Research in Sexual Dysfunction for Women with Breast Cancer: Statistical Fulfillment or Patient Satisfaction?

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Breast cancer is one of the most frequent malignancies among Iranian women. The mortality rate of breast cancer was 14.2 per 100,000 women in Tehran in 2012. The incidence and prevalence of breast cancer in women in Iran were 24.2 and 37.7 per 100,000, respectively[1]. In the past four decades, breast cancer incidence rates has increased and made it one of the most common malignancies in this population. Iranian breast cancer patients are relatively younger than their counterparts in Western countries[2,3].

Breast cancer has frequently been studied in terms of the psychological and psychosocial aspects of the disease[4]. Maguire argued that up to 30% of these patients develop some type of anxiety or depression within a year of diagnosis[5]. Depression, disturbance of body-image and female self-concept, and sexual dysfunction are the most frequent problems experienced by breast cancer patients. The latter problem, however, is not being assessed by health care professionals specifically in Iran. Clinicians are more concerned with assuring survival and restoring physical integrity. Besides, breast is a symbol of womanhood and sexuality[2]. Many doctors and patients in Iran are hesitant to discuss sexual behaviour. Modern sexology infers the association between somatic and psychological factors and also relationship and thus sexual dysfunction[6].

Young couples experience more severe emotional distress, and seeking a new relationship is a special stressor for single women. From the studies by Kedde et al., it was concluded that 68% of women who underwent treatment faced sexual dysfunction. Various factors such as hormonal alterations caused by chemotherapy and radiotherapy, physiological and functional disturbances induced by the deterioration of physical condition, anxiety and depressive reactions to illness and treatment, regressive tendencies and loss of self-esteem due to feeling inadequate about the physical appearance can lead to sexual dysfunction. Furthermore, the onset of cancer as an obstacle to normal sexual behaviour may lead to relationship problems, such as dissatisfaction with the partner and searching for a new partner[7].

Sexual issues are not addressed in regular visits to oncology clinics as a result of insufficient

allocation of time, unreliable environment, and lack of sense of privacy that may compromise the doctor-patient confidentiality and inhibit the patient from disclosing uncomfortable or intimate information. Thus, the absence of questions is not indicative of satisfactory adaptation to the situation[7]. Discussing sexuality is a sensitive topic that patients hesitate to engage in. Therefore, the health care team should be vigilant that patients may not voice their problems, and bear in mind that they themselves may have to take the initiative in raising this issue. This should commence at the beginning of treatment and continue through the follow-up visits to the end of treatment. Health care professionals (other health care team members) are responsible for referring patients to specialists and helping them to find solutions. Interdisciplinary teams including an oncology nurse, social worker, psychologist and sexologist may be required to provide psychosocial care to patients and ensure that any existing barriers to such discussions are removed. Indeed, evaluation and management of sexual difficulties should be a standard part of clinical care of women with breast cancer[8].

Women in Islamic countries such as Iran usually have reservations in talking about and reporting sexual problems or seeking professional help[9]. In fact, women's sexual role is affected by religious and cultural issues. For instance, the desire for sex by women is perceived negatively, and men usually take the initiative for sexual activities. Additionally, the husband's preference and satisfaction are often viewed as more important than the wife's[9]. In addition, mastectomies are also believed to be frequent precipitants of divorce or other break-ups of relationships[10]. Moreover, legal multiple marriages in Iran allow men to proceed with another marital relationship in such situations. Therefore, joint sessions with the women's partner facilitates open communication about sex. Men may also benefit from individual counselling. The clinician can help the couple to open the discussion about resuming their sexual relationship and bring up their individual problems and concerns; as a result, their need for expert advice tailored to their particular health history will be recognized[11].

Conducting in-depth interviews is a good opportunity to deeply explore valid information about respondents' attitudes, values, and opinions, and yields rich data and detailed cultural-based insights from breast cancer survivors; also, we can receive answers close to the respondents' real views and concerns which are not accessible through standard questionnaires and close-ended questions. Open-ended questions allow interviewees to explain and clarify the situation in as much detail as they want, and increase the likelihood of gathering useful responses[12]. Because of the sensitive and emotionally evoking context, a well-qualified and highly trained interviewer is needed[13]. Moreover, sexually high-risk cases should be carefully considered among this group of women: single women, those who have had unhappy relationships or have sexual problems, young women, and those who wish to have more children.

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