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Let's talk about sex after cancer: exploring barriers and facilitators to sexual communication in male cancer survivors

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Abstract

***Objective*: Changes to sexuality are a primary concern amongst cancer survivors, leading to psychological distress and impacting long-term quality of life. Effective sexual communication has been found to be critical in improving sexual satisfaction post-treatment. However, research suggests that many men struggle to disclose sexual concerns and preferences. This study aimed to qualitatively explore the common barriers and facilitators to sexual communication in male cancer survivors (MCSs).**

***Methods*: Seventeen MCSs participated in semi-structured telephone interviews, which were transcribed and coded using Grounded Theory methodology.**

***Results*: The emergent theory described that those MCSs with lower quality sexual communication experienced diminished perceived masculinity following cancer-related sexual dysfunction. These feelings of inadequacy were compounded by inadequate partner support. Contrastingly, participants reporting effective sexual communication expressed the importance of a stable self-esteem and flexible partner support.**

***Conclusions*: This study challenges the notion that men naturally struggle with intimate dyadic communication and suggests that adequate partner support and a stable sense of self can mitigate MCSs' communicative behaviour, subsequently bolstering self-esteem. Future research should more broadly explore the diverse experiences of MCSs to enhance the efficacy of psychosexual interventions.**
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Background

Common sexual problems facing male cancer survivors (MCSs) include erectile dysfunction (ED), diminished libido, penile shortening, infertility, and muted, painful, or dry orgasm [1]. Many survivors are unprepared for such sexual changes [2]. Sexual satisfaction is a crucial element in relationship adjustment and quality of life post-cancer and can depend on effective sexual communication [3,4]. Sexual dysfunction, particularly in the context of pervasive male gender norms, may prompt feelings of embarrassment, frustration, or avoidance of emotional topics that men perceive as implying weakness, in turn, undermining useful sexual communication [5,6].

Cancer survivors are often forced to adapt their sexual identity, which relies on self-awareness and open communication of their physical and psychological condition [7]. However, avoidance of sexual communication might strengthen fears, insecurities, and emotional isolation [8]. Male communication styles have been linked with the prevailing, idealised masculine 'gender scripts' of being strong, autonomous, and stoic [9]. Although not rigid, such representations of the male gender role can inhibit disclosure and open communication [6,10]. Open and honest sexual communication between survivors and their partners is paramount to relationship stability and deserves more theoretical and empirical attention.

Cancer survivors and their partners have unique perspectives and beliefs regarding their sexuality and sexual desires. Healthy sexual communication provides opportunities to combine these independent sexual narratives to achieve a unified sense of meaning [11]. Notably, sexual communication involves the revealing of facts, thoughts and feelings, and nonverbal behaviour regarding sexuality. Moreover, 'sex' involves more than intercourse, genital stimulation, and orgasm, but also xincorporates attitudes, experiences, perceptions, and values surrounding sexuality [12]. Accordingly, effective sexual communication can allow for voicing of concerns, sharing burdens and, if needed, reaching agreement to renegotiate sexual routines in response to cancer-related dysfunction [13].

There remains a dearth of in-depth knowledge about sexual communication amongst survivors and their partners. A majority of studies have examined general 'couples communication' [13] or 'relationship-talk' [14] with

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a focus on the disclosure of cancer-related concerns (e.g. mortality, physical side effects) [15,16]. Sexual communication is typically regarded as just one facet of couples' communication, and therefore its complexity and utility to cancer survivors are often overlooked [17]. Importantly, many couples describe having an underdeveloped sexual communication skillset [8]. The empirical literature is yet to fully describe the barriers and facilitators of sexual communication and how they present and persist in MCSs.

Utilising a qualitative methodology, this study aims to develop a conceptual model of influences on sexual communication in MCSs. The goal is to better understand the processes underlying MCSs' sexual communication and how to best facilitate effective sexual communication.

Methods

Participants

Eligibility included: (a) identify as male; (b) >18 years of age; (c) cancer diagnosis ≥ 6 months; (d) in an intimate relationship for ≥ 6 months; and (e) English-speaking.

Participants were recruited via email invitation to support groups for MCSs ($n = 12$) and via physician referral ($n = 10$). Five individuals were deemed ineligible.

Participants were aged between 24 and 77 years ($M = 57.47$, $SD = 16.99$), and the mean age at diagnosis was 53 years ($SD = 18.10$). Thirteen MCSs (77%) were married with the remainder in committed relationships. Prostate cancer was most frequently reported ($n = 7$; see Table 1). A purposive sampling approach was enacted to ensure representation across cancer types, ages, and experiences.

Procedure

Following informed consent, telephone interviews were conducted by the primary author and ranged in length from 40 to 95 min ($M = 54$, $SD = 13.96$). Interviews were digitally recorded and transcribed verbatim. Transcripts were de-identified and imported into *NVivo10* [18].

The interview guide included open-ended questions aiming to pursue inquiry identified in the literature focusing on: (a) relationship background, (b) quality of sex post-cancer, (c) cancer's impact on identity and masculinity, and (d) sexual communication style. Interviewer prompts were used to elicit detailed accounts of the subjects' experiences [19].

Throughout data collection, specific content and wording of questions were iteratively reviewed and revised as directed by Grounded Theory principles, asserting that theory development stems from a nuanced, reflexive evolution of questioning [20].

The Sydney Local Health District Human Research Ethics Committee approved all procedures.

Data analysis

Beginning with a segment-by-segment analysis or 'open coding' [21], basic concepts related to the research question were identified and assigned a code. During this stage 'cross-coding' [22] was undertaken where colleagues C.L. and K.T. independently assessed six interviews. Results were compared, and all modifications were based on consensus [23].

Table 1. Participant demographic information

ID	Name[a]	Age (years)	Cancer diagnosis	Years since diagnosis	Treatment[b]	Relationship length (years)
1	Adam	24	Non-Hodgkin's lymphoma	2	C	1
2	George	71	Lung	4	C,R	15
3	Samuel	57	Prostate	3	S	29
4	John	68	Bladder	3	S	45
5	Michael	52	Kidney, melanoma	0.5	S	2
6	Edward	65	Prostate	2	S	35
7	Joel	40	Testicular	0.5	S	11
8	Rodney	76	Prostate	8	S,R	51
9	Eric	73	Kidney	1	S	51
10	Jeremy	61	Prostate	4	S	12
11	Max	58	Bladder	9	S	35
12	Eugene	52	Prostate	2	H,R	26
13	Will	27	Osteogenic sarcoma	16	C,R,S	2
14	Frank	63	Prostate	3	S	42
15	Ben	36	Testicular	4	S, C	7
16	Andre	77	Lung, brain	0.5	S, R	54
17	Robert	77	Prostate	9	S	42

Note.
[a]Pseudonyms are used.
[b]Treatment symbolised by: S = Surgery, C = Chemotherapy, R = Radiotherapy, H = Hormone therapy.

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Next, 'axial coding' [23] was conducted, wherein preliminary codes were organised into higher-order, more meaningful categories and subcategories based on theoretical interrelations. This provided several complete categories by the seventh interview after which 'selective coding' began [23]. Here, new data was reviewed with the aim of substantiating existing concepts while considering diversity within them.

Theoretical saturation was reached after 14 interviews at which point distinct, higher-order themes had emerged. To ensure the reliability and phenomenological accuracy of the researchers' interpretations, member checking [24] was employed with the final three participants. Each was asked to comment on a description of the emergent theory.

Methodological rigour [24] was achieved through creating memos, transcription review, verbal debriefing, member-checking, cross-coding, and iterative revision of the interview guide.

Results

Participants in this study described a shift in their worldview after cancer that included a change in life priorities. This shift was described as relating to individual traits (e.g. resilience, optimism), sexual dysfunction, and partner support. Where positive changes involved feelings of personal and relational stability and enhanced self-esteem (SE); negative changes related to low SE, specifically perceptions of diminished masculinity. Furthermore, an enhanced or preserved masculine identity may have facilitated sexual communication. Generally, participants described high-quality sexual communication and satisfaction of psychosexual needs, which reportedly strengthened their sense of stability and SE. However, inadequate partner support and post-treatment sexual dysfunction corresponded to low SE and questioning of masculinity. Such processes appear to underlie sexual communication.

Figure 1 depicts the emergent model in which cancer and the associated changes in self-perception potentially favourably and unfavourably influence sexual communication through changes in, or protection of, SE and sense of masculinity. This framework suggests that these relationships are impacted by post-treatment sexual function, the quality of partner support, and individual factors.

Shift in worldview: adjusted priorities and perspectives

Participants reflected on how cancer had a profound effect on their life view. Regardless of diagnosis, many reported that the threat of mortality was a catalyst for altering their perspective. Samuel commented on how the '*perspective of what you're living for*' changes, engendering a positive change in his behaviour.

When describing this shift, many used inclusive language. Samuel referenced his partner in stating, '*I've become a lot more focused on where we're going, what we're doing*,' suggesting that this adaptation was a shared process. Indeed participants' relationships played a central role in their post-cancer worldview, with the majority of men reporting that their priorities had shifted towards their partners who they had previously '*taken for granted*.' Eugene described cancer as a '*serious paradigm shift in what's important*,' explaining how it provided a sense of clarity for his view of the future, with his marriage at the forefront.

These adjusted priorities and perspectives appeared to play a role in changes in self-perception. However, such changes were influenced by partner support, individual traits, and extent of sexual dysfunction.

Sexual functioning

All men related their sexual functioning to their sense of masculinity and overall SE. Persistent sexual dysfunction was only reported by the 11 participants with testicular, prostate, or bladder cancers. A shift in self-perception accompanying dysfunction was common, with Joel expressing how his '*masculinity had to be adjusted a bit because you sort of feel like…something has been taken away from you.*' Comparatively, the six MCSs not reporting significant sexual dysfunction were those with non-urogenital cancers, and they reported little effect on their SE. George and five others whose sexual dysfunction did not persist described how '*it's sort of like starting again…but not starting from scratch*.'

The way in which the 11 MCSs coped with their sexual dysfunction was reportedly dependent on their partners' supportive responses, either entrenching feelings of inadequacy, or affirming their masculinity. John felt like he had '*let the team down*' when his wife suggested ceasing sexual contact, while Eugene's wife motivated him '*to go further, try harder, together,*' to compensate for his ED. Importantly, the six men who reported no sexual dysfunction described sufficient partner support.

Moderators of self-perception

Twelve MCSs explained how their relationship quality had improved post-cancer and suggested a similar shift in their partner's perspective may have fostered this closeness. Rodney stated, '*when you get these difficult moments you tend to get close to one another*.'

However, not all men identified greater partner support, with some viewing the effort in the relationship as '*one-sided*'. Eugene expressed how his work and material possessions were now secondary priorities to his wife and family:

> '*My close relationships were the only things that mattered to me anymore…and I suspect she found that a bit challenging…I don't feel supported.*'

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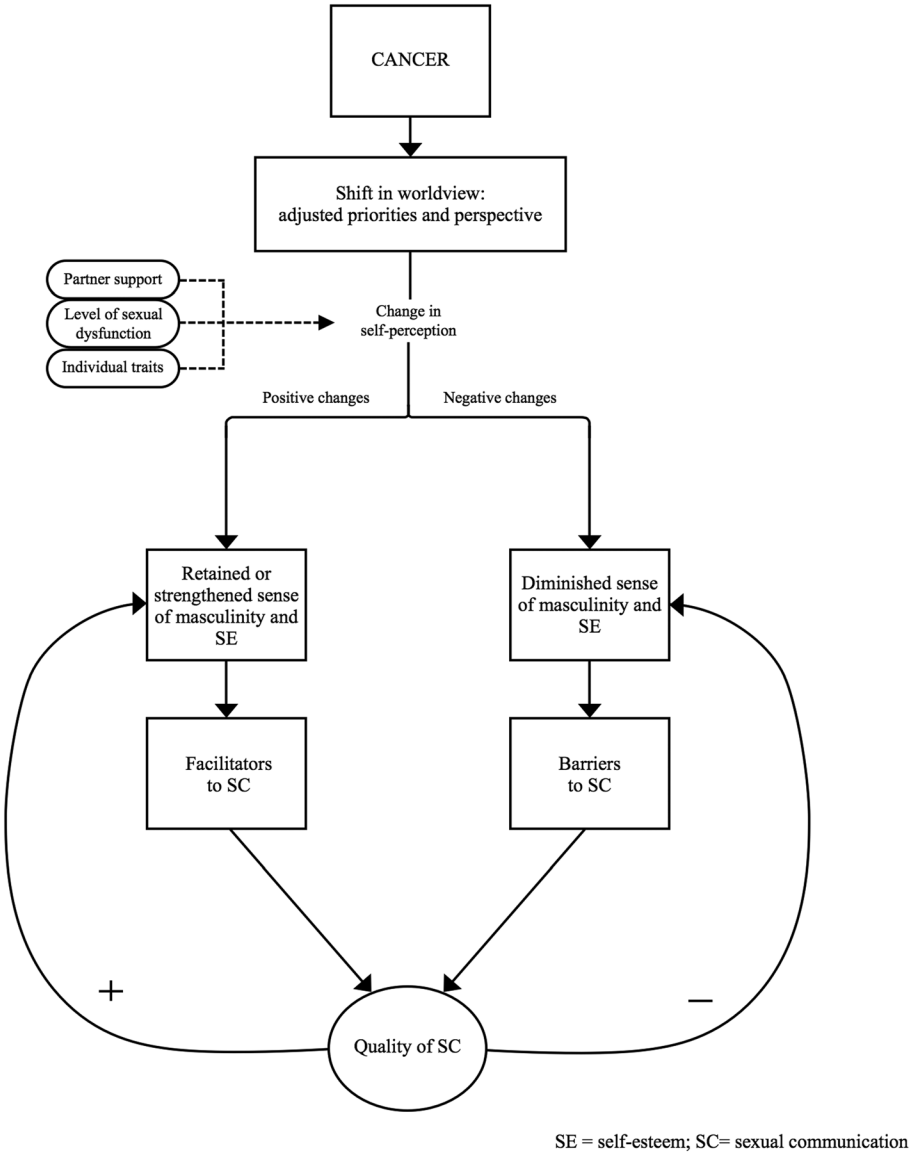

Figure 1. Emergent model of sexual communication

Many noted that '*team work*' in the relationship was fundamental to regaining a sense of normalcy, and Joel explained that supportive partners '*bring certain qualities out of you…I felt strong and comfortable in myself thanks to her.*'

Joel, who underwent orchiectomy, described changes in self-perception by noting how important a flexible identity was in overcoming hardship, '*the next stage, is, well, that's who you are now*.'

Changes to self-perception

Retained or strengthened sense of masculinity and SE

For the 10 MCSs who perceived adequate partner support and saw themselves as resilient and optimistic, cancer seemed to strengthen their positive outlook and sense of masculinity. The perception of successfully adjusting to cancer was described by some men with a sense of accomplishment and personal development. A few participants noted that cancer '*made me face up to a few things.*' They described that they came to better understand and respect themselves, '*not as a broken man but as a changed man*' (Samuel).

Diminished sense of masculinity and SE

The combined negative impact of insufficient partner support, high levels of sexual dysfunction, and perceived '*wounded*' masculinity was evident in the remaining seven urogenital MCSs. John reported that his ED made him self-critical and insecure.

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I forget about the little cuddle. I get angry at myself for it sometimes…I feel guilty again. I think, 'Shit, John, why didn't you grab your wife's hand?'

Jeremy explained how his masculinity had '*taken a hit…I've always been a man's man*,' and, following his diagnosis, he described how this perceived emasculation was a barrier to '*much needed*' sexual communication.

Barriers to sexual communication

The barriers to effective sexual communication were reported as both individual and dyadic barriers. All participants acknowledged the value of effective sexual communication. Yet, five MCSs spoke of individual discomfort or awkwardness in self-disclosing, having low SE or anger in verbalising sexual concerns or falling into a gendered communication norm, whereby they preferred to practically problem-solve rather than emotively communicate.

Dyadic barriers were more often reported, with seven of the MCSs describing attempts at sexual communication that were not reciprocated, triggered conflict, or went unacknowledged, leading to relationship frustration. Others withheld sexual communication altogether despite feeling confident in doing so, for fear of upsetting their partner. Such dyadic barriers were perceived as fixed and '*out of my control, there's nothing I can do*' (Max). This became a cyclical process that resulted in sustained feelings of low SE and inhibited sexual communication (see Table 2).

Table 2. Individual and dyadic barriers to sexual communication

Theme	Frequency (*N* = 17)
Individual barriers	
Discomfort or awkwardness	5
Oh, I'm not over the moon [self-disclosing]…it turned into a situation where you're being offered [sex] and you've got to say, no, look, I've got a headache darling…if things are really awkward or anything I tend to quieten down a bit, and don't say a great deal. (Rodney)	
Low self-esteem verbalising concerns	4
I'm pretty hopeless. I'll sit on stuff. I must say, when I wrote her a letter it was stuff I'd been-I stew on stuff, which is something that hasn't changed…Yeah, very, very tentative about bringing it up. (Eugene)	
Gender communication norms	3
My wife pointed out many years ago that women want to talk about something whereas men want to fix it…They want to unload all the crap that went on when the car broke down. So that happens in the sexual area as well. I'm not interested. I think it's a male/female thing. (Frank)	
Anger	2
I can't even function as a man any more. And yes, I get really pissed off and angry with her about it and, of course, I know that's the wrong thing to do…(Jeremy)	
Dyadic Barriers	
Lack of reciprocation	6
I'm going, 'Well, if you don't discuss it, you don't talk about it, we can't sort it out'. 'But it should be natural it should flow' she says… And I keep opening that dialogue up; I keep getting closed down again. (Jeremy)	
Conflicting priorities	4
She would say things like, 'Well, you know, we'll get over it. It's [sex] not the biggest thing in the world'…I was still on treatment where I did try to explain, in fact, it is a big deal. After a year, it is a big deal. (Eugene)	
Fear of upsetting partner	4
Well, I knew what the response would be so there's no point… If I kept on bringing it [sex] up every couple of weeks or every couple of months or things like that…I'd be out the door, I'd say. The thing is you just have to be respectful of your partner's situation. (Max)	
Lack of change—frustration	5
But I think I'm the only one that initiates the conversation to say 'I'm not happy with where we're at.'…I just keep repeating it like a broken record. So I find that pretty frustrating. (Eugene)	

Facilitators of sexual communication

The 10 MCSs who reported effective sexual communication recognised SE and partner support as the facilitators influencing their positive, intimate conversations (see Table 3). Feelings of long-held confidence and the ability to be direct and assertive in discussing sex were described as important facilitators. However, as with barriers, the dyadic support process was central in impacting behaviour. MCSs that felt sexual communication was a mutually significant priority reported a strengthened desire to be open and honest and that such exchanges had become a comfortable ritual, with Samuel describing how, '*we now acknowledge that we've got to talk about these things to make ourselves happy*.' The high quality of sexual communication that these men reported reaffirmed their positive self-perception and fostered confidence in future candid communication. Several participants explained that sexual communication had helped them to discover new sexual desires and, in turn, had strengthened their perceived manhood regardless of sexual dysfunction.

Discussion

The model illustrates two potential psychosocial pathways by which MCSs come to have high or low quality sexual communication. Partner support and stable SE were two prominent facilitators described for effective sexual communication. Conversely, a diminished perception of masculinity following sexual dysfunction and inadequate partner support were reported as barriers. The quality of sexual communication was reported to feedback into the MCSs' perceived masculinity and SE.

The current findings challenge typical male 'gender scripts' [25] proposed in the existing literature, which

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Table 3. Facilitators to sexual communication in participant experiences

Theme	Frequency (*N* = 17)
High self-esteem openly communicating	10
I can't think of any specific moment in time where I've been a bit bashful talking about sex with my partner…on a scale of 1–10, I'd say I'm a good 7.5–8. (Adam)	
Sex talk prioritised in the relationship	8
Well, in some ways it's better, in terms of being open about these things and discussing these issues… We talk about the problem because you can't ignore it obviously. But that's good. (Edward)	
Partner supports communication	
So we basically sat down and said, right, what do we do about this? What was there to do? What was available? And I think she opened up quickly to what options were available on the internet…we're comfortable with each other and we're comfortable to talk about it. (Samuel)	10
Directness and assertiveness	5
I might have said 'hello madam, you're looking very nice this morning.' She would say, well, 'what do you mean you dirty old perv. I'm old.' And I'd say… 'have we got any of those blue pills left?' (George)	
Ritual or script	3
I'd guess I'd say rehearsed…it's a ritual in a sense after the five decades of doing it…we're certainly not at the stage where we're trying to remember. (Andre)	

frame MCSs as limited by a 'code of silence' that inhibits emotional disclosure [5]. Consistent with the assertion that gender-based stereotypes often do not guide or explain behaviour [26,27], the majority of MCSs expressed the importance of effective sexual communication and willingness to initiate intimate conversations with partners. Challenge to such traditional scripts involves acknowledging variation in MCSs' ability to communicate about sexuality after cancer. This variation is likely influenced by changes in sexual functioning, SE, and sense of masculinity. Notably, their partners' interest and support may highly influence positive self-perceptions and, in turn, facilitate sexual communication.

A reductive perspective of masculinity as an accumulation of broad stereotypes may be more damaging in supporting MCSs than beneficial [6]. Instead, the assertion that 'gender is more likely a negotiation between the individual and socially and culturally situated life events like cancer,' [26, p.89] seems to be a less stigmatising, and more personalised perspective, when considering sexual communication and masculinity.

The shifts in perspective reported by participants reflect how relationship satisfaction had become of higher priority. Indeed, cancer itself may act as a catalyst for sexual communication as MCSs often framed sexual disruption as a problem introduced into the relationship that required a solution [14]. While sexual dysfunction may make sexuality a more prominent concern [2], the threat to masculinity may not necessarily diminish, but rather promote, their desire to talk about problems with their partner.

The most prevalent and detrimental barriers to sexual communication were not those linked with MCSs' masculinity, but rather the dyadic barriers whereby their partners did not reciprocate or had conflicting priorities and were reluctant to discuss sexual concerns. The demand-withdraw pattern of interaction [28] was described. Yet, the MCSs reported that they were generally demanding more of their partner, rather than the more common female initiation [29]. These findings may have gone undetected in previous studies that have typically focused on the quantity, and not the quality, of sexual communication [e.g. 14].

While these findings require critical corroboration from partners, they offer unique insight, challenging the hegemonic belief that men struggle to communicate and instead promote the importance of a partner who is flexible, empathetic, and willing to communicate. Reciprocal partner sexual communication was found to lessen MCSs' insecurities surrounding their perceived 'precarious' or 'wounded' masculinity. Indeed, mutuality and reciprocity have been repeatedly described as essential to communication quality and relationship functioning in couples where one partner is ill [16].

The current model is consistent with a previous finding that SE directly affects sexual communication quality [30]. However, our model suggests that the quality of sexual communication either positively or negatively feeds back into SE, serving as an enriching experience for some and a challenge for others. This presents an opportunity for future research, suggesting that sexual communication may affect relational functioning and satisfaction, and also self-perception, by either reinforcing SE or fuelling feelings of masculine inadequacy.

In the current model, sexual communication amongst MCSs demands multidimensional consideration. The level of sexual dysfunction, partner support, SE, and individual traits were distinct, but interacting facets impacted the quality of sexual communication. This highlights the crucial need for an integrative approach to addressing sexual communication in cancer couples. Observations point to critical differences in the sexual communication between those with and without sexual dysfunction and warrant more focused investigation.

It is possible that the nature of this study attracted a sample with greater than usual ease and confidence in communication. Further, the absence of partner testimonies should also be considered when interpreting results, as sexual communication is fundamentally interactive. Future studies should more carefully consider couples' pre-cancer sexual relationship and communication.

Maintaining objectivity is an inherent challenge of Grounded Theory [21]. However, methods were

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employed to minimise researcher subjectivity. Finally, causal relationships cannot be determined and results represent only one possible set of relations amongst variables. However, this research presents a comprehensive and empirically driven theory of MCSs' sexual communication. The inclusion of participants across cancer types adds to an area of research that over-represents prostate and testicular cancer survivors.

Future work should gain a more comprehensive understanding of sexual communication amongst MCSs and identify concerns of at-risk groups (e.g. young adults, gay men). Finally, sexual communication of unpartnered MCSs should be investigated, as they potentially disclose sexual concerns to multiple or new partners and likely possess unique needs.

This model supports the potential for a targeted sexual communication intervention for MCSs. Cancer's impact on SE and masculinity is patient specific. Normalising fears regarding sexual dysfunction might serve to heighten SE and in turn improve sexual communication. Importantly, sexual communication interventions should aim to include both MCSs and partners.

The current research contributes to the limited, but rapidly expanding literature on psychosexual concerns of MCSs. The presented model supports existing research promoting the extensive benefits of effective sexual communication. It revealed that quality of sexual communication might alter the impact of sexual dysfunction, potentially affecting MCSs' relationship satisfaction and SE. Findings challenge male communication stereotypes and suggest that partners' reciprocal and normalising sexual communication can combat MCSs' non-compliance and facilitate MCSs' desire to engage in cooperative problem solving.

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