>
> (P13, 62 years)

In addition, the women expressed that the gynecologist's gynecological examination gave them reassurance in relation to the physical aspect of their SH. The gynecological examination gave the women courage to restart sexuality, especially knowing that the possible physical changes were not a barrier to resume sexual activity.

Those women in sexual relationships emphasized the importance of communication with their partners. Two of the participating women also reported a noteworthy improvement in their sexual relationships with their respective partners after treatment, attributing this positive change to enhanced communication within the couple.

> Do I want it to be like it was before the treatment? That is actually a good question. Because I do not really want that. You see, this has been an eye-opener [being diagnosed with GC]. Now, we have more physical contact [without it leading to sex] and the whole relationship is more intimate than it used to be….
>
> (P5, 36 years)

4 | DISCUSSION

Our findings revealed that the women's experiences with SH communication were influenced by their individual perceptions of sexuality, as well as the extent to which they encountered sexual concerns or problems following treatment. Furthermore, the women expressed considerable benefits from engaging in communication with nurses to facilitate the process of readjusting their sexuality post-treatment.

According to theme one, the underlying basis for the participants' desire to engage in SH communication with nurses was rooted in their understanding of sexuality. Most of the participants described how SH encompassed physical, psychological, and relational aspects in line with the framework of Cleary and Hegarty[6] and WHO's definition of sexuality.[8] This holistic and personal meaning of sexuality was also reflected in how the participating women were overwhelmed and dissolved in tears during the interviews. Our findings may reflect the shift described by Hordern,[23] that SH in cancer care the last decades has moved from a medicalized and functional approach that solely focuses on the genitals to recognizing it as a distinct and personal experience that progresses over a lifetime.

Despite the participants' variable understanding of sexuality, they still held certain normative assumptions that might have influenced their communication. One such assumption was that sexual health might also be seen by older people as an unimportant aspect in their lives due to a negative cultural views that frame sex as unnatural in old age.[24] There is a general decrease in sexual activity associated with aging, but it is important to note that many people continue sexual activity even after 80 years of age.[25] Furthermore, in the context of cancer treatment, HCPs should keep in mind that sexual activity in older adults, as in younger adults, is affected by the physical, psychological, and social factors related to cancer treatment.[26]

The eldest participants in our study revealed several nonverbal cues, such as a constrained vocabulary, resorting to metaphors and pausing with greater frequency during the interviews. This could be seen as a consequence of deprived sex education that can result in embarrassment when communicating about SH.[24] It is important that such nonverbal signs are detected by nurses to avoid patient confusion.[10]

According to the second theme, the sexual concerns and problems reported by half of the participating women influenced their need for SH communication. The late effects they listed are well known from previous research, where physical sexual concerns are the most prevalent.[1] However, the different dimensions are often closely related and influence the way women look upon themselves and their sexuality.[27] In our study, many of the women experienced that GC treatment had affected their genital organs, influencing both the physical and the psychological aspect of their SH. The reason could be that the treatment frequently involves changes in physical appearance, such as scarring or loss of organs associated with femininity, which can lead to distorted body image and change in sexual identity.[28] Body image and sexual esteem are part of the sexual self-concept according to the framework of Cleary and Hegarty[6] and are fundamental when relating to oneself and others sexually. This could have been one explanation for why the participants appreciated the gynecological examination. The gynecologist gave the participants a reassurance that sexual activity could resume, so the examination also had an important psychological impact on readjustment.

Another common psychological concern, that is, decreased sexual desire, was also reported. Despite this concern, the participants

who had engaged in sexual activity with a partner ($n=14$) prior to undergoing cancer treatment had resumed sexual activity within a year. Furthermore, all of the participants who were sexually active before the treatment, except one, said that the cancer treatment had not negatively impacted their sexual relationships. This finding contrasts with a survey of 261 GC survivors where the participants were most of the participants reported concerns and changes in sexual activity in their sexual relationship when asked how the treatment had affected their intimate and sexual life with a partner.[2] An explanation for this discrepancy could be that the women in our study, in addition to the nurse, also had supportive partners to communicate with, which is a crucial factor associated with better SH outcomes.[29,30]

According to the third theme, the participating women benefited from learning from the nurses that sexual post-treatment changes were normal. They appreciated the opportunity to gain information and ask questions, which is an important aspect of nurse–patient communication.[9] The participants expressed that the nurses treated them with respect and care, which is often shown through nonverbal communication skills such as active listening, checking of understanding, and nonverbal behaviors conveying empathy and warmth.[10] Our results are in line with others that have found that even short sessions on SH were beneficial for women treated for GC.[31,32] However, a review on the existing interventions and education of oncology healthcare professionals could not provide a recommendation for specific type of intervention due to limited number of studies and heterogeneity of the data.[33]

Even though others have reported that cancer treatment might negatively affect sexual activity, sexual functioning, and sexual relationships in women treated for GC,[2] most of the participating women in our study had adjusted by being pragmatic and by prioritizing SH. The nurse–patient SH communication could have positively contributed to this adjustment, which is in line with a review by Chow et al.[11] indicating that psychoeducational interventions by nurses can have positive effects on GC patients. Most participants indicated a preference for discussing the psychological and relational facets of sexuality with nurses. This preference might have been influenced by the nurses' central role in handling SH communication with the women in the LETSGO study.[14] This role clarification could have fostered the perception that addressing sexuality constitutes an integral component of nursing assessments,[34] reflected in the consultations. Meeting the same nurse at each consultation was considered crucial for facilitating the adjustment of SH. This was also emphasized in our interview study of LETSGO nurses, in which establishing a nurse–patient relationship based on trust was essential before SH was addressed.[14]

We found that the participants experienced that the best time to communicate about sexuality was during follow-up consultations, which is in line with another study.[4] A majority of the participants felt that they did not have the focus to deal with information regarding SH before they reached the post-treatment phase. A few participants also supported the recommendation of Hay et al.,[4] who suggest that sexuality and possible side effects impacting sexuality should be thematized by HCPs both at the time of diagnosis and during treatment.

Trustworthiness is the fifth stage of the approach by Fleming et al.[17] Lincoln and Guba[35] suggest four general criteria for evaluating the quality of qualitative research: credibility, dependability, confirmability, and transferability. We established credibility, confidence in the truth of data and interpretations of them,[35] by ensuring that the perspectives of participants were represented as openly as possible by, for example, using direct quotations from all the participants in the findings. Additionally, data from all the participants were represented in all the subthemes and themes in the analysis process. The women's participation in the LETSGO study for a year further increased the study's credibility as it provided them with rich experience from being in a follow-up setting. However, the result that all the women ($n=14$) that were sexually active prior to cancer treatment had returned to being sexually active within a year post-treatment. Due to the major sexual consequences that are seen in relation to SH after treatment for GC[1] this result was unexpected. It is possible that this is selection bias, as the participating women may have been a selected group with pre-existing positive attitude toward SH communication. In addition, as previous mentioned, they may have been in strong relationships having effective communication with their partners ($n=12$) or sex-partners ($n=2$). However, when qualitative researchers aim to capture individuals' lived experiences, informant bias and subjectivity are not issues to be resolved but rather are integral aspects of the research focus.[36] Dependability, the stability of data over time and over the conditions of the study,[20] was obtained through an audit trail, a transparent description of the research step process, including data collection, analysis and reporting of the results.[35] The findings were also discussed in research groups with colleagues who had no knowledge of the study, and we received valuable feedback that expanded our understanding.[37] Confirmability, the study's objectivity or neutrality,[20] was gained by including participants who varied in terms of age, diagnosis, treatment modalities, and marital status. However, it could be a limitation that the participants were homogenous in terms of sexual orientation and ethnicity because this could have influenced their understanding, attitudes, and experience of sexuality. Sample size was discussed among the authors with the consideration that it should be large enough to capture a range of experiences while also being carefully balanced to avoid the data collected from participants becoming repetitive.[38] We believe that we achieved data saturation, indicating that further data collection no longer offered new or valuable insight that aligned with our research question. The ample amount of data we gathered encompassed both the depth and breadth of information about the phenomena. Nonetheless it remains uncertain whether our findings would have varied had more women from non-Western countries or those in same-sex relationships been included. In that case transferability—the extent to which the findings can have applicability in other contexts than in GC follow-up[35] - may be restricted to women with similar diseases or treatments that impact female reproductive organs in similar contexts such as

women with breast cancer, conditions such as endometriosis or a history of BRCA mutation.

5 | CONCLUSION

In this study, we describe how survivors of GC experienced SH communication in nurse-led follow up consultations in a routine follow-up setting. Our findings underscore the connection between post-treatment experience and SH communication, highlighting the personal, sensitive, and emotional aspects of survivorship. Based on our results, we recommend that trained nurses are integrated as key members of the follow-up team. Nurses should adapt their SH communication strategies to align with each woman's unique understanding of sexuality and specific concerns. We suggest that GC survivors with SH concerns at the end of treatment should be informed that their sexuality may improve during the follow-up phase. As it may take time for survivors to adjust to their new situation, SH communication should be an ongoing process throughout survivorship. Incorporating these recommendations into clinical practice can help healthcare providers better address the specific and sensitive needs of GC survivors, ultimately enhancing their overall quality of life and survivorship experience.

Further research is needed to better understand the attitudes and perceptions of SH in women with GC, particularly among women without partners, women in same-sex relationships, and older women.

AUTHOR CONTRIBUTIONS

The first author contributed to the data collection and writing of the manuscript. All the authors contributed to the study design and preparation, the data analyses, the interpretation of results, reviewed, and commented on the manuscript draft, and approved the last version.

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CONFLICT OF INTEREST STATEMENT

No conflict of interest.

ETHICS STATEMENT

The LETSGO study follows the principles of the Helsinki Declaration and was approved by the Regional Committees for Medical and Health Research Ethics on February 18, 2021 (11093). The present study was approved by the Norwegian Center for Research Data on February 25, 2021 (678860), the Faculty Ethical Committee on March 18, 2021 (INC0654117), and the data protection officer at the five participating hospitals. Informed consent was obtained from all participants before the interviews. As SH can be a sensitive and personal issue, all the participating women were offered a consultation with a nurse and sexologist who had no relation to the LETSGO study after the interviews.

ORCID

Anita Paulsen https://orcid.org/0000-0002-3070-3044
Ingvild Vistad https://orcid.org/0000-0002-5262-6326

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