Cervical Cancer: Issues of Sexuality and Fertility

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Carter et al provide a nice summary of current knowledge of sexual dysfunction in and rehabilitation of women with invasive cervical cancer. The prevailing perspective of their review, however, seems to be that most women treated for cervical cancer are white, middleclass patients at major cancer centers. In order to make a difference in the quality of life of the majority of cervical cancer survivors, we have to understand who they are and recognize the impact of social and gender inequality on their lives and relationships.

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Cervical Cancer and Socioeconomic Status

The authors cite the decline of cervical cancer from first to third most common reproductive tract malignancy in the United States, but fail to mention that 78% of cervical cancers occur in developing nations, where the malignancy remains the second most frequent cause of cancer death.[1] A recent meta-analysis of 57 case-control studies found a 100% worldwide increase in risk of cervical cancer among women of low vs high social class.[2] This relationship was especially strong in countries with low to middle incomes, and in the United States, where disparities in medical care greatly exceed those in other wealthy nations. In the United States, the incidence of cervical cancer in women over age 40 is substantially higher among African-American[3] and Hispanic[4] women than among non-Hispanic white women. The association between cervical cancer and socioeconomic status reflects lifestyle factors as well as access to cytologic screening. Because of the importance of the human papilloma virus (HPV) in the initiation of cervical cancer, elevated risks have consistently been seen in women who, over a lifetime, have more sexual partners.[5] Yet in many cultures that allow men to have multiple partners but strictly enforce female chastity and fidelity, a woman's risk of cervical cancer may depend on her husband's sexual history, including his lifetime number of sexual partners, whether he frequents prostitutes, and whether he is circumcised.[6] Along with exposure to HPV, a woman's risk of invasive cervical cancer is related to her use of tobacco and the health of her immune system. Women who are positive for the human immunodeficiency virus (HIV) are at higher risk of cervical dysplasia and cancer. Once a woman develops dysplasia, however, the most crucial factor in progression to invasive cervical cancer is lack of screening for and treatment of precursor lesions.[7]

Cultural Influences

Sexual rehabilitation after cervical cancer presents a special challenge because the women most at risk for this malignancy often have less knowledge about female sexual function, less access to information or counseling, and less control over their sex lives and relationships. Even in the United States, women with a college degree have half the rate of sexual problems reported by women who do not finish high school.[8] The article by Carter et al notes that a woman's negative sexual selfconcept influences her functioning after cancer. Many cervical cancer survivors do not have the luxury of worrying about their body image or self-concept. If they are not able to satisfy their husbands sexually, they may be physically abused or abandoned. Furthermore, even for women in more loving and egalitarian relationships, having less education or being part of a minority subculture in the United States is associated with more conservative values about sexuality. The traditions of privacy and silence associated with women's sexuality in Hispanic, Asian, and more rural African-American families present a challenge to even the most empathic and dedicated clinician in trying to provide information and counseling. For years, those of us who work with sexuality and cancer have been lobbying for specialty clinics in cancer centers and training for nurse clinicians and social workers who could provide sexual counseling when the oncologist is too busy and overwhelmed, or at least referrals to a network of specialty providers outside the hospital—all suggestions made by Carter et al. None of these strategies, however, is likely to reach most women treated for cervical cancer. Peer Counseling
Sexual rehabilitation may have the best chance to benefit poor women if programs reach out into the community, partnering with influential organizations from particular ethnic or religious groups. My research team recently developed a peer counseling program in reproductive health for African-American breast cancer survivors in partnership with Sisters Network, Inc, a national advocacy organization. We created a workbook with three chapters, including one that focuses on sexuality. Keeping the reading level as basic as possible, and using African-American-themed clip art, the chapter presents information on genital anatomy and sexual response, the impact of cancer treatment on sexual function, sexual communication with a partner, how to approach dating for single women, how to use vaginal lubricants and control the muscles surrounding the vaginal opening to minimize pain during sex, and how to enhance sexual desire, which is often reduced after cancer treatment. Three peer counselors went through an intensive training period, and then met with each participant for three sessions. Preliminary results suggest that women in the program did improve their sexual function and satisfaction. We are embarking on a larger, randomized trial of effectiveness. This same model would work well for cervical cancer survivors. We found that the privacy of one-on-one meetings allowed participants to disclose sexual problems that were not being discussed in the support groups offered by the local chapters of Sisters Network, Inc. A peer counseling program can also overcome barriers to sexual counseling such as stigmatization of seeing a mental health professional, lack of insurance coverage, lack of transportation or child care, and lack of trained, mental health professionals who are familiar with both sexual and cancer counseling. **Conclusions**

Peer counseling is not the only innovative model for offering sexual rehabilitation. Use of the Internet and multimedia presentation of information are also useful with low-income women, whose literacy may be limited.[9] If we are to make a difference for this most vulnerable group of cancer survivors, we need to look beyond our traditional treatment settings, our traditional treatment programs, and our traditional complaints about the low priority that cancer treatment centers place on sexual rehabilitation.

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**References:**


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