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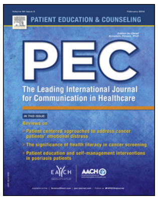

Communication about sexual health with breast cancer survivors: Variation among patient and provider perspectives☆

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ABSTRACT

Objective: Breast cancer survivors experience a range of sexual health (SH) issues. Communication problems between patient and provider can prevent survivors from pursuing SH goals and can negatively influence biopsychosocial outcomes. The primary aims of this study were to identify provider communication behaviors that facilitate or impede clinical interactions regarding SH (according to survivors and providers) and to highlight discrepancies that affect care.
Methods: Forty breast cancer survivors and forty health care providers from a variety of specialties participated in semi-structured interviews informed by the Critical Incident Technique. Transcripts were thematically analyzed using the constant comparative method.
Results: Survivors and providers discussed the importance of honoring individual patient needs and conveying compassionate messages. However, accounts varied significantly regarding the appropriate timing and method of initiating SH discussions and the helpfulness of certain support behaviors and linguistic devices.
Conclusion: Provider and survivor accounts of what constitutes helpful and unhelpful provider communication behaviors when discussing SH concerns are misaligned in nuanced and meaningful ways. These discrepancies reveal potential areas for educational intervention.
Practice implications: SH discussions require providers to examine assumptions about patients' communication preferences and information needs. Patients may benefit from frank yet sensitive discussions earlier in the cancer continuum.

1. Introduction

Breast cancer survivors experience a range of sexual health (SH) issues that affect quality of life. While other quality of life issues may improve two-to-three years after primary treatment, SH concerns have been reported in up to 50% of survivors and are among the complications that may worsen over time [1]. Sexuality is a complex topic. Women report physical problems such as pain during intercourse or difficulty reaching orgasm, psychological struggles like poor body image as well as relational issues with partners stemming from decreased intimacy and poor communication [2]. These issues are interrelated such that clinical conversations considering one aspect in isolation could fail to capture the multidimensional nature of SH [3]. As such, SH issues present a challenge for providers seeking to deliver comprehensive care.

The sensitive nature of sexuality intensifies this challenge. Cancer patients report they want to receive SH care, but are

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uncomfortable engaging in the conversation [4,5]. Providers also report personal discomfort is a barrier in clinical interactions about SH [6,7]. This is troubling as poor patient-provider communication may perpetuate or worsen survivors' SH issues [8]. Despite the importance of SH discussions much of the research regarding SH focuses on the lack of provider-initiated talk and patients' reluctance to introduce the topic [9,10]. Little is known about the nature of conversations and what constitutes helpful and unhelpful provider communication behaviors when discussions occur.

Currently, there is a scarcity of evidence-based interventions to enhance SH communication [8,11]. Before interventions can be designed, more must be understood about providers' and survivors' perceptions of SH conversations. The primary goals of this study were to identify how provider communication behaviors facilitate or impede clinical interactions regarding SH and to highlight discrepancies that affect care. Capturing patient and provider perspectives may shed light on how they talk and think about SH, align perceptions where variations exist, and help providers contextualize their use of communication practices.

2. Methods

2.1. Recruitment & sampling

Following IRB approval, survivor recruitment proceeded through various channels. Flyers were sent to navigators and social workers based in medical centers. Recruitment materials were distributed to survivor support groups. Purposive sampling was used to recruit women with breast cancer who were at least 18 years old and had completed their last primary cancer treatment (chemotherapy, radiation, or surgery).

Health care providers were recruited from a Mid-Atlantic community hospital. The research team recruited providers from specialties that care for breast cancer survivors, specifically, family medicine, internal medicine, oncology, obstetrics and gynecology, and behavioral health. Sample characteristics are presented in Table 1.

Table 1
Sample characteristics.

Variable		N (%)
Survivor Demographics		
Age Group	Young Adulthood (<40)	12(30)
	Middle Adulthood (41–59)	16 (40)
	Older Adulthood (60+)	12 (30)
Race	White	30 (75)
	Black	6 (15)
	Latina	3 (7.5)
	Multiracial/Other[a]	1 (2.5)
Relationship Status	Committed Relationship	6 (15)
	Married/Civil Union	34 (85)
Education	High school graduate	4 (10)
	Some college/vocational training	7 (17.5)
	College graduate	20 (50)
	Completed graduate school	9 (22.5)
Survivorship Length	0–2 years	13 (32.5)
	2–5 years	14 (35)
	5+ years	13 (32.5)
Provider Demographics		
Sex	Female	20 (50)
	Male	20 (50)
Provider Type	Family Medicine Physician	12 (30)
	Gynecologist	11 (27.5)
	Oncologist	3 (7.5)
	Internal Medicine Physician	3 (7.5)
	Behavioral Health Specialist	4 (10)
	Nurse Practitioner	7 (17.5)
Years of Practice	1–5	10 (25)
	5–10	14 (35)
	10+	16 (40)

Notes: Total = 80 (survivors and providers).
[a] Other includes, Asian, Native American, Native Alaskan, Pacific Islander.

2.2. Data collection

Provider interviews were conducted face-to-face in private medical offices. Interviews with survivors were conducted via telephone. The Critical Incident Technique (CIT) informed the creation of interview scripts [12]. CIT is a flexible set of principles, which help researchers understand how participants experience and behave in a certain situation as well as the meanings they attach to its significance [13]. CIT techniques elicited participants' memories of an incident(s) in which they discussed or attempted to discuss SH concerns in a clinical interaction.

A semi-structured script comprised of primarily open-ended questions guided the interviews. Questions focused on the nature of SH concerns, topics of SH conversations, what was said and done by providers, and contextual factors that influenced how these behaviors were perceived. Interview scripts for patients and providers included identical foundational questions, making comparisons possible across perspectives.

2.3. Data analysis

Interview transcripts were thematically analyzed using the constant comparative method [14]. Active codes were assigned to the transcript text and categorized into overarching interpretive themes [15]. Themes were further developed through the identification and refining of properties. As data applicable to each recurring theme was constantly compared, conceptual definitions were modified to fit new data or divided to create new codes. This process continued until themes and properties were easily distinguishable and succinct [15]. Themes for each group (survivor and provider) were then systematically compared to identify similarities and discrepancies.

2.4. Methodological rigor

Several procedures were employed throughout the research process to ensure rigor. Interview scripts were pilot tested with the first three survivors and providers to verify that the methodological mechanism was congruent with the study aim and to modify the approach to enhance fit [16]. Data analysis processes ran concurrently with data collection [17] in order to adapt the script across interviews. This supported researcher reflexivity, allowing for monitoring and confirmation of emerging insights. Sampling continued until saturation of themes was achieved [16].

3. Results

Notable areas of agreement between survivors and providers were identified for both helpful and unhelpful communication. In addition, analysis revealed important variations among provider and patient perceptions, which may negatively affect survivors' SH (see Table 2 for thematic findings).

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