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Impact of an Educational Program on Sexual Distress Associated with Cervical Cancer

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Abstract

Background: Sexual distress is an extrinsic word that comprises sexually disrupted sexual distress and dysfunction, orgasm reduction, dyspareunia, vaginal disease. Sexual anguish can actually cause persons tension and anxiety**. Aim:** The impact of an educational programme on cervical cancer women's sexual suffering is studied. **Methods:** A quasi-experimental design. ***Setting***: Beni-Suef University Hospital out-patient clinic in an oncology unit. ***Subjects:*** A deliberate 70 female sample. Tools: structured questionnaire questioning and women's sexual distress. ***Results***: The findings of the study showed that all measures of female sexual anguish have regressed compared to pre-1 after the programme. **Conclusion:** The teaching programme for women with cervical cancer was highly successful for the regression of all sexual distress. **Recommendations:** Women's advice on cervical cancer, sexuality and sexual distress should be popular and facilities and decision-making aid for those who need it should be provided.

Keywords: Cervical Cancer, Sexual Distress.

1. INTRODUCTION

Cervicular cancer has an impact on the entire life of a woman [1-5]. It may arise as a result of the nature of cannery as a consequence of treatment, such as surgery, chemotherapy, or radial therapy, that changes the mechanical or hormonal pathways of sexual function. The mental anguish of being diagnosed may also occur [6-11]. Sexual distress comprises all sexual discomfort and dysfunction including diminished desire, orgasm, dyspareunia, vaginal dryness and vaginism [12–14]. Sexual anguish can actually cause people tension and anxiety. Sexual suffering has been documented by researchers at all stages and in follow-up to cervical cancer [12]. Sexual self-concept is defined by Pitche et al. (2018) as a psychological and cognitive idea of how you experience and

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understand your sexual identity [15]. For many couples, fulfilment of sexual life is crucial as it is a chance to bind, intimacy and quality times. Sexual problems following cervical cancer may be unpleasant to couples since they may feel that the essential component of the connection is gone [13]. Ratner et al. (2014) observed that approximately 30% of women receiving cervical cancer treatment had some sexual disorders, and that most women are at increased risk for vaginal stenosis and agglutination within the first three months of biotherapeutic treatment [16].

The nurse is an assistant in the management of physical needs, disease prevention, and treatment for patients [17-19]. Nurses must monitor the patient and capture essential data to help them make decisions about the treatment. The nurse monitors the progress of the patent throughout the treatment process and acts in the best interests of the patient appropriately [20-22]. The nurse is responsible for the holistic Castro of patients [23-24], and provides care beyond the treatment of the medication and other treatments. In the domain of prevention, treatment, therapy, rehabilitation, education and the promotion of health, communications are a vitamin of all nursing work. Moreover, it is through dialogue and interpersonal conversation, with specific verbal communication skills that the nursing process as a scientific approach for the practice of nursing is realized. The treatment consists, on the one hand, of or communication to authorities and nurses on public health, and, on the other, to the patient, or his relatives [25]. Oncology nurses are the first to be able to explain themselves readily to women and to be adept at reducing their fears over sexual intercourse.

The loss of fertility and sexual changes associated with cervical cancer operations can be profoundly tritonic in some women. Patients working with patients who deal with this type of problem must be able to discuss sexual problems comfortably and to give a non-therapeutical setting for patients who are able to ask themselves questions. In addition, cervical women need a lot of support and may need social work and psychological counselling interventions in the early stages of their treatment. It is up to the nurses to treat these patients and to coordinate their components [28]. Molin&Gallo (2020) maintains that nursing care should be comprehensive and individualized to satisfy the needs of patients. This could include particular pain procedures or tailored follow-up, for example. In their study, patients who received a telephone follow-up showed high levels of satisfaction and chose telephone contact over regular medical treatment because of increased comfort [29].

The caregiver guided the survivor of cervical cancer to restore confidence and adjust them to physical and mental alterations in order to optimize survivor autonomy [1,30]. Psychosexual counselling in patients with gynaecological cancer can considerably enhance sexual function. Post-cannering education and counselling for women may also lessen sexual difficulties and enhance the relationship between women [31]. While some people believe the last thing, they have to do following therapy is sexual connection, others sense an increased yearning for closeness. An intimate relationship with the partner might make the patient feel loved and supported by the impact of cancer. Cancer can nonetheless complicate relation, pain, or intimacy problems prior to the diagnosis of cancer [32].

2. SIGNIFICANCE OF THE STUDY

Changes following the treatment of cervical cancer can involve vaginal shortening or reduction in vaginal lubrication. Women who had previously been pre-menopausal may also become postmenopausal because of pelvic reradication, ovarian surgery, or chemotherapy. The effects of these physical changes on sexual intercourse might be caused by pain, intercourse difficulty due to a vagina reduced or shortened, a lack of pleasure in sex, and climax trouble [33].

Dyspareunia, the existence of scar tissue after operations, sexually-transmitted illnesses, and decreasing lubricating after cervical cancer therapy, may be caused by insufficient lubrication.

Vaginismus is a painful and unintentional spasm of the vaginal entrance muscles. It could happen in women who fear penetration [15,34]. Sexual oncology is increasingly recognised as an important field in nursing and researching. Oncology nurses must be highly sensitive to the degradation of sexual health in patients. However, because of limitations such as wrong assumptions and ideas about sexual concerns, sexual health is still being treated inadequately. Nurses are among health professionals in the first stage, in which patients with cervical cancer can be able to contact conveniently and effectively remove sexually linked problems [35-40]. Norouzinia et al. (2016) have emphasised that good communication skills, confidence, listening capability, and expertise on a nurse or health professional are needed to ensure the provision of information. Sexual education and advice are nursing procedures used to treat azsistic patients to address their sexual difficulties [41]. In healthcare, a healthcare provider gives patients with information and helps them to decide [42-43].

3. AIM OF THE STUDY

The purpose of this study is to assess the influence of the educational programme for women with cervical cancer on sexual discomfort

4. HYPOTHESIS

Women who participated in the programme will experience sexual discomfort regression with cervical cancer.

5. SUBJECTS AND METHODS

5.1. Research Design

A quasi-experimental (pre-post) test study design was used.

5.2. Setting

The outpatient clinic at the University Hospital of Beni-Suef.

5.3. Subjects:

5.3.1. Type: a purposive sample of women who met the criteria for inclusion in this study.

5.3.2. Size: 70 women were selected.

5.4. Tools of Data Collection

To attain the aim of this study, two tools were used for data collection;

5.4.1. **Tool I**: **Structured interviewing questionnaire** sheet. It included social-demographic features, medical and surgical history and women's obstetric histories.

5.4.2. **Tool II: Female sexual distress scale**; It has been improved for assessment of distress in hypocritical females. The questionnaire is a self-report by Derogatitis et al., (2008) [44]. There are 13 articles which evaluate different aspects of women's sexual distress. All things are marked at a 5-point Likert scale of 0 (never) to 4 (Allwas), with a higher score suggesting a greater level of sexual trouble. The scale has been converted into Arabic.

Scoring system for tool II (Female sexual distress scale)

This measure includes 13 items to evaluate different elements of women's sexual suffering. Women have been tampered with the number that characterises the frequency of sexual discomfort they have experienced during the past three months. All items are marked with the Likert scarlet in five points. The total scores earned are between zero (never) and 4 (still), with higher scoring indicating higher sexual anguish; women who received 11 or higher scoring scores are considered to have sexual disorder.

5.5.Validity and Reliability

Before the fieldwork began, three pregnancy specialised specialists examined the prepared instruments and considered their remarks. In order to examine the dependability of produced

instruments by their internal consistencies, Crownbacharpha and Spearman-Brown coefficients were calculated.

5.6.Administrative & Ethical Considerations

Prior to the study, the Director of Beni-Suef University Hospitals acquired the authorisation was. Every woman recruited in the study had consent. Participants were said to have been exceedingly confidential in their data. Women have gained informed permission once they have explained the goal of the study.

5.7.Field work

5.7.1. Preparatoryphase

The review of the associated literature and theoretical knowledge on different elements of the topic was provided. The investigator assessed the tool's validity by means of a jury of experts to evaluate its content, knowledge, accuracy and relevance.

5.7.2. Pilot study

A pilot study was conducted on 7women.

5.7.3. Data collection phase

The data were collected from August 2019 to the end of January 2020 during a period of six months. The researcher described the purpose of the study before the collection of data to women. The questionnaire was for a woman about 15-20 minutes. Sexual nursing advice is offered in three meetings by the researcher in the outpatient unit. Every week, telephone calls are used for training and strengthening on sexual counselling subjects. The effect of sexual nursing was evaluated by compare the pre and post-intervention state of women (sexual discomfort) during a month.

5.8.Statistical analysis

The data were reviewed, categorised, tabulated and incorporated in −PC using the Social Science Package (IBM SPSS 25.0). At p-vàlue<0.05 was considered the importance of statistical tube. Appropriate examination of the type of datas obtained for each parameter was presented.

- Mean ± SD, and range for parametric numerical data.
- Frequency (N), and percentage (%) of non-numerical data.
- Student t-test
- Mann-Whitney
- Kruskal-Wallis tests were used.
- Colum chart for graphic presentation.

6. RESULTS

Table 1 showed that over one-half (48.6 per cent) of the investigated women had secondary education; their age exceeded 50 years. At age less than 20, more than half married. **Table** 2 shows that for the study sample the middle age of menarche was 2.45±12.4 years, 41.4% of examined females had amenorrhea and 32.8% had irregular menstrual conditions. **Table** 3 demonstrates that 72.8% of analysed women had indications and symptoms identified cervical cancer, and 35.7% of women were diagnosed with cervical cancer in the first degree. More than three-quarters (81.4%) of females had overall hysterectomy as far as treatment type is concerned. **Table** 4 shows regression of all items with post-program sexual discomfort scores compared to pre-1. More than half (64.3 percent) of those studied had been annoyed by and stressing their sexual issues, more than half (38.6 percent) had also been humiliated by their sexual problems, and more than one-third of them (38.6 percent), respectively, by the preprogramme. Regarding one-third (34%) of women being guilty of sexual difficulties they had always felt responsible before the programme was implemented, around one-third (32.9%) of their sexual life at the pre-program had been unhappy and angry. The same chart shows that over a half (61.4%) and (57.1%) of women seldom have been convicted or regretted

for their sexual intercourse, respectively. In terms of the satisfaction of the sexual relationship, more than 50% (55.7%) of women rarely felt sad, and more than half (52.9%) seldom felt less than half (51.4%) had not been disappointed or furious about sex life or post-intervention.

Figure 1 shows that more than three quarters (88.6%) of the women investigated had pre-program sexual distress and all of them (100%) no post-program sexual distress. The overall sexual distress measure shows a highly statistically significant difference for women.

Table (1): Distribution of demographic characteristics of the study subjects (n=70).

Demographic characteristics	No	%
1. Age		
▪ 30:<40 years	15	21.4
▪ 40:<50 years	19	27.1
▪ > 50 years	36	51.4
Mean ± SD	49.4 ± 9.38	
2. Educational level of women		
▪ Illiterate	2	2.9
▪ Basic education	24	34.3
▪ Secondary education	34	48.6
▪ Above secondary education	10	14.3
3. Job		
▪ Working	25	35.7
▪ Not working	45	64.3
4. Residence		
▪ Rural	33	47.2
▪ Urban	37	52.8
5. Marriage age		
▪ < 20 years	40	57.1
▪ 20: 30 years	30	42.9
Mean ± SD	19.1 ± 4.23	

Table (2): Distribution of the study subjectsaccording to their obstetric/gynecological history (n=70)

Obstetric and gynecological history	No	%
1. Menarche age		
▪ < 12 years	13	18.6
▪ 12: 15 years	55	78.6
▪ > 15 years	2	2.8
Mean ± SD	±12.4 2.45	
2. Menstrual period		
▪ Regular	18	25.7

Obstetric and gynecological history	No	%
▪ Irregular	23	32.9
▪ Amenorrhea	29	41.4

Table (3): Distribution of the study subjectsaccording to their medical-surgical history (n=70).

Medical surgical history	No	%
1. Detection of cervical cancer		
▪ When regular screening	11	15.7
▪ During delivery	8	11.4
▪ From symptoms	51	72.8
2. Degree of disease when detected		
▪ Zero degree	16	22.9
▪ 1st degree	25	35.7
▪ 2nd degree	22	31.4
▪ 3rd degree	4	5.7
▪ 4th degree	3	4.3
3. Type of disease intervention		
▪ Radiotherapy	4	5.7
▪ Surgical	9	12.9
▪ Chemotherapy and surgical	14	20
▪ Radiotherapy and surgical	17	24.3
▪ Radiotherapy, Chemotherapy and surgical	26	37.1
4. Surgery type		
▪ Local tumor surgery	6	8.6
▪ Partial hysterectomy	7	10
▪ Total hysterectomy	57	81.4

Table (4): Percentage distribution of women's sexual distress scores pre/post program implementation.

Items	Pre-program					Post-program				
	N	R	O	F	A	N	R	O	F	A
	%	%	%	%	%	%	%	%	%	%
1. How often did you feel distressed about your sex life?	0	12.9	34.3	35.7	17.1	2.9	45.7	35.7	12.9	2.9
2. How often did you feel unhappy about your sexual relationship?	0	0	21.4	64.3	14.3	8.6	55.7	0	32.9	2.9

3. How often did you feel guilty about your sexual difficulties?	0	0	24.3	41.4	34.3	11.4	61.4	25.7	1.4	0
4. How often did you feel frustrated by your sexual problems?	0	2.9	8.6	24.3	64.3	4.3	51.4	42.9	1.4	0
5. How often did you feel stressed about sex?	0	0	15.7	42.9	41.4	4.3	47.1	44.3	4.3	0
6. How often did you feel inferior because of sexual problems?	0	0	30	41.4	28.6	11.4	52.9	34.3	1.4	0
7. How often did you feel worried about sex?	0	5.7	25.7	44.3	24.3	5.7	40	48.6	5.7	0
8. How often did you feel sexually inadequate?	2.9	4.3	24.3	42.9	25.7	14.3	32.9	52.9	0	0
9. How often did you feel regrets about your sexuality?	0	5.7	30	41.4	22.9	10	57.1	27.1	5.7	0
10. How often did you feel embarrassed about sexual problems?	0	1.4	20	40	38.6	14.3	41.4	42.9	1.4	0
11. How often did you feel dissatisfied with your sex life?	2.9	0	15.7	48.6	32.9	15.7	44.3	38.6	1.4	0
12. How often did you feel angry about your sex?	4.3	12.9	30	20	32.9	10	51.4	37.1	1.4	0
13. How often did you feel bothered by low desire?	5.7	7.1	31.4	31.4	24.3	14.3	32.9	52.9	0	0

"N": Never, "R": Rarely, "O": Occasionally, "F": Frequently, "A": Always

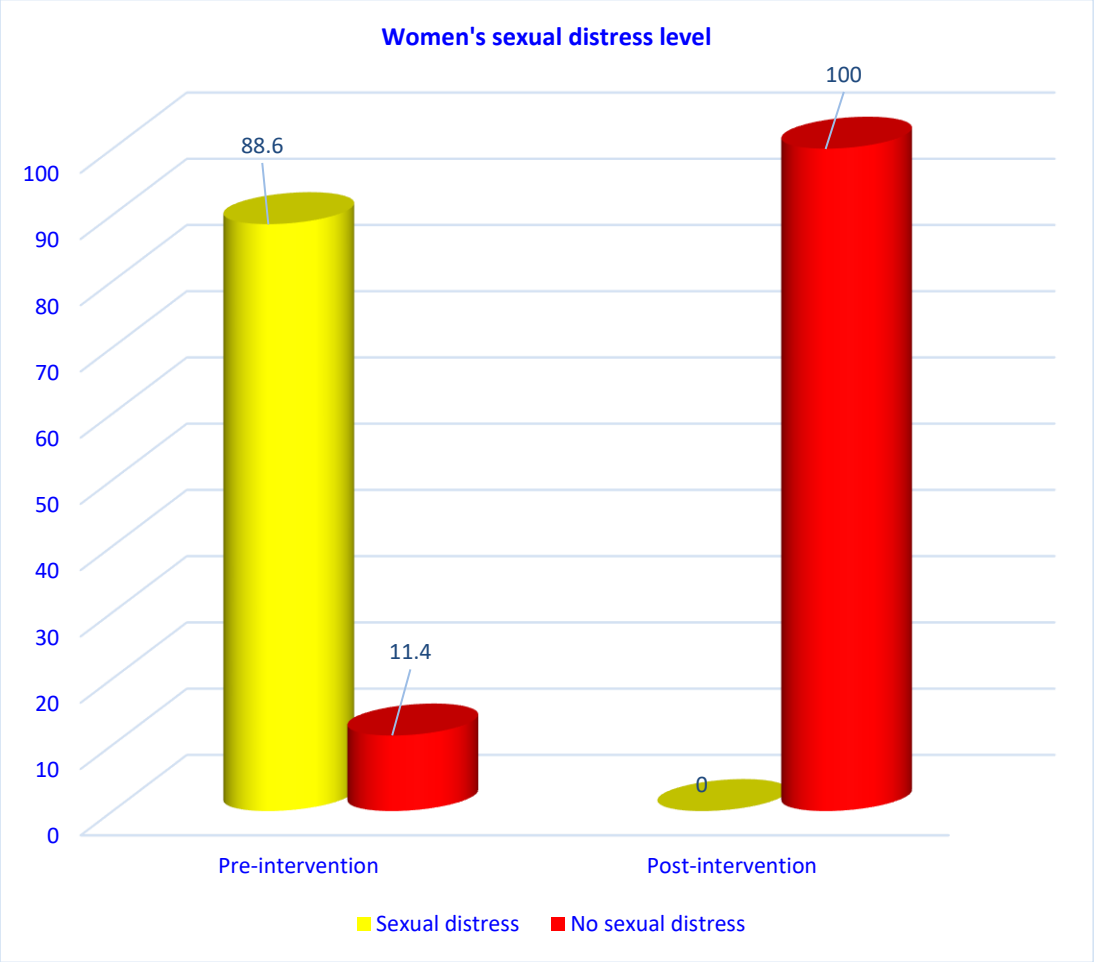

Figure (1): Percentage distribution of women's total sexual distress scores pre/post program

7. DISCUSSION

Sexuality, however, is one part of the carcass that has been generally disregarded by care professionals for a number of reapsons. While patients wish to raise the whole question, they want to raise the issue with the healthcare professional. On the other hand, medical practitioners reject the dialogue and prefer to wait for the patient to express their concerns [45]. Sexuality is part of clinical therapy with relatively basic strategies. The first is to tackle personal attitudes which can prohibit a health care practitioner from incorporating the subject in medical or nursing care. Personal sexual attitudes need to be assessed, which can be done privately or in workshops where discussions are possible [46].

On view of the previous study, the researcher undertook this study to evaluate the influence of a progressive education for women with cervical cancer in sexual distress. With respect to ageas of the sample samples analysed in the study subjects as a component of the demographic features, the present study showed that just over a half of the study samples are older than 50 years. The study Zhou et al. (2017) which has discovered that slightly fewer than a half of women were identified in an exploratory investigation of patterns and predictors of the healthcare of cervical cancer survivors in their sexual issues; their age varied from 46-55 years [47], similar to the study found today. Education has demonstrated that women are empowered. With respect to women's education levels, the current study shows that slightly fewer than half of the investigated females are secondary school teachers and two thirds' housewives. Zhou et al. (2017) also supported this by finding that patients were trained at or below junior high level [47].

In relation to the medical and surgical history of the study sample, a diagnosis of cervical caccer from signs and symptoms by a healthcare provider was made slightly less than three-fourths of the patients, and a diagnosis with cervical caccer by a second degree were slightly higher than one-third of the females in the 1-th degree.

In accordance with our study results "Stardized Oncology Care Care Response for the Reduction of Sexual Dysfunction among Women of CervicelCarnacol Survivores" Solimān&Abd-Elsòlãm (2018) conducted their study in Egypt, distributed cervical carncers between woman stages, representing 16 per cent of IIIA by 32 per cent, IIIB by 32 per cent and cervical cyncers by women, representing 16 per cent,

Just over a third of women had undergone combination cervical therapy. This finding is consistent with Ahmad&Hassan (2016), which showed that little over half of the cervical cardiovascular samples were noticed by the doctor [49]. In discrepancy, Zhou et al., (2017) in Chinā showed the majority of patients suffering from stasis II or lower stasis and having undergone a combined treatment [47], according to current study's findings. This may be linked to the increasing requirement for utilisation of combination therapy increases in cervical cancer. This study shows that the majority of studied women have had pre-programma sexual distress (100 percent) and that they have no post-programming sexual distress (100 percent). The results showed that all the measures of sexual anguish among women are regressing post-programma compared to pre-1. Accordingly, the study "Sexual distress and sexual function in the samples for Irish women with gynaecological chroniclers," conducted in Iron (2018) showed that the FSFI mean score was 19.4. This score shows that gynecologic cancer patients have little sexual function. The average total score for sexual distress was 29.2, again showing modest levels [50].

Bakker (2015) found that the sexual distress of Pasticipants did not alter significantly over time in contradiction with the current study. Due to the pre-diagnosis status, at 12 months after rehabilitation treatment, participants reported high levels of sexual distress at 6 months after RT and Continuing trends at high levels. Moreover, following RT treatment, the levels of sexual anguish of participants during the operation didn't significantly decrease later. This may be linked to the

evaluation of research participants during the rehabilitation stage, consequently sexual distress among GCS can recover again between 12 and 24 months [51].

The results of the current study have shown that all items in female sexual distress had regressed compared to pre-1 in the post-program. The participation in training sessions [12,52-55] can be attributed to this. In addition to the educational material, the achievement and retention of knowledge was very significant. The information and educational process for reproductive organs and sexual activity, including anatomy and physics of female genitals, the explanation in the cycle of female sexual intercourse, types of dysfunction of sex, sexual disorders, various relaxation and other workouts, etc. it contains information on various physical, psychological, sexual and sexual problems; Booklets are best used to be brief, written in straightforward language, filled with beautiful photos and when other types of instruction are taken into account. This is in keeping with the Learning Pyramid of EdgárDale or the NTL quoted by many researchers as 10.0% of what they see and hear is retained by the pyramid illustrated by individuals (audiovisual). The originator of sami noted that one retains 50.0% of what he learns in a debate [56-66].

8. CONCLUSIONS

Based on the findings of this study: the instruction of the psychology of women with cervical cancer can be extremely useful in the regression of sexual anguish. The research hypotheses are therefore accepted.

9. RECOMMENDATIONS

Based on the results of the investigation, the following are proposed:

i. Disseminate a pamphlet in the fields of educational medicine, gynecology, and cancer.

ii. Maternity proper oncology training Senior nurses reverberating into cervical cancer-related sexual distress to increase their ability to improve women's cervical cancer sexual distress.

iii. The advice of women in cancer, sexuality, and sexual distressing should be widely available to individuals who need it and should include facilities and decision-making.

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