

SEXUAL HEALTH CHALLENGES AMONG MARRIED WOMEN WITH BREAST CANCER: A QUALITATIVE EXPLORATORY STUDY IN PAKISTAN

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Abstract

Background:

Breast cancer and its treatment significantly affect women's sexual health and intimate relationships. In sociocultural contexts such as Pakistan, sexuality remains a sensitive topic, often resulting in unmet informational and psychosocial needs.

Objective:

To explore sexual health challenges and concerns among married women undergoing breast cancer treatment in a tertiary care setting in Pakistan.

Method:

A descriptive qualitative study was conducted using in-depth, semi-structured interviews with 20 women who had completed breast cancer treatment. Participants were recruited through purposive sampling. Interviews were audio-recorded, transcribed verbatim, translated into English, and analyzed using qualitative content analysis.

Results:

Three major themes emerged: (1) Treatment-induced sexual health difficulties, (2) Communication gaps and informational needs, and (3) Relationship dynamics and coping mechanisms. Participants reported physical discomfort, altered body image, and emotional distress affecting intimacy. Cultural taboos and a lack of communication with healthcare providers contributed to misinformation and unmet needs. Spousal support and religious coping played a key role in adaptation.

Conclusion:

Breast cancer treatment profoundly impacts sexual health and relationships. Integrating culturally sensitive, couple-centered sexual health education into oncology care is essential to improve survivors' quality of life.

INTRODUCTION

Breast cancer (BC) is the most common cancer among women worldwide, accounting for 11.7% of all cancers globally (World Health Organization, 2021; Bray et al., 2018; Globocan, 2020). Advances in early diagnosis and treatment have significantly improved survival rates, with more than 85% of women surviving beyond five years (National Cancer Institute, 2018; World Health Organization, 2019; Albers et al., 2019; American Cancer Society, 2022; Marianne et al., 2022).

Despite improved survival, many women experience persistent physical, psychological, and social challenges that negatively affect quality of life (Sisler et al., 2016; Lovelace, McDaniel, & Golden, 2019). Sexual health is a fundamental component of well-being and plays a crucial role in overall quality of life (Davies et al., 2017). Breast cancer and its treatment—including surgery, chemotherapy, radiation, and hormonal therapy—can significantly impair sexual functioning due to physical changes such as pain, vaginal dryness, fatigue, and premature menopause, as well as altered body image and femininity (Charos & Vivilaki, 2022; Ooi et al., 2021; Vegunta et al., 2022).

In sociocultural contexts such as Pakistan, sexuality is often considered a taboo subject, which limits open discussion between patients and healthcare providers (Kiran & Anmol, 2019). As a result, many women experience unmet informational and psychosocial needs regarding sexual health. Clinical observations suggest that patients often feel hesitant to raise such concerns, while healthcare providers may avoid initiating these discussions due to cultural sensitivities.

Sexual dysfunction has been defined as difficulties that prevent individuals from experiencing satisfaction during sexual activity (Villines, 2022). These challenges may be further influenced by age-related hormonal changes, including menopause, which is associated with reduced sexual functioning (Wieczorek et al., 2022; Burry, 2023). Given the cultural sensitivity of the topic and the complexity of experiences, a qualitative exploratory approach is appropriate to understand

women's lived experiences and identify gaps in care (Cleland, 2019). Therefore, this study aimed to explore sexual health challenges among married women undergoing breast cancer treatment in Pakistan.

Materials and Methods

Study Design:

A descriptive qualitative study design was employed to explore women's experiences of sexual health following breast cancer treatment.

Data Collection

In-depth semi-structured interviews were conducted using open-ended questions during follow-up visits in outpatient clinics from August–December 2024.

Interviews were conducted in Urdu in a private setting to ensure confidentiality. Each interview lasted approximately 20–30 minutes and was audio-recorded with participant consent.

The interview guide was developed based on researchers' clinical experience and a review of the literature addressing sexual health among breast cancer survivors (Appendix 1). Probing questions were used to obtain detailed insights.

Data Analysis

Data were analyzed using qualitative content analysis. Transcripts were read multiple times to achieve immersion, followed by open coding, categorization, and theme development into categories. Finally, themes and subthemes were developed from the entire dataset.

Trustworthiness

To ensure rigor, the study adhered to the criteria of credibility, dependability, confirmability, and transferability. Credibility was enhanced through prolonged engagement and peer debriefing. Dependability and confirmability were ensured through audit trails and team-based analysis. Thick descriptions support transferability.

Ethical consideration:

Ethical approval was obtained (IRB 23-43), and written informed consent was secured. Written

informed consent was obtained from all participants. The confidentiality of data was strictly maintained.

Setting:

Data were collected from a private cancer specialty hospital in Lahore, Pakistan.

Sample Size and Sampling Technique:

A total of 20 married women who had completed breast cancer treatment were recruited through purposive sampling. Inclusion criteria included women aged 18–55 years, diagnosed with stage I–III breast cancer, and at least one year post-treatment. Women with metastatic disease or significant psychiatric comorbidities were excluded.

Results: Table 1: Demographic Characteristics of Study Participants (n=20)

Variable	Category	Frequency	Percentage (%)
Age Group	25-35	6	30
	36-45	12	60
	46-55	2	10
Level of Education	University	6	30
	Secondary School	8	40
	Less than Secondary	1	5
	No Schooling	5	25
Place of residence	Punjab	16	80
	Khyberpakhtunkhwa	3	15
	Sindh	1	05
Profession	House wife	11	55
	Teacher	4	20
	Private job	5	25
Number of Children	No children	4	20
	1-3	10	50
	4-6	6	30

Table 1 summarizes the demographic characteristics of the study participants. A total of 20 women took part in this study, with variables including age, level of education, place of residence, number of children, and profession. The majority of the study participants, 12 (60%), were middle-aged women (36-45 years); 6 (30%) fell in the age group of 25-35 years, while only 2(10%) participants were 46-55 years old.

Regarding level of education, 8 (40%) women had a secondary school education, which was 2/3 of the total sample size; 6 (30%) had higher education up to the master's degree level, 5 (25%) had no formal schooling, and only 1(10%) had not completed the secondary level of education. A significant number of the population (80%) were residents of the Punjab, followed by 15% from Khyber Pakhtunkhwa, and a very small number of

participants accounted for 5% of the total population from the province of Sindh.

By profession, more than half (55%) of the respondents were housewives, 25% were workers in private organizations, and 25% of them were teachers in schools or colleges. The majority of the women had children, as 50% had 1-3 children, 30% were with 4-6 children, and 20% of the women had no children yet. Overall results of the demographic data show that the majority of the respondents were middle-aged, in domestic roles, belonged to the province of Punjab, and had children ranging from 1 to 3, and specifically, the majority of them were under matric.

The participants experienced various physical, psychological /emotional, social, and spiritual challenges that affected their sexual function due to breast cancer treatment. Participants described complex and interrelated challenges affecting their sexual health following breast cancer treatment. These experiences were organized into three overarching themes:

1. Treatment-Induced Sexual Health Difficulties
2. Communication Gaps and Informational Needs
3. Relationship Dynamics and Coping Mechanisms

Theme 1: Treatment-Induced Sexual Health Difficulties

Breast cancer treatment had a profound impact on women's sexual health, affecting both physical functioning and psychosexual well-being. These challenges were often interconnected and collectively influenced intimacy and marital relationships.

Subtheme 1.1: Physical and Physiological Sexual Dysfunction

Participants frequently reported treatment-related physical symptoms that negatively affected sexual functioning. These included vaginal dryness, dyspareunia, fatigue, and reduced libido, often associated with chemotherapy, hormonal therapy, and premature menopause. One participant shared: "Intercourse was quite painful due to dryness... the pain was so intense that I don't want to have it again" (P11). Another noted: "Pleasure is

not like before... I feel body aches even the next day" (P5).

These symptoms often led to reduced sexual activity and avoidance of intimacy. Additionally, chemotherapy-related side effects such as nausea, weakness, and premature menopause further diminished sexual capacity and energy levels.

Subtheme 1.2: Psychosexual Impact and Altered Intimacy

Beyond physical symptoms, participants described significant emotional and psychological challenges affecting their sexual relationships. Altered body image, feelings of incompleteness, and reduced self-confidence were commonly reported following surgery and treatment-related changes such as hair loss and scarring. One participant stated: "I cannot expose myself in front of him. I feel incomplete" (P17). Emotional distress, including guilt, anxiety, and fear of not fulfilling marital expectations, further compounded these challenges. Many women described a conflict between their desire for emotional closeness and their inability to engage in physical intimacy: "I want to hug but cannot" (P17).

These experiences often resulted in reduced intimacy, emotional withdrawal, and strain in marital relationships.

Theme 2: Communication Gaps and Informational Needs

A major challenge identified by participants was the lack of communication and education regarding sexual health within the healthcare system, compounded by sociocultural barriers.

Subtheme 2.1: Absence of Sexual Health Communication in Clinical Care

Participants consistently reported that healthcare providers did not address sexual health concerns during treatment or follow-up care. Clinical discussions primarily focused on survival and physical recovery, with limited attention to relational or sexual well-being. One participant expressed: "No one talked about husband-wife relationship... doctors think more about saving our life" (P1).

Several participants reported receiving incomplete or vague information, often limited to contraception advice, without practical guidance on managing sexual difficulties.

Subtheme 2.2: Sociocultural Barriers and Patient Hesitation

Cultural norms and feelings of shame significantly limited open discussion about sexual health. Many women felt uncomfortable initiating conversations with healthcare providers due to embarrassment or perceived social boundaries. *"We felt shy to ask... these things are not discussed openly"* (P2).

Participants also described being emotionally overwhelmed during treatment, which further limited their ability to seek or process information.

Subtheme 2.3: Misconceptions and Informal Information Sources

Due to a lack of formal education, many participants relied on informal sources such as family members or other survivors, which sometimes reinforced misconceptions. A common belief was that cancer could be transmitted through physical contact. *"We were afraid it might be contagious... we used to keep a pillow between us"* (P13).

Reassurance from healthcare providers or other survivors helped dispel these fears, highlighting the importance of accurate and timely information.

Theme 3: Relationship Dynamics and Coping Mechanisms

Participants described diverse relational experiences and coping strategies that influenced their adjustment to sexual health challenges.

Subtheme 3.1: Spousal Support and Relationship Resilience

Many women reported strong emotional support from their husbands, which played a crucial role in coping with illness and maintaining relationship stability. *"My husband was extremely supportive... it was tough, but he was cooperative"* (P13).

In some cases, shared adversity strengthened emotional bonds and deepened mutual understanding.

Subtheme 3.2: Marital Strain and Vulnerability

Some participants reported emotional distancing, reduced intimacy, or even abandonment during treatment. As one participant shared, *"During my treatment, he married another woman..."* (P19).

Feelings of guilt and inadequacy were also common, reflecting internalized expectations regarding marital roles.

Subtheme 3.3: Religious and Emotional Coping Strategies

Participants frequently relied on religious beliefs, emotional resilience, and adaptive strategies to cope with their circumstances. Faith provided a sense of acceptance and meaning, helping women navigate both physical limitations and emotional distress. *"I am not guilty... all of this is from Allah"* (P1).

Some women also adopted practical strategies, such as using lubricants or adjusting expectations around intimacy, to maintain their relationships.

Discussion

This study explored the multidimensional impact of breast cancer treatment on women's sexual health within a sociocultural context where sexuality remains a sensitive and often neglected topic. The findings highlight the complex interplay between physical symptoms, psychological experiences, relational dynamics, and sociocultural influences.

Participants reported significant physical and psychosexual challenges, including vaginal dryness, dyspareunia, fatigue, and reduced libido. These findings are consistent with existing literature demonstrating that treatment-related hormonal and physiological changes contribute significantly to sexual dysfunction among breast cancer survivors (Talaat et al., 2023; Boquiren et al., 2016; Ljungman et al., 2018; Maleki et al., 2021). Emotional distress, including anxiety, guilt, and fear, further compounded these difficulties, reflecting the broader psychosocial burden

associated with breast cancer (Male et al., 2016; Roy, Chouhan, & Itoola, 2025).

Altered body image emerged as a critical factor influencing sexual identity and intimacy. Consistent with prior research, participants described feelings of incompleteness and reduced femininity following treatment, which negatively affected self-confidence and relationship dynamics (Ahn & Suh, 2023; Alaloul et al., 2019; Cernikova et al., 2024; Gao et al., 2025; Hasan et al., 2023; Erden, Celik, & Karakurt, 2025). These findings reinforce the importance of addressing both physical and psychological aspects of survivorship (Mohammadi et al., 2022; İzci et al., 2016).

A major finding of this study is the persistent communication gap between patients and healthcare providers regarding sexual health. Participants reported that discussions were largely limited to disease management and survival, with minimal attention to intimacy or relational concerns. Similar gaps have been reported in previous studies, where sexual health is often overlooked in oncology care (Anderson et al., 2025; Flynn et al., 2023; Paterson et al., 2022; Lee & Carvalho, 2021). Cultural taboos and patient hesitancy further exacerbate this issue, resulting in unmet informational needs and increased anxiety (Khan & Riaz, 2025; Ooi et al., 2021).

The study also highlights the importance of relational dynamics. While many participants experienced strong spousal support that contributed to emotional resilience, others reported marital strain or abandonment. These findings are consistent with literature emphasizing the role of partner support in psychological adjustment and relationship satisfaction (Paterson, Lengacher, & Donovan, 2022; Zhang, Liu, & He, 2023; Badr & Krebs, 2013).

Religious beliefs and coping strategies played a central role in helping participants manage their experiences. Faith provided emotional comfort and facilitated acceptance, aligning with previous studies highlighting the importance of spirituality in coping with cancer-related distress (Al-Azri et al., 2020; Shayan et al., 2017).

Overall, these findings underscore the need for culturally sensitive, couple-centered interventions

that address sexual health as an integral component of survivorship care.

Study Limitations

This study has several limitations. First, it was conducted in a single tertiary care center, which may limit generalizability to other settings. Second, the sensitive nature of the topic may have influenced participants' willingness to disclose personal experiences. Third, the sample size, while appropriate for qualitative research, may not capture the full diversity of experiences across different cultural and socioeconomic groups.

Clinical Implications

The findings highlight the need to integrate sexual health into routine oncology care. Healthcare providers should initiate culturally sensitive discussions, provide structured education, and involve spouses in counseling where appropriate. Nurse-led interventions and written educational materials may improve accessibility and patient comfort. Addressing sexual health as part of holistic survivorship care can enhance emotional well-being and relationship quality.

Conclusion

Breast cancer treatment significantly affects women's sexual health, emotional well-being, and intimate relationships. In culturally sensitive contexts, these challenges are compounded by communication barriers and unmet informational needs. Integrating culturally appropriate, couple-centered sexual health support into oncology care is essential to improve quality of life among breast cancer survivors.

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