

# COMPLICATIONS IN THE SEXUAL ACTIVITY OF WOMEN AFTER A SURGICAL INTERVENTION FOR BREAST CANCER

JOANNA KUSZ-MARCOL<sup>1 B,E,F</sup>  
MARIA KONIETZKA<sup>2 B,E,F</sup>  
JOLANTA ŻYCIŃSKA<sup>3 B,E,F</sup>

<sup>1</sup> Maria Skłodowska-Curie Memorial Cancer Center and Institute of Oncology, Gliwice Branch, Poland

<sup>2</sup> SWPS University of Social Sciences and Humanities, Faculty in Katowice, Poland

<sup>3</sup> SWPS University of Social Sciences and Humanities, Faculty in Katowice, Poland

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## ABSTRACT

Breast cancer is one of the most common types of cancer among women. The most common form of treatment of this illness is a surgical intervention consisting of a partial or radical mastectomy.

This article describes the psychological impacts of this experience on the frequency and occurrence of complications in the sexual activity of women and to determine the role that medical staff can play in helping patients cope with these challenges.

The loss of a breast can have negative effects on a woman's emotional state, specifically in terms of feeling feminine and the relationship with her partner. This is often reflected in a reduced quality of life.

The care extended to post-mastectomy patients should routinely include an assessment of possible sexual dysfunctions and monitoring of how such dysfunctions are coped with. The PLISSIT model makes it possible to indicate how post-mastectomy patients may be effectively supported by medical staff. It serves to define a group of patients requiring specialist help. It also aims to initiate a conversation about the difficulties of functioning in this sphere, to provide general information and change existing perceptions, to give specific advice on making referrals to a specialist, and to consider these types of existing problems. The described intervention model is applicable to individual work, as well as to work with couples and groups. This method depends on the type of intervention desired and on the current psychophysical state of the patient and her readiness to start a conversation concerning sexual activity.

**KEYWORDS:** breast cancer, mastectomy, sexuality, PLISSIT model

## BACKGROUND

According to statistics from the Polish National Cancer Registry, women's malignant breast cancer accounts for 22% of cases. Over 17,000 women were given this diagnosis in 2013, which was almost 2,000 more than three years earlier. The number of patients is expected to increase as the upward trend continues. However, the number of deaths caused by this type of cancer in Poland is decreasing and, in 2013, it was almost 20% below the average of other European Union countries [1]. For this reason, there have also been increases in the number of women who have undergone partial or radical mastectomies and then returned to daily activities like professional work and family life. This reintegration process brings with it completely new challenges, including the necessity to rebuild poten-

tially disturbed relationships with friends and family or to change current relationships, adapting them to the new experiences and feelings. The experience of having cancer often leads to radical changes in one's value system and perception of the world and requires building one's reality anew to make it consistent with one's current experience. A special focal area of work with a group of post-mastectomy patients, as compared to other types of cancer patients, is the relationship with an intimate partner, including sexuality, proximity, and tenderness [2].

The subject of people's suffering from the treatment of malignant tumors and its effects on sexuality has been discussed for some time in scientific publications and brochures for patients in the context of quality of life. They usually focus on descriptions of medical

problems, without also referring to psychological mechanisms that could allow them to better understand patients' behavior, as well as to formulate the principles of providing patients with adequate help from medical staff. This article aims to fill in these gaps.

### **NEGATIVE PSYCHOLOGICAL CHANGES RELATED TO THE TREATMENT OF BREAST CANCER**

Patients who are diagnosed with cancer are affected by strong negative emotions, especially surrounding a fear of declining health and quality of life and also by a sense of threat. Patients report a low mood and other symptoms of depression, as well [3]. When the treatment begins and symptomatic improvement occurs, a patient's emotional state also gradually improves. Then, the patient begins to expect a return to everyday life, of the kind which she experienced before falling ill. This is the same for her expectations about her sex life.

As research has shown, after a mastectomy, women declare a lower quality of relationship with their intimate partners compared to before the disease [4]. Surgical treatment causes injury to the body and therefore, a disturbance of the patient's self-image [5,6]. The disconnect between reality and personal expectations of physicality can be a source of suffering and internal conflict. Most of the time women choose the mechanism of accommodation, which consists of changing one's own way of seeing oneself and one's body image under the influence of unfavorable and unaccepted bodily changes. The decrease of self-esteem experienced by patients after the surgical treatment of breast cancer is called the "half woman" complex [7].

Szadowska-Szlachetka and colleagues [8], studying the quality of functioning of breast cancer patients treated with radiotherapy, revealed low results of sexual satisfaction and functioning in this area, following an assessment of the surveyed women. Patients achieved similar low ratings in the field of body image. Negative body image was associated with the avoidance of a sex life, which may trigger a vicious cycle, as avoiding this activity strengthens the lack of acceptance of body changes related to the cancer treatment. Women may then feel that their physicality does not correspond to a sense of socially-defined "sexiness." Moreover, they are characterized by being less sexually spontaneous. Additionally, feeling embarrassed and lacking control in terms of sexual activity may cause a deterioration in the quality assessment of this sphere of life compared to the period before the disease.

When asked about the reasons for the decline in their sexual activity and the abandonment of various forms of activity in this area, women affected by cancer pointed first to physical factors, which was similar to the response from men given similar questions about their decline in sexual activity. Women specifically noted things like vaginal dryness, while men

noted erectile dysfunction or fatigue. However, while men later mentioned aging as the reason for the decline of their sexual functioning, women pointed to illness-related changes in appearance that led them to feel unattractive [9].

In conclusion, it can be said that for post-mastectomy women, an important element of returning to a functioning sex life is the ability to once again feel feminine which, in turn, raises their own self-esteem, and ultimately helps them return to life as it was before the disease happened at all.

### **SEXUAL ACTIVITY AND THE HEALING PROCESS**

A review of research on women post-mastectomy indicates that having a positive body image is associated with feeling greater sexual pleasure and may result in greater self-confidence in sexual contacts [7,10]. Furthermore, the indicators of body image correlate with a sense of sexual attractiveness. These can be influenced by the ability to take care of weight and physical condition and thoughts about their own appearance during sexual activity. Sexual satisfaction has also been significantly associated with the assessment of individual parts of the body, including the breasts [11]. Therefore, it can be affirmed that experiencing intimacy in sexual contacts makes it easier for women to cope with cancer and its treatment, which promotes recovery [7].

Solving sexual problems is also important for strengthening relationships with a partner. It would seem that the unconditional acceptance of the woman's situation by her partner is of great importance to the progress of her cancer treatment [2]. It also makes the partner open to the introduction of new solutions in the sphere of sexual activity, the aim of which is adaptation to the partner's health situation and the increase of satisfaction she feels. The research emphasizes that the partners of women affected by breast cancer are convinced that in the process of treatment, sexuality is a neglected aspect of the lives of their female partners [7].

### **MEDICAL STAFF PROCEDURES**

According to the published data, it is possible to identify a group of women at risk of sexual problems related to cancer treatment. These risk factors include: mental disorders occurring before initial cancer diagnosis, sexual dysfunction, mastectomy (compared to a breast-sparing surgery or mastectomy with deferred reconstruction), the first year post surgery, low self-esteem and libido, and associated behaviors such as avoidance strategies (lack of conversation with a partner or medical staff about sexual difficulties) [7].

The results of the study indicate that about 20–30% of patients ask the doctor conducting oncological treatment for help with sexual problems [7,12]. Assessment

of sexual dysfunctions and the monitoring of related coping strategies should be a component of routine care for this group of patients. It is recommended to use a multi-level model of intervention, also called PLISSIT, which takes into account the current psychophysical state of the patient and the patient's level of readiness to confront subjects related to the sexual sphere (for further explanation of this shortcut, see fig. 1; [13,14]).

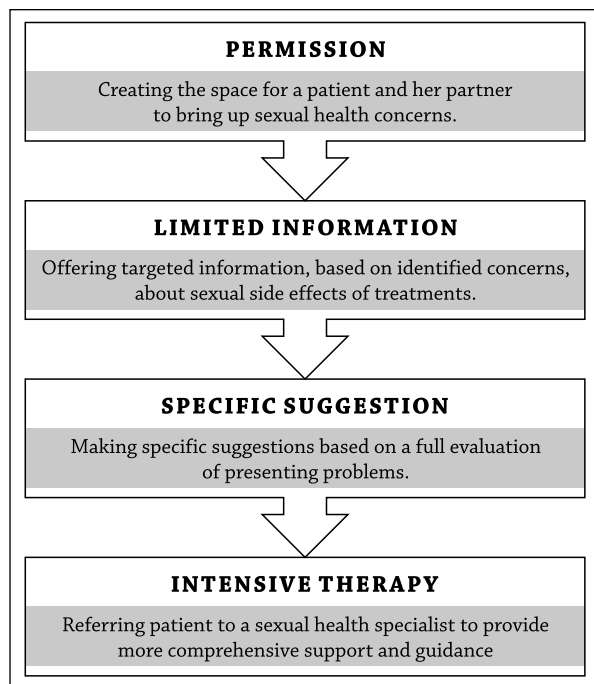


Figure 1. PLISSIT Model. Principles of intervention in the treatment of sexual dysfunction of patients with breast cancer.

Source: Authors' adaptation based on Faghani, Ghaffari, 2016; Ratner, Richter, Minkini, Foran-Tuller, 2012.

The first level (P—Permission) consists of medical staff initiating a conversation about sexual difficulties, showing acceptance of taking up such issues in the treatment process and in obtaining patient consent. The second level (LI—Limited Information) is based on medical staff providing basic information and correcting mistaken beliefs about sexual problems in the treatment of breast cancer. The next level of intervention (SS—Specific Suggestions) involves a discussion of the real difficulties reported by the patient, including a determination of what their subjective meaning is for

the functioning of the patient in terms of her assessment of herself and of her quality of life or the quality of her relationship with her partner, and whether or not strategies have thus far been used to attempt to overcome these difficulties. If the reported problems can be solved by the medical staff, then specific instructions and recommendations should be given. If, however, the solution is difficult due to the coexistence of complex life problems (e.g. addictions, depression, or anxiety disorders), then we are dealing with the fourth level of intervention (IT—Intensive Therapy) which consists of specialized treatment. In this case, it is necessary to refer the patient to a specialist, like a psychologist, psychiatrist, sexologist, or gynecologist. Help can be found for patients in accepting the losses associated with a mastectomy, including a perceived loss of femininity and the resulting difficulties navigating their own sexuality [15].

The use of the described intervention model in individual work, and also with couples or groups, makes possible an adequate and effective level of support for the needs of breast cancer patients during oncological treatment, which has been proven in research (Faghani, Ghaffari). The introduction of the PLISSIT method reflects the subjective treatment of the patient and also allows the identification of a group of patients requiring specialist assistance. In this sense, it is also an economic method.

## CONCLUSIONS

There are still few publications that deal with the issue of the psychological mechanisms' influence on the sex life of post-mastectomy patients. The type of cancer they struggle with and the specificity of treatment used in this disease affect both body image and self-esteem, which are directly related to changes in sex life and in the relationship with an intimate partner. Close relations often feel helpless because they are afraid that they may hurt their partner by raising this topic. They are therefore not able to communicate their needs and readiness to provide support in restoring sexual intimacy in the relationship. Hence, it would be worth educating the staff and families of patients, as well as the patients themselves, in the basic mechanisms that can cause sex life difficulties.

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**Correspondence address:**

Joanna Kusz-Marcol

Skłodowska-Curie Memorial Cancer Center and Institute of Oncology

Gliwice Branch

ul. Armii Krajowej 15, 44-100 Gliwice

E-mail: asia\_kusz@wp.pl

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