Published in final edited form as:
*Support Care Cancer*. 2022 June ; 30(6): 4935–4944. doi:10.1007/s00520-022-06917-7.

# Including Partners in Discussions of Sexual Side Effects from Breast Cancer: A Qualitative Study of Survivors, Partners, and Providers

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## Abstract

**Purpose:** Ensuring there are clear standards for addressing cancer-related sexual side effects is important. Currently, there are differences in two leading sets of clinical guidelines regarding the inclusion of survivors' romantic partners into clinical discussions between survivors and their providers about this issue. To help refine guidelines, we examine breast cancer survivor, partner, and oncology provider perspectives about including partners in discussions about cancer-related sexual side effects in a secondary analysis of a broader qualitative study.

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**AUTHOR CONTRIBUTIONS:** **Kelly Shaffer**: Conceptualization, Methodology, Data curation, Formal analysis, Resources, Writing-Original draft, Writing-Review & editing, Funding acquisition; **Erin Kennedy**: Methodology, Investigation, Data curation, Formal analysis, Writing-Review & editing, Project administration; **Jillian Glazer**: Data curation, Formal analysis, Writing-Review & editing, Project administration; **Anita Clayton**: Methodology, Resources, Writing-Review & editing, Supervision, Funding acquisition; **Wendy Cohn**: Conceptualization, Methodology, Resources, Writing-Review & editing, Supervision, Funding acquisition; **Jennifer Barsky Reese**: Conceptualization, Writing-Review & editing; **Trish Millard**: Conceptualization, Writing-Review & editing; **Karen Ingersoll:** Conceptualization, Writing-Review & editing; **Lee Ritterband**: Resources, Writing-Review & editing, Supervision, Funding acquisition; **Shayna Showalter**: Conceptualization, Methodology, Resources, Writing-Review & editing, Supervision, Funding acquisition.

**CONFLICTS OF INTEREST:** Authors have no conflicts of interest to report.

**ETHICS APPROVAL:** This study was approved as exempt research by the Institutional Review Board at the University of Virginia.

**CONSENT TO PARTICIPATE:** Informed consent was obtained from all individual participants included in the study.

**CONSENT FOR PUBLICATION:** N/A

**CODE AVAILABILITY:** N/A

**Methods:** Partnered female breast cancer survivors (N=29) completed online surveys, and intimate partners of breast cancer survivors (N=12) and breast oncology providers (N=8) completed semi-structured interviews. Themes were derived from thematic content analysis.

**Results:** Among survivors who reported a discussion with their provider, fewer than half indicated their partner had been present, despite most survivors expressing it was – or would have been – helpful to include their partner. Partners also largely indicated being included was or would have been helpful, when welcomed by the survivor. Providers similarly emphasized the importance of survivors' autonomy in deciding whether to discuss sexual concerns in the presence of a partner.

**Conclusions:** Partners were infrequently included in conversations about cancer-related sexual side effects, even though survivors, partners, and providers alike expressed value in these discussions occurring with the couple together – when that is the survivor's preference. Findings suggest future clinical guidelines should emphasize that incorporating partners into clinical discussions about sexual concerns is important for many breast cancer patients. Soliciting and enacting patients' preferences is essential for truly patient-centered care.

## Keywords

Breast neoplasms; Cancer survivors; Healthcare providers; Qualitative research; Sexual dysfunction; Spouses

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Breast cancer and its treatment can impact every phase of a woman's sexual response cycle [1,2], with about three in four breast cancer survivors reporting clinically significant sexual dysfunction [3–5]. Clinical guidelines for cancer care clearly recommend that all patients receive information about the impact of cancer on sexual functioning [6,7]. Prior studies suggest this practice is infrequent, with fewer than one in three breast cancer survivors indicating that they ever had cancer-related sexual side effects addressed by their providers [8]. Clinical guidelines also address the inclusion of partners in clinical discussions about the impact of cancer on sexual function, yet how often partners of women with breast cancer are included in these conversations is not known. Additionally, it is not known the extent to which survivors, partners, and healthcare providers find the inclusion of partners in these conversations to be beneficial or important to treating breast cancer-related sexual concerns.

Breast cancer survivors who are in cohabitating, committed intimate partnerships report more sexual concerns compared to those who are not [9]. Among partnered survivors, however, those who are able to confide in their partner about their concerns are more likely to report being able to resume gratifying sexual relationships [10]. This influence of partners is acknowledged in the biopsychosocial model of cancer-related sexual dysfunction that outlines multiple interacting etiologies, including physical problems (e.g., pain, loss of sensation, low libido), psychological problems (e.g., shame about dysfunction, body dissatisfaction), and relational problems (e.g., restricted communication, relationship discord and dissatisfaction) [11]. Fittingly, female cancer survivors consistently report a strong preference for their partners to be included in discussions of sexual side effects from cancer [12,13]. Much less is known about the experiences of partners of breast cancer survivors who report sexual side effects. Two studies suggest that partners have reported difficulty navigating sexual concerns with the survivor, describing how strong emotional reactions to the survivors' physical changes and fear of hurting their partner commonly affect their sex life with the survivor [14,15].

Given the relational nature of cancer-related sexual concerns, cancer care guidelines address the inclusion of partners in clinical discussions between providers and survivors about sexual side effects. Comparing existing guidelines, however, reveals slight, but possibly meaningful, differences in the value and process of including partners in these conversations. Specifically, the Cancer Care Ontario (CCO) guidelines recommended that discussions with survivors about cancer-related sexual side effects should "ideally … include the patient's partner, if partnered" [6]. By contrast, in their adaptation of these guidelines, the American Society of Clinical Oncology (ASCO) lessened the emphasis on including partners from 'ideally' to "*could* include the patient's partner," and introduced the importance of taking this measure "*only if the patient so wishes*" (emphasis original, denoting revisions [7]).

Ensuring there are clear standards for comprehensive and patient-centered care for the prevalent and distressing issue of cancer-related sexual side effects is important. Better understanding breast cancer survivor, partner, and oncology provider perspectives about including partners in clinical discussions about cancer-related sexual side effects will help continue to refine clinical guidelines. Towards this aim, we present the first data from these three groups, as part of a secondary analysis from a broader qualitative study, regarding the importance of including partners in these conversations and the importance of patient choice regarding including their partners.

# METHODS

## Procedures

This qualitative study was approved by the University of Virginia (UVA) Institutional Review Board (IRB); see Supplementary Table 1 for COREQ checklist. The primary aim of the overall study was to assess perspectives about an intervention for couples to address cancer-related sexual concerns [16], with an emphasis on partner and provider input as survivor perspectives have been more thoroughly described previously (e.g., [12]). This secondary analysis focuses specifically on items assessing the inclusion of partners in clinical discussions regarding breast cancer survivors' cancer-related sexual side effects – these data have not been published previously.

Recruitment and data collection occurred between October 2019 through April 2020. Potentially eligible survivors were approached in-clinic at the UVA Breast Care Center by an LPN experienced in study recruitment; interested survivors provided their contact information and were emailed a survey link. Partners were both approached in-clinic and referred by participating survivors. Providers were informed about the study at a clinical team meeting and were contacted individually to request participation. All participants provided informed consent prior to completing online surveys (survivors) or semi-structured interviews (partners, providers).

## Participants

Women were eligible for inclusion if they were partnered, aged 45-65, diagnosed with stage I-III breast cancer, and were 6 months to 5 years from their final breast cancer treatment (active treatment with adjuvant endocrine therapy was permitted). The age requirements were set in order to limit the influence of cancer-related fertility concerns or typical age-related sexual changes on survivors' responses. Given this study was aimed towards collecting novel data on partner perspectives on cancer-related sexual concerns and to facilitate recruitment, partner eligibility criteria were left broad. Specifically, partners were eligible if they were aged ≥18 and in a romantic relationship with a female breast cancer survivor. While it was not a requirement, 11 of the 12 partners who enrolled in the study were in a relationship with a participating survivor. Providers in this study included all UVA Breast Care Center licensed independent providers (excluding SS, a study design team member).

## Data Collection

Study materials, including the complete survey instrument for survivors and interview guides for partners and providers are available at http://bit.ly/BrCaQual. Within these data collection instrument documents, items are highlighted that were specifically analyzed for the present study.

**Survivors.—**Survivors independently completed HIPAA-compliant online surveys that assessed whether or not they had discussed concerning sexual side effects with a healthcare provider, and if so, whether their romantic partner had been present during the discussion. Survivors indicating that their partner was present were asked to rate how helpful that was; survivors indicating their partner was *not* present were asked to rate how helpful they believe it *would have been* to have their partner present.

**Partners.—**Partners completed audio-recorded interviews with EMK by telephone. They responded to items assessing whether they had ever been present for a discussion between their partner (the survivor) and a healthcare provider about cancer-related sexual concerns. If they had been present for a conversation, partners were asked about how helpful those conversations had been; if they had not been present, partners were asked whether they would have liked the opportunity to be included in such a discussion.

**Providers.—**Providers completed in-person audio-recorded interviews with EMK. They responded to prompts regarding their beliefs about the importance and appropriateness of including their patients' romantic partners in discussions about sexual side effects from breast cancer treatment.

## Data Analysis

Survivor responses to the selected items were tabulated. For partners and providers, audio recordings of interviews were transcribed through a fully-automated online transcription service (https://trint.com); transcripts were reviewed for accuracy by a trained research assistant.

We used an interpretive description methodological approach to generate clinically-relevant information regarding current clinical guidelines on including partners in conversations about cancer-related sexual side effects [17,18]. We completed a thematic content analysis of the items from the partner and provider interviews pertinent to the research question (partner and provider interviews were coded separately) [19,20]. Transcripts were inductively and iteratively coded by two separate coders in Dedoose software (https://www.dedoose.com). The coding team (KMS, EMK, JVG) defined initial codes, which were then reviewed with other members of the study team (AHC, WC, SS). Discrepancies between coders were resolved by coding team consensus. We next considered how constructs from our data sources related to the differing features of the two sets of clinical guidelines on including partners: specifically, whether including partners is 'ideal,' and regarding patient choice for including partners.

## RESULTS

The majority of participating survivors (N=29) and partners (N=12) were middle aged (M=55.07, range=45-65 and M=54.67, range=36-70, respectively), were non-Hispanic white (n=24 [83%], n=9 [75%]), and had completed a college degree or higher education (n=16 [55%], n=9 [75%]). All survivors and all partners indicated that they were married; as previously mentioned, there were 11 survivor/partner married couples within the sample. Although recruitment was not limited to heterosexual relationships, all participating survivors' partners and participating partners were men. Survivors, on average, self-reported their sexual functioning to be within the range of clinically significant sexual dysfunction (Female Sexual Function Index M=24.26, SD=6.49 [cutoff ≤ 26]), although they also reported high relationship satisfaction with their partner on average (Relationship Assessment Scale M=4.42, SD=0.66 [mean scores range 1 to 5, higher scores = better satisfaction]). Partners, on average, self-reported good sexual functioning (PROMIS Sexual Functioning T-score M= 56.38, SD= 9.27). The provider sample (N=8) comprised 3 medical oncologists (38%), 2 surgical oncologists (25%), 1 radiation oncologist (12%), and 2 nurse practitioners (25%). Of providers, 3 were men (38%) and 5 were women 62%).

In Figure 1, we outline findings and how they relate to the unique aspects of the CCO and ASCO guidelines on including partners in conversations about cancer-related sexual side effects between patients and healthcare providers – namely, emphasizing inclusion as "ideal" (CCO) and emphasizing patient choice (ASCO).

### Survivors

Only 13 partnered breast cancer survivors of 29 surveyed (45%) reported that they had discussed sexual concerns or side effects with a health care provider. Of those 13, 6 (46%) indicated that their partner had been present (see Table 1). Four of these women (67%) agreed that it was helpful to have their partner involved; the remaining 2 (33%) neither agreed nor disagreed. Of the 7 women (54%) whose partners had not been present for the discussion, most agreed that their presence would have been helpful (n=5, 71%).

## Partners

Twelve partners were interviewed, of whom 4 (33%) recalled being involved in a discussion about cancer-related sexual side effects between the survivor and provider (see Table 2 for Partner Interview Data). These partners tended to report regularly accompanying the survivor to her oncology appointments and that the subject of sexual side effects was raised as part of routine care at those appointments. Generally, these partners expressed that the *discussion was helpful*, specifically by informing them about potential side effects the survivor might experience. For instance, one partner said that he had been included “multiple times” in conversations with his wife and two of her healthcare providers about sexual side effects of her cancer treatment, and that the team had been “pretty upfront telling us a lot of the side effects and preparing us for that, so nothing really has been a big surprise.” One partner indicated the *discussion had not met his and his partner’s needs*, although not as a result of him being included, but rather that information provided by the provider was not adequate.

Partners who had not been involved in such discussions fell into three groups – those who indicated they believed *cancer-related sexual concerns had not been addressed during the survivors’ care* (or had not needed to be addressed), those who expressed that they would join a conversation if it was requested by the survivor, and those who specifically expressed that being included in a conversation would have been helpful for them individually. Those expressing their own interest in being included in a conversation suggested that *inclusion would have been helpful* by increasing their understanding of potential sexual side effects of the survivors’ treatment. As one partner said, it “would have been nice to have someone give [us] more of their thought process about what is going to be affected at each stage of the treatment.”

Other partners who did not specifically express interest in being involved for their own benefit indicated they would be *willing to be involved if the survivor chose*. These partners clearly indicated that they wanted to follow the survivor’s preferences about such conversations, with one saying “I’d be comfortable [being included] if that’s what my wife wanted, but it didn’t seem to me that [was] what she wanted for herself.” Another said that he would be willing to be included in a conversation about cancer-related sexual concerns just as he had been with his wife through conversations about other side effects to be supportive, with his only hesitation being “if for some reason she didn’t want me to” be involved in those conversations.

## Providers

From provider interviews, three primary themes indicated that they believed in the importance of including partners in discussions about sexual side effects from cancer, while respecting patients’ choice, and noting several barriers to including partners routinely in these discussions (see Table 3 for Provider Interview Data). Six of the eight providers emphasized that *including partners is “very important.”* Reasons given for this importance reflect providers’ appreciation of the interdependent nature of sexual well-being between partners, and that addressing symptoms comprehensively may require involving the partner. One provider stated that it was important for providers to include partners to validate that "sexual health is important to your relationship… it not only affects the patient in front of us, but it does affect their partners;" another indicated how partners "are going to have insights and… they're going to be a necessary partner in all of this."

While providers clearly acknowledged the inclusion of partners as important, they also emphasized that it should be the *patient's choice whether to include their partner*. One provider indicated that "it's ultimately up to the patient. You [the provider] need to know how much involvement do they want the partner to have, depending on what the issue is." Another provider specifically described the language they would use to navigate this discussion with the patient: "as providers, we need to at least extend that offer: 'Do you want us to talk to your partner? Do you want your partner to be here when we're having this conversation?'"

Providers also identified *barriers to including partners in conversations* with patients about cancer-related sexual side effects. Explicitly discussing with patients whether they would want their partner included was deemed important as *some patients do not want their partner included*. One provider stated, "Certainly we have patients who don't want their significant other there. It's unusual, but it's definitely a possibility." Providers also addressed how *partners infrequently being at appointments* was a barrier to more routinely including them in conversations. Two providers also discussed how addressing a couple's needs can be beyond their scope of practice as their *attention is on the individual patient*. One provider discussed how shifting the conversation to the level of the couple could divert necessary focus from the patients' needs to the partner, which may be detrimental to the patient given the limited time providers have with their patients.

## DISCUSSION

To our knowledge, this is the first study to assess breast cancer survivors', partners' and healthcare providers' perspectives regarding the importance of including partners in clinical discussions of cancer-related sexual side effects. In practice, survivors and partners alike reported that such discussions were infrequent. While guidelines from Clinical Care Ontario (CCO [6]) recommend including partners in conversations as "ideal," American Society of Clinical Oncology (ASCO [7]) guidelines indicate partners "could" be included depending on the patients' wishes. Our analysis of data from breast cancer survivors, partners, and providers support aspects from both sets of guidelines – that inclusion of partners is important for many survivors, and it is also important to all parties involved to know that survivors are comfortable with the partner being included. Taken together, findings suggest the importance of (1) soliciting survivors' preferences for including their intimate partners in discussions about cancer-related sexual concerns, and (2) where survivors wish to include their partners, taking necessary efforts to include the partner in such a discussion.

At the core of patient-centered care is the customization of care to the unique needs and preferences of an individual patient [21]. Therefore, patient-centered care necessarily begins with actively soliciting these needs and preferences from the patient. Providers raised instances from their practice where their patients explicitly did not wish for their partners to be involved in their care – both overall, and more specifically to addressing sexual side effects. Some partners, too, indicated that they believed their wives had not wanted them actively involved in their medical appointments. Survivors themselves did not universally report that including partners was, or would have been, helpful. We did not have further data regarding why in these instances survivors did not wish their partners to be involved. Further study on this issue would help determine when encouraging conversation may be helpful (e.g., when a supportive partner may help a survivor overcome significant shame about a symptom) versus when including a partner would not be helpful, or even harmful. Taken together, these findings are consistent with recommendations in the ASCO guidelines to solicit survivors' preferences about including partners in discussions of sexual health.

Our data suggest, however, that survivors are not routinely asked about whether they would want their partner included. Specifically, most survivors who indicated they had a conversation alone with one of their healthcare providers about cancer-related sexual concerns also reported it would have been helpful for their partner to be present – had these women been asked about their preference, perhaps they would have had the opportunity to have included their partner in their care. Emphasizing the inclusion of partners as the ideal practice as per CCO guidelines, where agreed upon by a survivor, may help encourage this first important step towards ensuring patient-centered care for sexual concerns. Findings support the value of including partners as well, from each of the stakeholders' perspectives. Most of the survivors whose partners were present for a conversation about sexual side effects similarly indicated that it had been helpful. These findings concur with prior research suggesting most survivors would like their partners to be present for discussions about cancer-related side effects [12,13]. Some partners also explicitly indicated being included would have been helpful for them, and most providers considered including partners to be very important to comprehensively addressing cancer-related sexual side effects.

Findings from the broader qualitative study from which the present data were drawn suggest these inclusive conversations may be useful by validating the couples' experience, opening the opportunity for couples to converse about this concern more freely, and providing basic information to both individuals about how breast cancer and its treatment has diverse and long-reaching effects on women's sexual functioning [16]. As described by one of the partners, however, even such an inclusive conversation between the provider and couple offering specific suggestions will not address all couples' needs. Couples facing significant problems addressing cancer-related sexual concerns, for instance, may benefit from intensive intervention. Still, many couples' concerns can often be effectively addressed with targeted information and specific suggestions, which will require providers to understand patients' needs and preferences and provide customized care accordingly.

## Study Limitations

This study describes results of an exploratory secondary analysis of a subset of qualitative data. As such, there are limitations worth noting. Study sampling was not based on the research question addressed in this paper, meaning there is a risk of bias and findings may be incomplete. For example, we do not have further data to better characterize what survivors perceived as most beneficial – or *would have been* beneficial – about including their partners in clinical discussions, nor regarding to survivors' and partners' experienced barriers that prevented partners from joining. Data are also limited given that our samples, as well as the study team, primarily comprise non-Hispanic white, highly educated, and heterosexual individuals; therefore, findings are not necessarily representative of preferences differing by race, culture, healthcare access and literacy, and sexual orientation. Given that individuals who identify with marginalized groups often experience greater barriers to accessing comprehensive survivorship care [22,23], it is likely couples from these backgrounds have even greater difficulty accessing information and interventions to address their shared cancer-related sexual concerns. Future study of these three stakeholder groups that focuses on this research question and includes more diverse samples is warranted for confirmation of these preliminary findings.

## Clinical Implications

Findings suggests that – despite survivors frequently valuing the opportunity to include their partners in clinical discussions about cancer-related sexual concerns – ongoing discussions with survivors regarding whether, when, and how to include their partners are not occurring regularly in standard practice. Models for discussing sexual side effects with patients – including the PLISSIT model [24,25] and 5A's model [26,27] – emphasize signaling that raising the topic is appropriate. Findings support that this step should be extended by providers clearly asking the patient whether they would wish their partner to be included in conversations about sexual concerns. This ask could be framed to partnered survivors as: "It can be helpful to have your partner involved when we discuss sexual side effects from cancer so you both know what to expect and what might help. Would you like for your partner to be included in any conversations we may have about sexual side effects?" Similarly, even before a more comprehensive discussion regarding sexual side effects may be needed, providers may signal the potential value of sharing information with partners. For instance, when providing information about potential sexual side effects of a new treatment, providers may recommend that the patient consider sharing the information with their partner, so the partner may better prepared to support the patient should she experience those issues.

Additionally, initial discussions between providers and patients may be warranted regarding what boundaries survivors wish to set (e.g., which symptoms they would feel comfortable discussing in front of their partners), what concerns they may have, and what might be most useful about such a conversation. These discussions with the survivor should also be ongoing, as survivors' preferences may change across the treatment trajectory and with changing partners. Having these discussions in advance may help couples plan for the partner to attend an upcoming appointment, addressing one of the primary barriers to practically carrying out discussions with couples together. Alternatively, it is worth considering other effective and accessible means to incorporate partners into care beyond the traditional in-person appointment – for instance, with telehealth appointments, couple-oriented educational materials, or digital health interventions (e.g., [12,16]).

## Conclusion

This study provides novel insights into breast cancer survivors', partners', and providers' perspectives regarding including partners in clinical discussions of sexual concerns and side effects from breast cancer – and how these preferences align with current clinical guidelines.

Each of these three stakeholder groups emphasized potential benefits for partners to be included. Partners and providers both emphasized the importance of respecting survivors' preferences. In order to respect these preferences, survivors must have an opportunity to express them, which has not been offered routinely in standard practice. Future clinical guidelines should acknowledge that including partners in discussions of cancer-related side effects is important for many, but not all, partnered survivors. Emphasizing this importance may help advance patient-centered care for sexual side effects of cancer by encouraging the more frequent solicitation of patients' preferences for including their partners, and then the customization of their care to align with those preferences.

## Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

## ACKNOWLEDGMENTS:

Authors are sincerely grateful for the participation of the survivors, partners, and providers in this study; for the support of the UVA Breast Care Center; and for the recruitment assistance of Dora Irvin, LPN.

### FUNDING:

This study was funded by a University of Virginia (UVA) Cancer Center Cancer Control and Population Health Sciences (CCPH) program Population Research Pilot Projects award. Dr. Shaffer was supported in part by the National Institutes of Health (NIH) National Center for Advancing Translational Sciences (NCATS) Award Numbers UL1TR003015 and KL2TR003016. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

## AVAILABILITY OF DATA:

Data available upon reasonable request from the authors.

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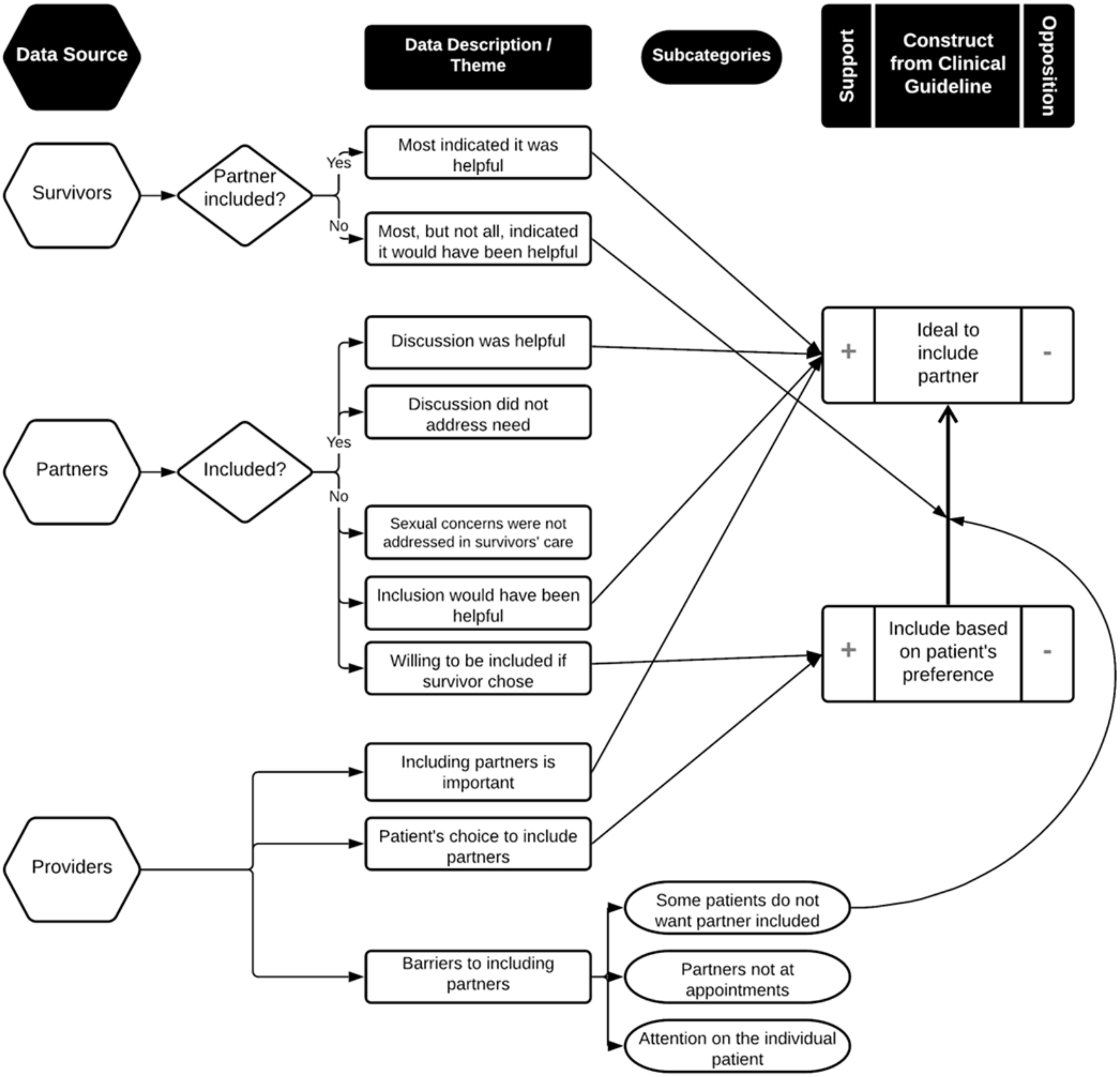

**Figure 1.**

Concept Map of Relationships Between Data and Clinical Guidelines

## Table 1.

Survivor survey (N=29) – tabulated responses

| | **n** | **%** |
|---|---|---|
| **Since your diagnosis, have you discussed sexual concerns or sexual side effects with any of your health care providers (any doctor, nurse, or therapist)?** | | |
| Yes | 13 [a] | 45 |
| No | 16 | 55 |
| [a] **Was your romantic partner present for a discussion of sexual concerns or side effects with any of your health care providers?** | | |
| Yes | 6 [a1] | 46 |
| No | 7 [a2] | 54 |
| [a1] **Generally speaking, it was helpful having my partner present for discussions of sexual concerns or side effects with my health care providers.** | | |
| Strongly agree | 2 | 33 |
| Somewhat agree | 2 | 33 |
| Neither agree nor disagree | 2 | 33 |
| [a2] **Generally speaking, it would have been helpful to have my partner present for discussions of sexual concerns or side effects with my health care providers.** | | |
| Somewhat agree | 5 | 71 |
| Neither agree nor disagree | 1 | 14 |
| Somewhat disagree | 1 | 14 |

Note: Matching superscripts indicate where respondents were asked follow-up questions

## Table 2.

Partner Interview Data (N=12)

| **Did the partner report being included in a discussion about cancer-related sexual concerns?** | **Theme /** ***Quote*** |
|---|---|
| Yes (N=4 *) | **The discussion was helpful (n=2)**<br>*“[I was included] multiple times - her oncologist and her regular doctor, they both brought it up. They were pretty upfront telling us a lot of the side effects and preparing us for that. So, you know, nothing really has been a big surprise.”*<br>*“[Both her surgical and medical oncologist] mentioned it as far as potential side effects. Mostly it’s not anything we didn’t already know, but it was good to get it out in the open.”* |
| | **The discussion did not address need (n=1)**<br>*“We went in because we were struggling over the sexual relationship, so we were trying to seek help. We were told it’ll get better, lubrication would help, using a vibrator would help. Then when she was alone… they said the same thing.”* |
| No (N=8†) | **Sexual concerns were not addressed in survivor’s care (n=2)**<br>*“We haven’t talked about it because it hasn’t been an issue.”*<br>*“I went with her to most of her treatments… but no, they didn’t [discuss sexual side effects].”* |
| | **Inclusion would have been helpful (n=2)**<br>*“I think I should be doing that… I don’t really know what to expect, but… I want to know what she really feels about our sex life.”*<br>*“It would have been nice to have someone give us more of their thought process about what is going to be affected at each stage of the treatment.”* |
| | **Partner willing to be included if survivor chose (n=4)**<br>*“[I would be willing] if it needed to be done for her benefit… I would do whatever is necessary to make my spouse feel whole.”*<br>*“I’d be comfortable if that’s what my wife wanted, but it didn’t seem to me that was what she wanted for herself. If she wanted it for me, then I would be OK doing it.”* |

[*] One partner did not indicate whether the conversation was helpful.

Note: N / n = number of partners with theme represented in their interview. Each example quote within a cell is from a separate partner.

## Table 3.

Provider Interview Data (N=8)

| **Theme** | **Subcategory /** ***Quote*** |
|---|---|
| Including partners is important (N=6) | *“It’s very important. [Partners] are going to have insights and … they’re going to be a necessary partner in all of this… it’s seriously important”*<br>*“It’s knowledge and understanding, and giving ideas of things that can be done. It just doesn’t have to be an accepted side effect. I think we as providers have to validate that sexual health is important to your relationship and it’s important to individuals. It not only affects the patient in front of us, but it does affect their partners.”* |
| Patient’s choice to include partners (N=6) | *“It’s ultimately up to the patient. You need to know how much involvement do they want the partner to have, depending on what the issue is. If the patient thinks it’s appropriate, they’ve brought their partner to their appointment - I think it’s implied if [the patient has] brought their partner with them and [the patient] bring this up.”*<br>*“It depends on the patient… Certainly I think, as providers, we need to at least extend that offer. ‘Do you want us to talk to your partner? Do you want your partner to be here when we’re having this conversation?’“* |
| Barrier to including partners in conversations (N=6) | **Some patients do not want partner included (n=4)**<br>*“Certainly we have patients who don’t want their significant other there. It’s unusual, but it’s definitely a possibility.”*<br>*“Sometimes [patients] want to involve their partners, other times I’ve been asked to talk to the patient after the partner’s left, because they’re not comfortable with that whole context of the conversation.”* |
| | **Partners not at appointments (n=3)**<br>*“Do I include [partners]? Hardly at all - it’s very frequent that the partners are not brought to the visits or are not available.”*<br>*“A lot of times partners don’t come to appointments, and I have never offered to call a partner to intervene or get their take on it.”* |
| | **Attention on the individual patient (n=2)**<br>*“Having partners more engaged … in some ways might also be a barrier because it takes from me talking about a patient to them… it’s like ‘well, it’s not about you for a moment, it’s about this person.’ … that feels like way more than I can fit in any given visit. … I think it’s helpful, it just changes the dynamic.”*<br>*“[Sexual side effects] not only affect the patient in front of us, but it does affect their partners. Not sure we’re always good about that, I tend to focus on my patient.”* |

Note: N / n = number of providers with a theme / subcategory represented in their interview. Each example quote within a cell is from a separate provider.