Exploring Cervical Cancer Treatments, Coping & Women‘s Sexual Self-Concept after Cervical Cancer

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OBJECTIVES

- Relate associations identified among cervical cancer treatment, demographic variables, and coping of women who were treated for cervical cancer
- Discuss unexpected findings
- Identify clinical significance of findings

No actual or potential conflict of interest

BACKGROUND

Cervical Cancer

- 4000 deaths annually
- Non-invasive and Invasive cervical cancer
- Significant demographics –age, race, SES
- Provider reluctance and patient reticence

Problems Common with All Forms of Treatments

- Surgery, Chemotherapy, Radiation & Combinations
- Physical and Psychological Sequelaee

MAJOR PROBLEMS

Cervical cancer treatment is stressful and negatively impact how women cope with sexual health and sexual self-concept after cervical cancer treatment(s).

There is no systematic approach to help women after cancer treatment(s)

Women silently endure the related problems.

PURPOSE

- Understand the impact of coping on sexual self-concept
- Identify predictor(s) that may promote early intervention to prevent or diminish physical and psychological sequelae after cervical cancer treatment

DEFINITIONS

Sexual self-concept – combination of sexual beliefs, feelings & perceptions

Coping adaptation – behavior &/or thoughts to manage & problem solve

Cognitive coping – use of thoughts to manage & problem solve

Religious coping – use of religion to protect, transform & problem solve

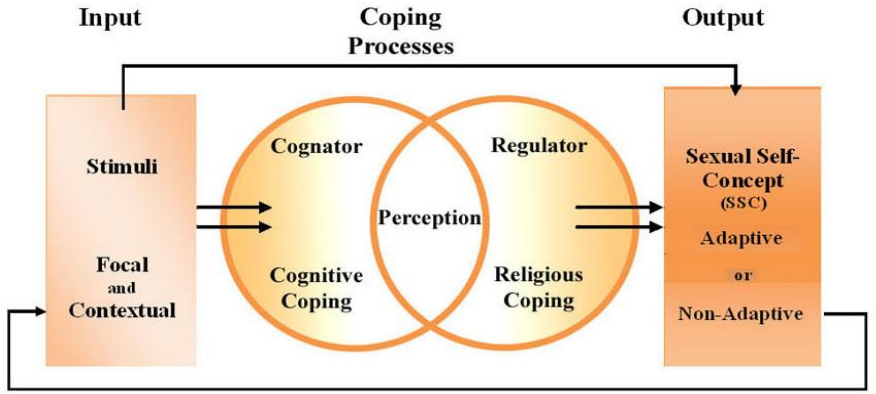
Time since treatment began – time passed after treatment began

THEORETICAL FRAMEWORK: SEXUAL HEALTH ADAPTATION (SHA) THEORY
DERIVED FROM ROY'S ADAPTATION MODEL (2009)

Effective adaptation promotes survival, growth, integrity, and women's sexual self-concept and quality of life.

Roy & Andrews (1991)

THEORETICAL FRAMEWORK cont.: SHA Theory



Focal = cancer treatments
Contextual = demographics

CAP = cognitive adaptation processing involves cognitive and religious coping to help seek meaning and ways of handling/responding to a changing environment in daily and critical situations.

Output = behavior related to adaptive or non-adaptive. sexual – self concept (SSC).

SSC = composite of beliefs and feelings about sexual self.

Figure 2. Sexual Health Adaptation Theory Diagram

METHODS

- Design - Cross-sectional Descriptive Correlational Design
- Setting - Online Research study
- Recruitment via Online Cancer/Nursing Organizations and Print Media
    - National Cervical Cancer Coalition
    - Michigan Cancer Consortium
    - Oncology Nurses' Facebook Page
    - Survey Monkey Zoom Panel Service
    - Michigan Chronicle Newspaper
    - Detroit Free Press Newspaper
- Sample N=66
- Inclusion – Was at least 18 years old, English speaking, first treated in USA
- Exclusion - Experienced treatment for recurrent disease

METHODS – con't

- A link to the online questionnaire was published through all online and print media recruitment sites
- The link opened to information page that explained study purpose, associated details and consent process
- Proceeding beyond information page implied respondent's consent to participate in research study
- Data was collected for 7 weeks and maintained by Survey Monkey and downloaded into SPSS

METHODS - Instruments

1. Demographic and Health Status Form
2. Cognitive Coping Adaptation Processing Scales (CAPS) (Roy, 2009)
3. Brief Religious Coping Scales (Brief RCOPE) (Pargament, 1998)
4. Multidimensional Sexual Self-Concept Questionnaire scales (MSSCQ) (Snell, 1997)
5. Socially Desirable Response Set-5 (SDRS- 5)(Hays, Hayashi & Stewart, 1989)

INSTRUMENT STATISTICS (N = 66)

Instrument	Rating Scale	Potential Range	Study Range	Score Mean (SD)	Scale Mean (SD)
CAPS Resourceful and Focused Subscale (α = .94)	1-5	10- 50	10-50	37.4 (7.15)	3.72 (.02)
CAPS Systematic Processing Subscale (α = .86)	1-5	6-30	10-30	22.15 (3.94)	3.69 (.01)
Brief RCOPE Positive Religious Subscale (α = 0.96)	1-4	7-28	7-28	14.04 (7.1)	1.97 (.02)
Brief RCOPE Negative Religious Subscale (α = 0.97)	1-4	7-28	7-28	10.4 (5.8)	1.47 (.01)
MSSCQ Sexual Esteem Subscale (α = 0.97)	1-5	5-25	8-21	15.17 (6.4)	3.03 (.32)
MSSCQ Sexual Satisfaction Subscale (α = 0.97)	1-5	5-25	5-16	9.67 (6.7}	1.93 (.01)
SDRS-5 (α = 0.62)	1-5	5-25	13-21	17.1 (3.68)	2.85 (.87)

DATA ANALYSES

SPSS version 20

t-Tests

Chi –Square

Correlation (Pearson's and Spearman rho)

DATA ANALYSES - Sample Characteristics (N = 66)

Age in Years: Range 20-70+	Relationship
20-30 years 15% 31-40 years 27% 41-51 years 29% 52-70+ years 29%	Single with same sex partner 4 (6.2%) Single with opposite partner 6 (9.2%) Married to same sex 2 (3.1%) Married to opposite sex 33 (50.8%) Single/Widowed/Divorced 20 (30.7%)
Race/Ethnicity:	**Faith Tradition Collapsed**
African American: 2 (3.0%) Hispanic-Latino White: 6 (9.1%) Non-Hispanic White: 55 (83%); Other: 3 (4.5%)	Jewish 1 (1.6%) Protestant 20 (32.2%) Catholic 8 (12.9%) Other 6 (9.6%) None 27 (43.5)
Level of Education	**Income**
High School Graduate 18 (27%) Some College-Associate Degree 22 (33.4%) Bachelors Degree 16 (24.2%) Masters Degree 6 (9.1%) Doctorate 2 (3.0%)	Less than $20,000 12 (18.2%) $20,000 - $40,000 19 (28.8%) $40,000 - $80,000 23 (34%) $80,000 - $100,000+ 12 (18.2%)

DATA ANALYSES - Differences Between Women Who Completed Questionnaire and Women Who Did Not

Characteristic	Chi Square	P value	Notes
Age	7.91	.245	Group with full data were slightly younger
Education	8.46	.294	Women in both groups had some college or an associates degree
Income	2.14	.83	Women in both groups were in the $40-60,00/year income group

FINDINGS

- Women with invasive cervical cancer used religious coping significantly more than women with non-invasive cervical cancer.
- There was a significant negative correlation between ‘time since treatment began’ & cognitive coping; overall, the further women were from the time their treatment began, the less cognitive coping was used. There was no relationship to religious coping.
- There were no significant associations between age, education, income, coping & sexual self-concept.
- There were no significant differences between coping of women of White-non Hispanic women & women of color, but there was a tendency for the mean values to be slightly higher in women of color.

UNEXPECTED FINDINGS

- Women who were treated with surgery (hysterectomy) reported the most problems after treatment and for longer periods
- More women of color were diagnosed at later ages, though more White women were diagnosed with late cancer stages
- No relationships were found between age, race or treatment
- Over 30% (21) of the women reported past sexual trauma prior to cervical cancer treatment (was rarely found/discussed in the literature); the impact of the trauma was not determined (9% of the women reported not being sexually active and it was not known if this was due to the trauma)

CLINICAL SIGNIFICANCE

- Radiation treatment caused the greatest physical problems for women
- Low sex drive was reported as the most frequent problem across all forms of treatment
- Cognitive coping was important predictor of sexual self-concept
- Religious coping was used more by women with invasive cancer, including women who reported not practicing a religion
- Women reported a more expansive, holistic viewpoint of sexual self-concept, beyond intercourse or other sexual activity

STRENGTHS & LIMITATIONS

Strengths

- Theory guided study
- National sample used
- Contribution made to practice to improve quality of life for women

Limitations

Convenience sample who self-reported

Small sample size

No generalization beyond sample

QUESTIONS & THANK YOU