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Feasibility of a Sexual Health Clinic Within Cancer Care

A Pilot Study Using Qualitative Methods

KEY WORDS

Cancer survivorship
Oncology nursing
Qualitative methodology
Sexual dysfunction
Sexual health

Background: As cancer survival rates increase, so does the imperative for a satisfying quality of life, including a fulfilling sexual life. Objective: The feasibility and effectiveness of a newly formed Sexual Health Clinic were determined using a nurse-led format, which provided support to survivors in a cancer care setting. **Methods:** Twenty-one cancer survivors received assessment, education, and tailored sexual health support by an oncology nurse with specialized skills in sexual health. Two months later, semistructured interviews focused on patients' personal experiences. Questionnaires were also administered to healthcare providers involved in providing the follow-up care. Results: Participants presented with sexual concerns that were psychological, physical, and/or relational. Scores on validated measures of sexual functioning were in the range comparable to those with a sexual dysfunction. Participants were open to being asked about sexual health and wanted professionals available who were skilled in dealing with sexual health services. Most participants experienced an improvement in their well-being and/or sexual life following participation. Some noted more confidence when speaking with their partner about sexual concerns. Conclusion: Our pilot Sexual Health Clinic was feasible, and evidence for its effectiveness was based on qualitative feedback. Participants and providers identified a strong need for the inclusion of sexual health services in cancer care. Implications for Practice: Oncology nurses are in a key position to initiate discussions surrounding sexual health issues related to cancer treatment. Self-awareness, sensitivity, and a nonjudgmental approach are required to address this dimension of holistic cancer care.

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exual dysfunction is the most common long-term consequence of cancer treatment, affecting approximately 50% of cancer survivors. As more cancer patients become cancer survivors, initiatives are underway to restore posttreatment quality of life. Unfortunately, sexual health is frequently ignored by cancer care providers despite being identified by survivors as an important aspect of care.²

In the 1990s, research on the prevalence of cancer-related sexual dysfunction began to link sexual difficulties to specific pathophysiological changes associated with cancer and its treatment (eg, surgery, radiation, chemotherapy, hormonal manipulation, and cytostatic medications).^{3–5} Surgery to remove malignant tumors has been associated with infertility, ^{6,7} diminished sexual function, ^{8–10} and alterations in body image. ^{11–13} Chemotherapy contributes to these outcomes due to temporary or often permanent loss of ovarian¹⁴ or testicular function¹⁵ and premature menopause.⁸ The effects of radiation therapy on vascular and nerve function can also lead to changes in sexuality and fertility. Dyspareunia, or pain with vaginal penetration, is a common adverse effect of pelvic radiation in women due to vaginal atrophy, stenosis, fibrosis, or shortening. 16 For men, radiation therapy also has deleterious effects on sexual response and desire due to decreases in testosterone secretion, testicular aplasia, diminished semen volume, and ejaculatory pain. 17,18 Hormonal agents given during cancer treatment can cause weight loss or gain, trigger menopausal symptoms, lessen sexual desire and arousal, 19 and produce masculinizing adverse effects in women²⁰ and emasculation in men,²¹ all of which contribute to lessened sexual satisfaction. Other adverse effects such as fatigue, pain, and nausea; alterations in bladder or bowel function; or changes in mobility and range of motion may also impact sexual functioning.¹³

The ways in which cancer impacts sexuality are based on a biopsychosocial framework.²² In addition to the aforementioned physical effects, cancer also impacts psychological well-being. Sexual function is inextricably linked with psychological well-being, quality of life, relationship satisfaction, and communication.²³ Changes to a survivor's sense of self and body image can directly impair his/her sexual response and satisfaction.²⁴ Distress, anxiety, and mood symptoms have an impact on sexual functioning and desire and alter a survivor's ability to attend to sexual cues.^{5,17,19,25–27} Partner-related concerns such as fear of recurrence²⁸ or worry about hurting their partner impact the sexual relationship. Throughout the cancer experience, partners play a variety of roles—such as caregiver, partner, lover—which can cause confusion and difficulty with intimacy. ^{13,29–31}

Clinicians may not be addressing sexual health concerns among their cancer patients, ^{32,33} and in particular for women and for individuals with a nonreproductive tract cancer. ³⁴ In 2012, the British Columbia Cancer Agency (BCCA) Outpatient Cancer Care Survey collected data from patients about their experience and satisfaction with cancer care services received at the Sindi Ahluwalia Hawkins Centre for the Southern Interior in Kelowna, British Columbia, Canada. Approximately 50% of respondents indicated that they were not given enough information regarding possible changes to their sexual health. ³⁵ In Ontario, Canada, at the Ottawa Hospital Cancer Centre, a recent evaluation reported that 40% of a sample of 113 gynecologic

cancer survivors expressed a desire for help and were worried about sexual health.³⁶

Despite extensive literature documenting the deleterious effects of cancer on sexual functioning and satisfaction, there is limited literature on effective treatment programs within a cancer care facility. Because a cancer diagnosis and/or its treatment can negatively impact sexuality through biological/physiological changes and psychological distress, a multidisciplinary treatment approach is usually advocated. Having resources available locally and access to professionals with expertise in sexual health and oncology ensure a more holistic approach for survivors.

Principal Research Objective

Canada has a limited number of programs that offer support to cancer survivors regarding sexual concerns. The purpose of the current study was to pilot test a Sexual Health Clinic (SHC) for cancer survivors at a major Canadian cancer treatment center to determine the effectiveness of using an education and referral-style format with qualitative methods. Also, given the limited funding available, we needed to determine if it was feasible to provide such a service.

Because of the exploratory nature of our research, it was pertinent to use a qualitative methodology to investigate current sexual health concerns among survivors and to explore the impact of participating in the SHC. Using this style of research provides the ability to explore topics in depth and the flexibility to tailor the interview process to discover details about the research questions or participants, allowing for a better understanding of the participants' experiences. We also included some validated measures of sexual functioning, stress, mood, and relationship functioning to allow us to calculate effect sizes for change following participation.

■ Methods

Participants

Inclusion criteria were (1) ability to read and write English, (2) 19 years or older, and (3) having a sexual concern resulting from a cancer diagnosis and/or current or past treatment for cancer. Excluded participants were those who were unable to speak English or have a diagnosis or history of psychosis or cognitive impairment that precluded the ability to provide informed consent.

Procedure

Ethics approval was obtained from the BCCA Research Ethics Board. The SHC was advertised in pamphlets and posters at the BCCA and throughout the local community. Participants were referred by general practitioners or oncologists or drawn from the BC Cancer Registry. The Figure shows the timeline for the pilot feasibility study. Participants completed consent forms at T0, and an in-person Sexual Health Intervention (SHI) was scheduled. Participants completed self-report questionnaires for quantitative analysis prior to and immediately following completion of the SHI (indicated as T1 and T2 in the Figure). At the time

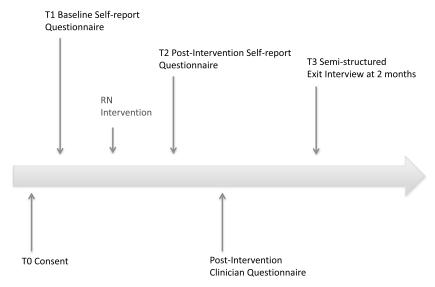


Figure ■ Timeline for Sexual Health Clinic feasibility pilot study indicating timing of questionnaires, RN intervention, and exit interview.

of the intervention, the registered nurse (RN) collected demographic characteristic information. Two months following the SHI, a research assistant (RA) conducted semistructured exit interviews (indicated as T3 in the Figure) for qualitative analysis. Finally, to gain the perspective of the clinicians involved in the SHC, a short, open-ended clinician questionnaire was completed.

Quantitative Measures

SEXUAL FUNCTIONING

Participants completed a series of self-report questionnaires before (T1) and after (T2) the SHI. We conceptualized sexual functioning using a biopsychosocial framework and selected measures of cancer characteristics, sexual functioning, and psychological functioning that tap into the myriad ways in which cancer impacts sex.

The International Index of Erectile Function,³⁷ a 15-item self-report questionnaire that assesses for erectile response and male sexual functioning, including orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction, was given to male participants. Internal consistency for the 5 domains were found to be good with Cronbach's α 's ranging from .70 to .90, and test-retest reliability was found to be relatively high with r = 0.82 for the total questionnaire.

The Female Sexual Function Index,³⁸ a 19-item self-report questionnaire, assesses sexual function in women and covers 6 sexual domains: lubrication, arousal, desire, pain, orgasm, and satisfaction. Scores range from 2 to 36, where increase in sexual dysfunction is represented by lower scores.

The Global Measure of Sexual Satisfaction (GMSEX) measures global satisfaction with the sexual relationship. Five items of the GMSEX use a 7-point bipolar scale to rate overall sexual relationship satisfaction (good-bad, pleasant-unpleasant, positivenegative, satisfying-unsatisfying, and valuable-worthless), with higher scores indicating greater levels of sexual satisfaction. Lawrance and Byers³⁹ found that GMSEX had good test-retest reliability

at 2 weeks (r = 0.84, P < .001) and at 3 months (r = 0.78, P < .001). Only the female participants completed the GMSEX measure.

Relationship functioning was assessed using the Dyadic Adjustment Scale. 40 It consisted of 32 items measuring 4 domains: dyadic consensus, dyadic satisfaction, dyadic cohesion, and affectional expression. For the purposes of the current study, we computed a total score and used a cutoff of 100 to determine higher levels of dyadic adjustment. (Typical cutoff scores between 92 and 107 are used to discriminate distressed from nondistressed couples. 41) Total score reliability (Cronbach's α) is .96, with subscales ranging from .94 to .73. Mood was assessed with the Beck Depression Inventory (BDI). 42 The BDI-II is a 21-item self-report questionnaire revised from the original BDI and designed to assess the severity of depressive symptoms. Each item is rated along a 4-point scale from 0 to 3, with higher numbers reflecting increasing severity, and total BDI scores can range from 0 to 63. A score 15 or greater denotes probable depression.

Given the established relationship between stress and sexual functioning, 43 perceived stress was measured using the Perceived Stress Scale (PSS-10). 44 The degree to which an individual perceives aspects of their life as uncontrollable, unpredictable, and overwhelming was assessed. In an analysis of 3 large national surveys, Cohen and Janicki-Deverts 45 found internal reliabilities for the PSS-10 ranging from α = .78 to .91. A multisite study of 285 undergraduate university students 46 found that the PSS-10 had good reliability with Cronbach's α reliability coefficients of .89 for the total score (10 items), .85 for the 6-item Perceived helplessness subscale, and .82 for the 4-item perceived self-efficacy subscale. Convergent validity in this study was shown by computing Pearson product-moment correlations between the PSS-10 and the State-Trait Anxiety Inventory Trait subscale (r = 0.73, P > .0001).

DEMOGRAPHIC CHARACTERISTICS

At the time of the SHI, demographics and cancer characteristics data were collected. Variables included age, relationship status,

education, ethnicity, and menopausal status (women only). The RN inquired about cancer diagnosis, stage, treatment, and current medications. Participants were asked whether they were satisfied with the level of closeness in their current relationship (yes/no answer).

Sexual Health Intervention

The SHI consisted of an in-person sexual health assessment and education session performed by the clinic's RN for an approximate duration of 1.5 hours. Research has shown that nurses are well positioned to promote sexual health recovery in cancer patients.⁴⁷ Our sexual health assessment was based on the standard practice of care at the BC Centre for Sexual Medicine, a tertiary care clinic in the University of British Columbia Department of Psychiatry, and has been adapted from Katz'48 Breaking the Silence on Cancer and Sexuality: A Handbook for Healthcare Providers. The RN followed the BCCA Symptom Management Guidelines: Intimacy and Sexuality. 13 Specialized training was provided to the RN by the BC Centre for Sexual Medicine sexual health nurse clinicians who routinely carry out sexual health assessments integrating a comprehensive biopsychosocial approach. We encouraged participants to consider the ways in which their current sexual symptoms were impacted through cancer.

Participants were assured that their participation was optional and that all information was confidential. The RN identified participants' sexual health concerns, education and resources were provided, and appropriate follow-up referrals were made to either a gynecologist, urologist, psychiatrist, private-pay psychologist/sexual

therapist, the BCCA Patient and Family Counselling Team, or the BCCA Pain and Symptom Management team.

Qualitative Measures

SEMISTRUCTURED EXIT INTERVIEWS

Two months after the nurse-led SHI (indicated as T3 in the Figure), an RA conducted a 30-minute semistructured exit interview, either in person or over the telephone (Table 1). Before considering the feasibility of offering a permanent SHC, the research team needed contextual information about the individual participants. Qualitative data on the changes and improvements in sexual functioning, sexual distress, and the quality of life as a result of the participant's experience and treatment within the SHC were collected to document nuanced ways in which sexuality was impacted that might not be detected using the quantitative questionnaires. 49 Transcripts were analyzed separately by an RA and an author with qualitative expertise using thematic analysis⁵⁰ as detailed below.

CLINICIAN QUESTIONNAIRE

To explore the perspective of the healthcare providers within the SHC, all referring physicians, the RN, and specialists providing follow-up care completed a short open-ended clinician questionnaire (Table 2).

Statistical Analyses

Participant characteristic data were recorded from the self-report questionnaires into SPSS version 14.0 (SPSS Inc, Chicago, Illinois).

Table 1 • Key Questions for the Semistructured Exit Interview

- 1. Identifying the main concern
- 2. Assessing the impact of the problem/issue
- 3. Assessing the impact of the Sexual Health Clinic intervention
- (a) "Could you tell me the main reason/challenge/issue/problem that you came to the Sexual Health Clinic for?"
- (b) "Why did you seek sexual health services?"
- (a) "What has been the impact of this sexual concern on your life?"
- (b) "What changes in your sexual life have there been since being diagnosed with cancer?"
- (c) "What impact has cancer and its treatment had on your sexual life?"
- (d) "Did the oncologist discuss how your treatment would impact your sexual health?"
- (a) "Can you tell me a bit about what changes you've noticed, if any, as a result of participating in the Sexual Health Clinic?"
- (b) "Can you tell me a little bit about your sexual health at present, and how you integrated the Sexual Health Clinic information or skills into your life?"
- (c) "Is there anything you were hoping to obtain that during these/this intervention(s) that did not happen?"
- (d) "What has been the most helpful for you?"
- (e) "What has been the least helpful?"
- (f) "What additional services related to improving your sexual health would you have liked to receive?"
- (g) "In 6 months from now, how do you think these interventions will have helped to improve your situation?'
- (h) "What advice would you give to individuals with a similar concern? To healthcare providers?"
- (i) "What impact did receiving help from the Sexual Health Clinic have on you?"
- (j) "What would you have done if this Sexual Health Clinic had not existed?"
- (k) "Would you have seen your physician, leave the problem as is, or waited to see if things got better?"
- (l) "On a scale of 1–10 (1 being very low and 10 being very high), how well do you think the nurse/urologist/gynecologist/psychiatrist understood your situation?"

Please answer the following questions in point form:

- 1. Did the Sexual Health Clinic effectively address your patient's concerns?
- 2. What impact do you think the Sexual Health Clinic had on your patient(s)? For your practice?
- 3. How did you know your patient(s) had sexual concerns?
- 4. Did you refer all your cancer survivor patients who expressed a sexual concern to this clinic? Why or why not?
- 5. What feedback did you receive from your patient(s) on the Sexual Health Clinic?
- 6. Do you think the Sexual Health Clinic should continue in the future? If so, how would you be involved with this clinic? What types of patients would you refer/do you think would benefit from the clinic?
- 7. What resources do you think need to be available to meet the needs of cancer survivors experiencing sexual health concerns?
- 8. Any other comments?

Given the small sample size, we elected to report only effect sizes, using Cohen d, for all validated measures that were administered before and after the intervention. We used d < 0.5 to denote a small effect size, d = 0.5 to denote a medium effect size, and d = 0.8 or higher to denote a strong effect size.

The semistructured exit interviews were recorded on a digital device and later transcribed based on strict transcription protocol and guidelines. The resultant themes were compared to determine that both readers were picking up similar themes. The scheme consisted of nodes and subnodes (larger themes broken down into more specific related themes), and transcripts were sectioned and categorized into different nodes. Changes were made to the coding scheme throughout the process as more transcripts were read. In this way, analysis and coding occurred simultaneously. A larger team of investigators consisting of most of the authors then chose individual transcripts and reviewed these as a group.

■ Results

Participant Characteristics

A total of 43 survivors of cancer who had received treatment from our provincial cancer care center were informed about the study and agreed to participate. Of these, 21 survivors participated, 9 did not follow up on the referral, 6 declined because of medical reasons, 4 declined as they felt the questions were too invasive, and 3 participants dropped out for reasons unknown. The 21 participants consisted of 10 women and 11 men, and the ages significantly differed between the sexes, $t_{19} = -3.17$, P = .005 (Table 3). Most participants (95.2%) were of Euro-Canadian ancestry, and a small proportion (4.8%) identified as South Asian. A total of 85% had some post-secondary education, and all but 1 individual, who identified as bisexual, described their sexual orientation as heterosexual. All but 1 individual reported being in a committed relationship. In response to an investigator-derived dichotomous question, 25% reported not feeling satisfied within their personal relationship. Among the female participants, nearly half the sample reported having iatrogenic menopause (ie, surgical or hormonal). Most participants had received surgical (90.5%) or radiation (90.5%) cancer treatment with less than half receiving chemotherapy (42.9%). Notably, 47.6% of participants had previously sought treatment for a sexual concern.

Quantitative Analysis

BASELINE SEXUAL FUNCTIONING

Participants' mean scores on the International Index of Erectile Function (men only), Female Sexual Function Index (women only), GMSEX (women only), PSS, BDI, and Dyadic Adjustment Scale are presented in Table 4. As can be seen, scores for overall sexual functioning among women were in the clinically significant range.

Table 3 • Demographic Characteristics of Sample (n = 21)

	Male	Female
	•	Participants
Variable Assessed	(n = 11)	(n = 10)
Age, mean (SD), y	66.6 (4.3)	56.6 (9.5)
Relationship status		
In a relationship	90.9%	100%
Single	9.1%	—
Highest-level education		
High school	9.1%	22.2%
Undergraduate	72.7%	66.7%
Graduate degree	18.2%	11.1%
Ethnicity		
Euro-Canadian	100%	90%
South Asian	_	10%
Type of cancer		
Prostate	8	_
Colorectal/anal	1	1
Breast	0	7
Endometrial	<u> </u>	2
Lung	1	0
Lymphoma	1	0
Stage of cancer		
1	2	2
2	4	4
3	3	3
4	1	0
Unknown	1	1
Menopausal status		
Perimenopausal	-	4.8%
Naturally menopausal	-	14.3%
Iatrogenic menopause	-	47.6%
Satisfied with level of closeness in relationship	80%	70%
r		



Table 4 • Baseline Scores on Sexual Functioning for Men (International Index of Erectile Function [IIEF]), Women (Female Sexual Function Index [FSFI]), Sexual Satisfaction (Global Measure of Sexual Satisfaction [GMSEX], women only), Perceived Stress (Perceived Stress Scale [PSS]), Mood (Beck Depression Inventory [BDI]), and Relationship Adjustment (Dyadic Adjustment Scale [DAS])

Scale	Pretreatment, Mean (SD)	Posttreatment, Mean (SD)	Effect Size (Cohen d) Associated With Change
IIEF, men only			
Erectile function	7.91 (7.05)	9.18 (8.23)	0.19
Orgasmic function	3.45 (3.78)	4.55 (3.91)	0.32
Sexual desire	4.73 (2.69)	5.55 (2.81)	0.33
Intercourse satisfaction	2.91 (4.53)	4.00 (4.43)	0.27
Overall satisfaction	5.00 (2.45)	5.82 (2.32)	0.38
FSFI, women only			
Desire	1.95 (0.89)	2.03 (1.60)	0.07
Arousal	1.84 (1.42)	1.73 (1.83)	0.07
Lubrication	1.61 (1.81)	1.43 (1.66)	0.12
Orgasm	1.65 (1.93)	1.60 (1.96)	0.03
Pain	1.80 (1.47)	2.00 (1.81)	0.13
Satisfaction	2.7 (1.75)	2.20 (1.42)	-0.36
Total	11.55 (8.31)	10.98 (9.11)	-0.07
GMSEX, women only	24.43 (7.76)	23.36 (8.19)	-0.15
PSS	14.47 (8.12)	13.37 (7.72)	-0.15
BDI	10.67 (5.53)	8.57 (7.00)	-0.37
DAS	107.29 (11.38)	106.24 (12.62)	-0.10

Data represent means and SD for men (n = 11) and women (n = 10). Clinical cutoff scores: FSFI total score \leq 26.55; BDI \geq 15; DAS \leq 100.

EFFECTS OF THE INTERVENTION

We calculated Cohen *d* for each of the validated questionnaires and present the means and SDs in Table 4. Effect sizes for all domains of male sexual functioning were in the low to moderate range (0.19–0.38). For women's sexual functioning, all of the effect sizes were very small (Table 4). Similarly, the global measure of satisfaction, which only women completed, showed a small effect size following treatment. There was no change in perceived stress or in relationship satisfaction. There was a small effect size associated with a decrease in depressive symptoms.

Qualitative Analysis

The semistructured exit interviews performed by an RA provided qualitative feedback. Thematic analysis and qualitative coding revealed a number of major themes (Table 5). Of these interviews, 6 major themes were pertinent to the feasibility of offering an SHC in the future. Each of these themes, along with a selection of relevant excerpts, is discussed in turn.

REASON FOR ATTENDING THE SHC

The majority of participants engaged with the SHC because they were seeking solutions for problematic changes to their sexual health as a result of their cancer and/or cancer treatment. They were seeking information about or a resolution of the issues that they faced.

Participants sought help from the SHC for a number of reasons: loss of personhood, vaginal dryness, erectile dysfunction, loss of libido, painful intercourse, changes in sex life affecting

their relationship, sexual adverse effects of medications, urinary tract infections, the need for an SHC in Kelowna, and the psychological effects of cancer diagnosis and/or treatment.

IMPACT ON QUALITY OF LIFE

Most participants reported significant changes in their sexual life because of having cancer and cancer treatment. These changes were associated with a loss of some type: loss of identity, reduction in frequency of intimacy, loss of enjoyment or pleasure, performance issues, loss of spontaneity, a need to explore different techniques and/or use other products and dissatisfaction with the outcome, and an inability to achieve orgasm. There was also fear, even to the point of terror and panic, that the loss of sexual health was a loss that was going to remain forever.

I'm thinking, and I'm researching and [I was] very upset that this is the way that I was going to be forever, that my life would be forever changed, ...my husband felt bad because he felt that he couldn't satisfy me and it was... a difficult road. (53-year-old woman)

There were 3 areas identified where sexual health was impacting a patient's quality of life: psychologically, physically, and in relationships. Psychological issues identified were loss of self or identity as a sexual being, anxiety, increased stress and depression due to changes in sexual life, and ambivalence toward sexual life. Several participants wondered whether changes they experienced were due to aging and not the result of cancer or cancer treatment. One younger participant expressed psychological pain and suffering, which resulted from her sexual life coming to an abrupt halt:

Table 5 • Thematic Analysis and Qualitative Coding Scheme of the Semistructured Exit Interviews				
1. Main concern	(a) How participant learned about the study			
	(b) Reason for accessing the Sexual Health Clinic			
	(c) Problem/issue leading to accessing the Sexual Health Clinic			
2. Impact of problem	(a) Importance of sexual health to the patient's overall quality of life			
	(b) Impact of issue/problem on quality of life			
	(c) Patient's satisfaction with his/her sexual life before/after the Sexual Health Clinic intervention(s)			
	(d) Patient's attitude toward the issue/problem for which help was sought			
	(e) Talk of the patient's partner			
	(f) Comfort level of patient to discuss/disclose sexual health issue(s)			
3. Impact of the Sexual Health Clinic intervention(s)	(a) Intervention(s) used			
	(b) Success of intervention(s)			
	(c) Type of impact of intervention(s)			
	(d) Discussing Sexual Health Issues with Health Care Practitioners			
	(e) Helpfulness of the Sexual Health Clinic – most helpful/least helpful			
	(f) Rating of doctor			
	(g) Rating of nurse			
	(h) Need for the Sexual Health Clinic within the BC Cancer Agency			
	(i) Recommendations for the Sexual Health Clinic			
	(j) Patient's advice to others			
4. Awareness	(a) Participant's awareness of services/support available for sexual health			
	(b) Professionals' awareness/knowledge of the impact of cancer and/or treatment on sexual health—addressed with patients			
5. Other issues impacting access to services	(a) Travel and access			

Text in boldface indicates major themes that are discussed in the text.

Maybe... just because of age, your... sexual activity is already decreased, whereas [for a younger person it was] almost like it came to a grinding halt and that was, really... hard to accept and hard to figure out. (34-year-old woman)

Physical issues identified were fatigue, erectile dysfunction, vaginal dryness, pain or discomfort during sexual intercourse, and a desire to return to previous level of functioning prior to diagnosis and treatment. Relationship issues arose when changes in sexual relationship caused stress. Even when partners were perceived as supportive, change in sexual relationship was still a source of distress for participants. The most severe impact on relationship was noted as complete relationship breakdown:

You know... it's affected my marriage greatly. ... We had a very close marriage before, and now... we are quite distant. So, it's affected us a lot— ... it changed my marriage totally. ... There have been times that I have wanted to tell him to move on, find someone else. (54-year-old woman)

Some participants stated that they continued to engage in sexual activities in order to satisfy their partner even while experiencing pain or no satisfaction themselves. For 1 participant not in a relationship, anxiety was experienced at the thought of starting a new relationship.

DISCUSSING SEXUAL HEALTH WITH HEALTHCARE PRACTITIONERS

Those who were uncomfortable bringing up issues of sexual health themselves were open to being asked about it by healthcare practitioners or within the context of the SHC. Patients want healthcare practitioners to introduce the topic of sexual health. If a healthcare practitioner does not introduce the topic, it may signal to the patient that either the clinician is not comfortable discussing this or that the topic is not important enough to bring up. Patients are unlikely to raise the topic of sexual health with a healthcare practitioner for a variety of reasons.

...it's easier to talk to somebody who's from the Sexual Health Clinic rather than somebody else. ...I don't know if I would have approached my family doctor or not. I'd probably think it's just a trivial matter. (51-year-old woman)

Seven participants indicated that their oncologist had not discussed how their cancer treatment would impact their sexual health, 8 participants indicated that they had been told about the impact of cancer treatment on their sexual functioning, and 6 participants did not comment.

The most I've ever talked about [sexual health] is right now [at this exit interview]. If I had known that at the time and known what the impact of the surgery was going to be on me, I never would have had it. (67-year-old man)

Participants recommended that physicians talk to patients about what will happen to their sexual functioning ahead of treatment. They suggested that healthcare providers should bring up the topic of sexuality so that it can be discussed. The participants' comments support the notion that cancer patients want and need an SHC.

IMPACT OF SHC

Participants all had a teaching and assessment session with the SHC RN. In addition, there were individualized recommendations

for participants that resulted in a variety of interventions. These additional interventions included prescriptions for medications, penile injections, hormone replacement therapy, referrals to other specialists (10 referrals to a urologist, 5 referrals to a gynecologist, 1 referral to a plastic surgeon, and 2 referrals to a psychiatrist), information on relaxation techniques, sexual positions, lubricants and gels, and sexual aids. Two people were referred for printed materials and 1 person to community counseling resources.

Sixteen participants experienced an overall improvement in their well-being and/or sexual life after contact with the SHC. Some also noted that they experienced an increased comfort level when speaking with their partner about their sexual life. Three participants felt that nothing had really changed, and 2 people found only some aspects of the SHC helpful. Those who felt their involvement with the SHC was not successful were somewhat neutral in their responses.

...I mean it has confirmed whatever I was reading or whatever I knew before, ...there are no miracles apparently for me. (70-year-old man)

MOST HELPFUL

The purposeful function of the SHC alleviated discomfort and concerns that sexual health may not be appropriate or an important-enough health concern for patients to raise with their doctors. The most helpful aspects of the SHC were identified as having a safe environment to talk to a professional about sexual issues, appreciation for having access to help in a timely manner, confidence that these professionals would be nonjudgemental and sensitive to the participant's discomfort with the topic, and confidence that it was acceptable to speak about sexual health. There was an overarching theme of satisfaction and comfort with the healthcare practitioners involved with the SHC. Participants felt that the practitioners understood their problems and that they were helpful. Having this service available gave participants hope that their sexual lives could improve. Hopefulness was a strong theme and was associated with a reduction in feeling isolated when dealing with sexual health issues. Participants also expressed feeling reassured that they were not the only person experiencing sexual health concerns. The rating of SHC by participants was overwhelmingly positive. Participants commented that the clinic delivered what was promised in a supportive and positive way.

LEAST HELPFUL

Conversely, what was identified as least helpful was when participants had a sense of unfulfilled hope; they did not experience the improvement that they had hoped for even though that hope may have been unrealistic. Some participants wanted more information or resources, and several mentioned that literature specific to the issues that they were dealing with would have been an improvement. Two people mentioned being offered unwanted treatment.

The timing of the SHC would have been better if participants had not been so far post—cancer treatment and if the contacts with the SHC had been closer together. One participant would have liked more contact with the SHC. Given that there were 3 dif-

ferent RAs over the course of the study, 1 participant noted that a consistency in personnel would have been more helpful.

Despite the fact that partners were invited to come with participants to SHC appointments, there were a few people who commented that they would have liked their partner to be more included in the SHC or that their partner felt excluded.

NEED FOR SHC IN THE FUTURE

Participants identified the need to have professionals available who are skilled and experienced in dealing with sexual health. A few participants wondered if they could have received help from talking to a counselor rather than going to a physician for assistance. One participant thought that she would have pulled away from her partner if the SHC had not been available to her. Having services available in one place is important as people need to know where to go for help. One participant commented that the BCCA needs to address the mental and emotional effects of cancer in a holistic manner:

[the Sexual Health Clinic] is an integral part of the cancer health clinic. ... you can do one without the other, but there is going to be a huge part of a man or a woman's life that has not been adequately addressed in which they could potentially suffer from for many years and never be able to access the kind of help that they need. (53-year-old woman)

Participants were in favor of having an SHC available in their city in the future as they identified the need to have access to sexual health clinicians with whom they could safely and comfortably discuss their concerns.

...the clinic is good because it... gives you an opportunity... to start reflecting on the sexual health of a marriage or a couple or the things that you would like to see change. (53-year-old woman)

There was an overall lack of awareness of services and support available for sexual health prior to participants' involvement with the SHC.

ISSUES AFFECTING ACCESS TO SERVICE

Access to SHC services was impacted when travel was required, given the significant costs involved. Travel was time consuming, exhausting, and inconvenient. These services could be offered using telehealth technology to ameliorate this problem.

Some participants also experienced financial barriers to getting the help they needed. Some drugs and noncovered professional fees (eg, physiotherapy, psychology) were not available to some individuals because of financial constraints.

FURTHER RECOMMENDATIONS

Participants suggested that it would be helpful to have a library of resource materials available for loan, brochures and materials placed around the cancer clinic, a support group for this issue, and online call center for people not comfortable with face-to-face interactions. Participants wanted longer involvement by professionals after their treatment and continuity of care providers

to address ongoing issues beyond cancer treatment. It was suggested that the service always be available so that an individual could get the help needed when it was wanted. One person suggested having other support available that could help people to relax (eg, massage therapy). More involvement of participants' partners in SHC interventions was desirable.

Participants' recommendations to other survivors included discussing sexual health issues, seeking appropriate attention for mechanical problems, discussing concerns with your partner, knowing that you are not alone, and accessing the SHC.

Participants recommended that healthcare practitioners get comfortable with discussing sexual health with patients. The non-judgemental and sensitive care received from SHC practitioners was identified as crucial. One participant suggested that physicians should have ongoing training in the area of sexual health. Another participant indicated that if a clinician was not knowledgeable about sexual health they would "shut down" in their discussion with them.

Clinician Questionnaire Results

Twenty-one questionnaires were sent to all referring physicians (GPs and oncologists), the RN, and specialists involved in the SHC. Ten completed questionnaires were returned. Eight of the clinicians felt that their participants' concerns were addressed, whereas the other 2 clinicians were unsure. Clinicians indicated that the SHC had provided better assessment, conversations about sexual issues aiding in the normalization of the participant's experience, improved quality of life, increased support, and an opportunity to address sexual concerns in more detail. Either the participants had told clinicians about their sexual concerns, or the clinician had directly asked the patients. Some physicians indicated that they usually provide help to their patients with sexual concerns.

Most participants reported to clinicians that the clinic was useful for them and that they were pleased with their outcomes. The clinicians felt that the SHC was a useful resource, but also recognized that the demand for this type of clinic is not tremendous. One clinician commented that it is useful to be able to acknowledge the patient's concerns and have somewhere to refer them. One clinician suggested having online forums for patients who wanted to ask questions but may be uncomfortable having a face-to-face meeting regarding sexual health. Practitioners recognized the importance of having a gynecologist and urologist available who hold interest in the treatment of sexual health for cancer patients.

■ Discussion

The SHC provided a safe environment for participants to discuss their sexual health concerns—an important first step for many of them to obtain help. It was important to have clinicians attached to the SHC who were skilled, knowledgeable, and sensitive. Patients want to be asked about their sexual health; the literature indicates that this is an important issue for patients and one that is frequently ignored.²

Given the connection between sexual function and psychological well-being, ²³ it is reassuring that the majority of the participants indicated that they experienced an overall improvement in their well-being and/or sexual life after contact with the SHC. Some also noted that they experienced an increased comfort level when speaking with their partner about their sexual life. Feeling hopeful and feeling not alone were important, positive outcomes for participants.

It is important to offer sexual health services as part of cancer care treatment, given that sexual dysfunction affects approximately half of all cancer survivors. Qualitative feedback by participants indicated strong support for and feasibility of an SHC. Feedback indicated that the SHC addressed needs that were previously unmet by their healthcare providers.

Our quantitative assessment yielded only small to moderate effect sizes following treatment. It is possible that the intervention was too brief to elicit significant changes and strong effect sizes, or it may be that the ways in which sexuality was impacted with treatment were not detected with standardized questionnaires. This phenomenon is well known in sexuality research, wherein qualitative methodologies often detect nuances in the ways people experience sexuality that may not be detected with standardized questionnaires. 49 Although our sample sizes were too small to carry out comparisons by sex, it is notable that there were stronger effect sizes for improvement in the various domains of sexual functioning among the male survivors than there were among the female survivors. This suggests that our educational program may offer an alternative, or a complement, to the current roster of approved treatments for men's sexual dysfunction. For women, on the other hand, our findings suggest that improvements in sexual functioning through this brief educational intervention were not notable.

We also acknowledge the small sample size, and it is unclear whether the demonstrated feasibility would have also applied to a much larger and more representative sample of survivors or survivors who were not in a relationship. It is likely that the negative impact of sexual dysfunction is more apparent in partnered versus single individuals.

This was an important pilot study as there is little information available about the impact that newly offered sexual health services have on the patients who access them. As this study involved a small sample size, findings are not generalizable to the larger population. Small sample size means that a range of demographic variables are not represented. Given that participants self-selected to this study, they may represent a population that is more comfortable discussing sexual needs.

■ Conclusion

The SHC at the BCCA was feasible to offer and provided services that were welcomed by our participants. The SHC provided helpful information for patients experiencing sexual health issues. Participants identified the need to have the SHC as a stable part of cancer care services. Patients need to access help when they identify the need for it. Getting help early on would likely have a cost-saving benefit for the healthcare system. Early

intervention allows stress to be alleviated and reduces the need for other services. Of the participants involved with the SHC, approximately 76.5% had completed cancer treatment. Some indicated that they would have preferred to receive help from sexual health clinicians sooner than they did. To improve access to this service, it is recommended that SHC referrals be received from patients and healthcare providers rather than only being received from physicians.

Nurses are in a unique position to introduce the topic of sexual health to patients given the intimate interactions they already have with patients. Oncology nurses have a deep understanding of the impact of cancer and cancer treatments on sexual functioning and have the perfect skill set to enter into these discussions with patients. Clinicians are likely to assume that if sexual health is a concern of a particular patient, then the patient will bring it up. However, patients do not raise the topic of sexual health for a variety of reasons. If nurses are to fulfill their mandate as holistic care providers, they must address sexual health concerns. Nurse managers need to advocate for education that enhances nurses' confidence, private physical space, and nursing care delivery models that facilitate sensitive conversations.

The SHC was cost-effective and therefore completely feasible to offer. Running the SHC 1 day per month for 1 year was approximately \$5000.00. These costs included 1 week of training for the SHC nurse, the nurse's wages, and supplies for the urologist doing penile injections. Physician fees were covered by the BC Medical Services Plan. It would have been helpful to have clerical support to coordinate appointments.

In summary, the SHC offered at the BCCA, Sindi Ahluwalia Hawkins Centre for the Southern Interior in Kelowna, British Columbia, Canada, was a helpful resource for the majority of participants. The brief, in-house, nurse-led SHC provided an opportunity to discuss sexual health concerns in a safe and nonjudgemental environment.

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