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Perceptions of Gender Roles, Gender Power Relationships, and Sexuality in Thai Women Following Diagnosis and Treatment for Cervical Cancer

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Purpose/Objectives: To describe patients' and their partners' perceptions of gender roles, gender power relationships, and sexuality before diagnosis of and after treatment for cervical cancer.

Design: Descriptive.

Setting: Southern Thailand.

Sample: 97 women with cervical cancer who received cancer treatment, including radiotherapy, and their partners.

Methods: Structured interview methods were used to gather information relating to gender roles, gender power relationships, and sexuality.

Main Research Variables: Gender roles, gender power relationships, and sexuality.

Findings: Fifty-two percent of the women (n = 50) were diagnosed with stage II cervical cancer. The percentage of women who undertook various activities specific to gender roles before their diagnoses was higher than the percentage who undertook the same activities after treatment. An increased percentage of partners undertook the women's gender-role-specific activities after the women received cancer treatment compared with the percentage who did so before diagnosis. Little change in gender power relationships was reported. A high percentage of the couples reported changes in various aspects of their sexuality after cancer treatment compared with before diagnosis.

Conclusions: Gender roles, gender power relationships, and sexuality changed for women with cervical cancer and their partners after the women completed cancer treatment.

Implications for Nursing: Open discussions among women with cervical cancer, their partners, and oncology nurses are necessary to identify culturally sensitive and appropriate solutions.

Key Points . . .

- Thai women with cervical cancer and their partners reported changes in gender roles and sexuality after cervical cancer treatment compared with before the disease diagnosis.
- Little change in gender power relationships was reported by the women and their partners.

Cervical cancer is the leading cause of cancer death among women in developing countries, including Thailand, Vietnam, and Colombia (Dos Santos Silva, 1999; National Cancer Institute, 1996). The 1992–1995 age-standardized incidence rates of cervical cancer per 100,000 women in the Philippines (22.5) and Thailand (29.2) were considerably higher than the world incidence rate (9.0). In developing countries, most women are diagnosed with an advanced stage of the disease (Hacker, 2000). In southern Thailand, cervical cancer accounts for 24.8% of all cases of cancer in women, and more than half of patients are diagnosed at stage II or higher (Prechavittayakul & Sriplung, 1999).

Used to treat advanced stages of cervical cancer, radiotherapy has a number of side effects, including fatigue, decreased vaginal blood flow, and reduction of vaginal lubrication. Several studies have found that, following radiation therapy, women have a shortened vagina and dyspareunia (Flay & Matthews, 1995; Jensen et al., 2003). The illness also reduces self-image, sexual desire, and sexual intimacy between partners (Warner, Rowe, & Whipple, 1999). In a small study that explored beliefs about cervical cancer and the use of healthcare services among Thai women with the disease, Jirojwong, Thassri, and Skolnik (1994) found that women changed their relationships with their spouses, their daily activities, how often they left the home, and their relationships with family members and friends after their cancer diagnoses; however, little detailed information regarding the changes was provided.

Studies conducted in Sweden, Singapore, and New Zealand (Bergmark, Avall-Lunqvist, Dickman, Henningsohn, & Steineck, 1999; Cull et al., 1993; Flay & Matthews, 1995; Lalos & Lalos, 1996; Yeo & Perera, 1995) found that women with cervical cancer reported dyspareunia and a fear of disease recurrence, which explained the marked reduction in the fre-

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quency of sexual intercourse after cancer treatment. However, the researchers focused only on women's experiences and did not include their partners. No published articles reported information based on women and their partners. Gray and Punpuing (1999), who reviewed cervical cancer studies in Thailand, found that very few studies explored gender and sexuality among patients with cervical cancer and their partners. Kitcharoen and Nuaklong (1999) found that many Thai women with cervical cancer refused to have sexual intercourse with their partners and were fearful of the malignancy's recurrence. Some women's partners wanted a divorce because they believed their wives were no longer able to have sexual intercourse.

Several factors influence couples' sexuality, including the woman's illness status. In many societies, women's gender power relations or their ability to discuss sexual matters and express sexual desire probably played a major role in the decreased sexuality among women with cervical cancer (Ford & Kittisuksathit, 1996; Soonthornthada, 2001; "Managing Reproductive Health Services," 2001).

Gender and sex can be defined differently. According to the *American Heritage Dictionary of the English Language* (2000), both terms refer to the property and quality by which organisms are classified on the basis of their reproductive organs or the condition or character of being male or female. This article will differentiate between these two terms to apply them to the research. Sex refers to the physical or biologic characteristics that indicate whether a person is female or male (Gray & Punpuing, 1999; Simpson & Weiner, 1989; World Health Organization, 1998), whereas sexuality is defined as the feelings, desires, behavior, choices, and value related to sexual relationships ("Managing Reproductive Health Services," 2001). Gender is determined within a social and cultural context and can change over time (Gray & Punpuing; Simpson & Weiner).

Two major aspects of gender can be identified within a society: gender roles and gender power relations. Gender roles and power relations are defined by the relative position of women to men within a social and cultural context (Blanc, 2001; "Managing Reproductive Health Services," 2001). Gender power balance in gender relations tends to favor men and translates into an unequal power balance in heterosexual interactions, in which male pleasure takes precedence over female pleasure and men have greater control than women over when, where, and how sexual activity takes place (Gupta, 2000). Gender power relations also are related to the ability of an individual in a relationship to negotiate his or her needs.

Gender roles include women who traditionally are responsible for the household and care of all family members and men who are responsible for physical work and earning the family's income (Chayovan, Ruffolo, & Wongsith, 1996), although these gender roles can be reversed in many societies. For example, Thai women and their partners have an equal role in earning income. Thai women also do the majority of cooking and cleaning while their partners assist. However, Thai women rarely communicate verbally with their partners about sexual intercourse and would rather use nonverbal communication.

No studies have examined whether changes in gender roles occur after Thai women are diagnosed with cervical cancer. Lowdermilk and Germino (2000) stated that the progression of cancer or the illness status after the completion of radiotherapy is related to women's reduced capability to perform their role-based activities, which often must be assumed by partners or other family members.

Human sexuality is an important aspect of well-being that can be altered significantly by cancer and its treatment (Hughes, 2000). A cervical cancer diagnosis could have a profound impact on a woman's sexuality because it affects the very core of her identity as a female (Wilmoth & Spinelli, 2000). The effect on a woman's sexuality could be traumatic, but support from her partner might alleviate adverse sexual effects (Gray & Punpuing, 1999). The Oncology Nursing Society's standard on sexuality reinforces that sexuality is an integral part of well-being throughout the lifespan and that nurses need to identify alterations in sexuality caused by malignancy or treatment to help patients maintain their sexual identity (Nishimoto, 2001).

Cervical cancer and its treatment cause changes in reproductive organs that can influence women's sexual relations and ability to enjoy sexual intercourse. This study aimed to identify how the disease influences women's and their partners' perceptions of gender and sexuality before the diagnosis of cervical cancer and after the completion of treatment, including radiotherapy.

Methods

This exploratory study was conducted from July 2000–April 2001 at the Female Reproductive Cancer Unit in Songklanagarind Hospital, a major referral hospital in southern Thailand. The hospital has comprehensive medical resources to treat and care for women with different stages of cancer. Of approximately 400 women with cancer receiving treatment at the hospital in 1999, almost half had stage II or higher cervical cancer (Prechavittayakul & Sriplung, 1999).

Ethical approval to conduct the study was obtained from the Human Participants Committees of the Institute for Population and Social Research and Prince of Songkla University. All participants received an information sheet explaining the study before giving informed consent or being interviewed. Confidentiality and the right to refuse to participate in the study were emphasized.

Instruments

Studies by Bird (1999) and Blanc (2001) were used as guides to design closed-ended questions that would measure gender roles and gender power relationships. Existing tools were not used because of the beliefs and social and cultural characteristics of rural Thai women. Attitudes and behaviors regarding sexuality also were assessed using closed-ended questions. Women and their partners were asked to indicate which person in the household had the major responsibility for each activity in a list before diagnosis and after the completion of treatment. Five experts in sociology, gynecologic nursing, cancer care, and gynecologic medical care reviewed the questions to ensure content validity. A pilot study was conducted to assess the clarity, redundancy, comprehension, and ease of administration of the questionnaire. As a result, three questions were reworded to increase their clarity. Four women with cervical cancer who had received cancer treatment, including radiotherapy, and had a one-year follow-up visit at the study hospital and their partners participated in the pilot study.

The questionnaire was comprised of three components: demographic characteristics, gender roles and gender power

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relations, and sexuality. Reliability was not assessed because of the descriptive nature of the results.

The perception of gender had two domains: Gender roles were assessed with 10 questions, and gender power relations were assessed with 5 questions. The sexuality questionnaire had 10 questions that measured sexual behavior, relationships, and attitudes.

Procedure

All of the women with cervical cancer who had received cancer treatment, including radiotherapy, at the Female Reproductive Cancer Clinic and had a follow-up visit within one year after completion of radiotherapy, along with their partners, were approached and invited to participate in the study. Ninety-seven couples were approached, and all agreed to participate. The couples may have believed that they were obligated to participate because of the differences in social position between themselves and the research team; however, this is unsubstantiated. Women were interviewed in a separate room from their partners to ensure privacy and confidentiality. All interviews were conducted by the researchers and two trained research assistants. Quantitative data were collected by questionnaire, and the participants responded without validating information with other sources. Six couples of varied ages were invited to participate in a personal interview to gain in-depth information to further explain the quantitative data. Each in-depth interview session lasted about two hours.

Analysis

Demographic information and data collected from the questionnaire were analyzed using SPSS® (SPSS Inc., Chicago, IL). Before each interview ended, the researches and participants mutually validated field notes that were written during the interview. Data were analyzed manually using content analysis (Dempsey & Dempsey, 2000).

Results

Sample

The women's ages ranged from 30–65 years, with an average age of 47.2. Most of the women had completed an elementary education level, or six years of schooling (n = 67, 69%); were Buddhist (n = 87, 90%); and lived in rural areas (n = 59, 60%). Almost a third were farmers or engaged in fishing activities (n = 32, 33%) and had a monthly family income from $101–$180 (n = 33, 34%). Fifty-two percent of the women (n = 50) were diagnosed with stage II cervical cancer (i.e., the carcinoma extended beyond the cervix into either the vagina or parametrium but not to the lower third of the vagina or the pelvic wall) (Morris & Bodurka-Bevers, 2000). All of the couples were either married or in a de facto relationship. All partners were male and 32–65 years old, with an average age of 50.1. Most of the partners had completed an elementary education level, or six years of schooling (n = 61, 63%); and were Buddhist (n = 90, 93%). Thirty-five percent were manual workers or laborers (n = 34). The interval between the women's cancer diagnosis and the study ranged from 1–12 months. Among the 97 women, 19 received radiotherapy and surgery, 2 had radiotherapy and chemotherapy, and 76 had only radiotherapy. Social and demographic characteristics of the women and their partners are shown in Table 1.

Table 1. Demographic Characteristics

	Women		Men	
Characteristic	**n**	**%**	**n**	**%**
Age (years)				
$\bar{X}$	47.2	–	50.1	–
SD	9.0	–	8.8	–
Range	30–65	–	32–65	–
30–39	22	23	11	11
40–49	36	37	36	37
50–59	30	31	34	35
60–69	9	9	16	17
Education				
Informal	12	13	1	1
Elementary (year 6)	67	69	61	63
High school graduate (year 10)	8	8	21	22
Vocational	7	7	12	13
Bachelor's degree	3	3	2	2
Religion				
Buddhist	87	90	90	93
Muslim	4	4	7	7
Catholic	6	6	–	–
Occupation				
Government official	8	9	16	17
Trader	20	21	7	8
Laborer	17	17	34	35
Farming or fishing	32	33	32	32
Business	20	21	8	8
Stage of cancer when diagnosed				
I	19	20	–	–
II	50	52	–	–
III	26	27	–	–
IV	2	2	–	–
Monthly family income ($)				
45–100	–	–	32	32
101–180	–	–	33	34
181–230	–	–	4	4
More than 231	–	–	28	29
Residential area				
Urban	38	40	–	–
Rural	59	60	–	–

N = 97 couples

Note. Because of rounding, not all percentages total 100.

Perception of Gender Roles and Gender Power Relations

Activities related to gender roles and power relations of the women or their partners before the diagnosis and after completion of treatment are shown in Table 2. Seventy-three percent of the women reported that they did laundry before the disease diagnosis, compared with 52% after the completion of treatment, a reduction of 22%. However, the same percentage of women (3%) earned an income before diagnosis and after the completion of treatment.

The percentage of men who undertook various gender role activities increased after their partners underwent radiation therapy. These activities included doing laundry (4% increase), looking after the family's financial situation (6% increase), and earning family income (20% increase).

Fewer women solved family problems (3% decrease), made decisions about the number of children to have (2% decrease), and avoided or initiated sexual intercourse (3%

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Table 2. Behaviors Before and After Radiation Therapy

Reported Behavior	Women			Men		
	Prediagnosis (%)	Post-treatment (%)	Change[a] (%)	Prediagnosis (%)	Post-treatment (%)	Change[a] (%)
Gender roles						
Take care of laundering	73	52	–21	1	5	+4
Keep the house tidy	74	57	–17	3	7	+4
Look after family finances	56	47	–9	25	30	+5
Maintain household's facilities and its functions	19	11	–8	89	89	–
Prepare meals	69	62	–7	7	9	+2
Take care of the well-being of the family members	38	31	–7	20	23	+3
Purchase household goods	31	26	–5	21	25	+4
Take responsibility for conception control	71	74	+3	20	25	+5
Ensure the finance saving	65	63	–2	19	19	–
Earn family income	3	3	–	24	43	+19
Gender power relationships						
Solve family problems	22	19	–3	39	39	–
Make decisions about the number of children	29	26	–3	27	29	+2
Avoid having sex	93	95	+2	5	9	+4
Take responsibility for the prevention of sexually transmitted disease	15	17	+2	73	76	+3
Initiate sexual activities	1	–	–1	91	93	+2

[a] The percentage of change equals the percentage of women or their partners who reported that they undertook each behavioral item after the cancer treatment minus the percentage of those who reported the same behavior before the disease diagnosis.

decrease) after the completion of treatment compared with before diagnosis. However, a higher percentage of women (1% increase) protected themselves from contracting a sexually transmitted disease after the completion of treatment than those who took such precautions prediagnosis.

No change occurred in the percentage of men who solved family problems after the completion of treatment compared with those who did so before the disease diagnosis. Five percent of the men reported that they avoided having sexual intercourse with their partners before the diagnosis, which was slightly lower than the 9% who did so after treatment. A higher percentage of men (3% increase) used protective measures against sexually transmitted diseases after the treatment. Data suggested that the women and their partners shared decision making about the number of children to have and other family problems.

In-depth interview data indicated that women were fearful that their health would deteriorate, wanted to rest more, and needed family members to undertake some of their household activities. The women also reported that cervical cancer was a very serious condition that had major effects on their life and voiced their concerns about the probability of the disease being cured or controlled.

In-depth interview data indicated that the women perceived that they needed to increase the maintenance of their sexual health after having the disease by avoiding sexual intercourse. The women believed that having sexual intercourse would increase the rate of cancer metastasis and disease recurrence. Sexual intercourse also caused dyspareunia and anxiety. Partners reported fears of causing pain to their wives and being rejected when they wanted to have sexual intercourse.

The women in this study exerted more bargaining power and negotiating to reduce sexual activities than they had previously. Women used various strategies to avoid sexual intercourse, such as simply refusing, suggesting that their partners masturbate, or using physical symptoms (e.g., headache, abdominal pain) as an excuse.

Perception of Sexuality

Before the disease diagnosis, the majority of women (87%) reported that sexual intercourse was important to their married life, whereas only 65% had the same opinion after the completion of treatment, a 22% reduction. Thirty-eight percent more women reported that they did not have sexual intercourse within one month after the completion of radiotherapy, compared with those who reported the same was true within the month before their diagnosis. Only 3% of the women reported that they never had an orgasm during intercourse before the disease diagnosis, which was much lower than the 27% who reported the same experience after completion of cancer treatment. Nineteen percent more women reported not having sexual fulfillment during sexual intercourse with their partners after the completion of treatment compared with before diagnosis.

Eighty-six percent of men reported that they perceived sexual intercourse as important to their married life before their wives' diagnoses. This percentage fell to 67% after the completion of treatment, a reduction of 19%. Sixty percent of men reported that they had sexual intercourse with other women before the disease diagnosis. This percentage included sexual relationships before their marriage. Eighteen percent of men had extramarital sexual intercourse after their wives received cancer treatment. Thirty-six percent of the men reported that they did not have sexual intercourse within the month after the women completed treatment, and 12% reported that they never had an orgasm or sexual fulfillment during sexual intercourse with their wives during the same time period. The percentages of women and men who reported on various sexuality roles before the disease diagnosis and after treatment are shown in Table 3.

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Table 3. Behaviors or Attitudes Relating to Sexuality Before and After Radiation Therapy

	Women			Men		
Behavior or Attitude	**Prediagnosis (%)**	**Post-treatment (%)**	**Change[a] (%)**	**Prediagnosis (%)**	**Post-treatment (%)**	**Change[a] (%)**
Perceived the importance of sexual intercourse on my marriage life	87	65	–22	86	67	–19
It is wrong to have sexual intercourse with a person who is not my spouse.	85	77	–8	90	90	–
Perceived risk of contracting sexually transmitted diseases	43	38	–5	41	31	–10
Have had extramarital sex	3	–	–3	60	18	–42
Have knowledge relating to sexually transmitted diseases	55	55	–	77	78	+1
Frequency of sexual intercourse in the past month						
• 0	1	39	+38	–	36	+36
• 1–3	49	54	+5	44	55	+11
• 4–6	37	5	–32	32	8	–24
• 7–9	5	1	–4	9	–	–9
• More than 10	8	–	–8	14	1	–13
Have orgasm during sexual intercourse						
• Never	3	27	+24	–	12	+12
• Sometimes	74	60	–14	29	33	+4
• Every time	23	13	–10	71	55	–16
Have sexual fulfillment during sexual intercourse with my spouse						
• Never	2	21	+19	–	12	+12
• Sometimes	65	57	–8	31	39	+8
• Every time	33	22	–11	69	50	–19
Tired of having sexual intercourse with my spouse	74	78	+4	26	34	+8
Believe that women are able to discuss sexual relationships with their partners	79	79	–	74	73	–1

[a] The percentage of change equals the percentage of the women or their partners who responded positively to each question after the cancer treatment minus the percentage of those who responded positively to the same question before the disease diagnosis.

The data from the in-depth interviews indicated that the women and their partners had fewer occurrences of sexual intercourse and less sexual fulfillment after treatment. Most of the men reported that they were angry or stressed when they were denied, but some felt sympathy toward their wives. The partners coped by smoking, drinking alcohol, reading, doing more physically demanding tasks, or having extramarital sexual intercourse. The women felt sympathy for their partners because they were unable to fulfill their sexual role as wives. Some feared that their partners would have sexual relationships with other women, including commercial sex workers.

Discussion

The demographic characteristics of the women were similar to those from a study conducted in the early 1990s (Jirojwong et al., 1994). Most of the women in this study were middle-aged and had a low socioeconomic status.

Before the disease diagnosis, the majority of women took care of the household and maintained the health of family members, whereas men earned income and engaged in physically demanding work (Chayovan et al., 1996). In many cases, the disease caused fatigue and limited the women's ability to resume their roles, which might explain the decreased percentage of women who undertook various gender-related roles after their cancer treatment and the increased percentage of men who assumed some of those roles. Disparities between the percentages of women who no longer held a role and men who assumed it might exist because other family members, such as grown children living in the same household, undertook that activity. Another factor that contributed to the decreased percentage of women who assumed gender roles after treatment was that they were labeled as "sick" and therefore were exempt from normal daily activities (Fabrega, 1974).

Men and women reported little change in gender power relations, which was encouraging because it demonstrated that the disease and its treatment had little effect on the general gender relationship between the women and their partners. Healthcare professionals may have used selected aspects, such as a couple's ability to solve family problems, as a basis to discuss sexual relationships.

Studies of Thai women show that they learn at an early age that they have a passive role in initiating or negotiating sexual relationships (Ford & Kittisuksathit, 1996). In Thai society, male adolescents are permitted to have premarital sexual relationships with other women, including commercial sex workers (Isarabhakdi, 1999). Of concern to the researchers were the differences in sexual roles reported by the women before the disease diagnosis compared with after treatment, particularly the lack of sexual intercourse, orgasm, and sexual fulfillment during intercourse with their partners. Studies in several countries, including Sweden, Singapore,

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and New Zealand, also found that women who had undergone radiotherapy reduced the frequency of sexual intercourse and reported dyspareunia (Bergmark et al., 1999; Cull et al., 1993; Flay & Matthews, 1995; Lalos & Lalos, 1996; Yeo & Perera, 1995). The combination of these changes with a reduction in the appreciation of sexual intercourse as an important factor of married life could lead to unwillingness to remain married if other conflicts later develop. Another interpretation of the reduction in a couple's appreciation of sexual intercourse as important to their married life was that both partners might accept the lack of sexual enjoyment and decide to do nothing to remedy the situation. The researchers did not know whether sex therapy would be acceptable to Thais, particularly those from low socioeconomic backgrounds. The lack of sex therapists in many healthcare organizations in Thailand also indicates a taboo against discussing such topics openly. Nevertheless, open discussions between couples and healthcare professionals are needed to address sexual issues that may arise after treatment. Women and their partners should be informed of vaginal changes after radiotherapy, such as vaginal ulceration, scarring, and stenosis (Wilmoth & Spinelli, 2000). The marriage relationship needs to be assessed during the treatment process. Communication between women and their partners is required to reduce problems that may lead to feeling undesirable or unattractive. Problem-solving methods, such as the use of a lubricant or changing sexual positions, might be suggested.

Limitations

No theoretical model, sampling, or analysis was used in this descriptive study. Further studies are required to test the research tool and generalizability of the study in other settings and study groups. Sexuality is a sensitive issue to discuss; however, an effort was made during the interviews to ensure confidentiality and privacy. The participants provided information retrospectively and, thus, were subject to recall bias. The effect of the cancer's severity on gender and sexuality was not explored, and no relationships between two or more variables were assessed. Most likely, the couples' relationships before diagnosis influenced the information provided to the researchers. The participants in this study probably do not represent all Thai women with cervical cancer and their partners because 37% of women with cervical cancer do not receive treatments recommended by their doctors (Prechavittayakul & Sriplung, 1999). The data were used only to explain the findings collected from the questionnaires. Changes in the reported behaviors and attitudes of the participants were not assessed.

Implications for Nursing Practice

Cervical cancer affects patients and their partners. Nurses should think broadly about their roles in the field of oncology (Wilmoth & Spinelli, 2000). The study results indicate that women with cervical cancer and their partners may need counseling to understand the cancer treatment and side effects, as well as potential changes to gender roles and sexuality. Nurses should assess couples for potential gender role and sexuality problems they may experience.

Although women with cervical cancer routinely are taught about changes in sexuality and how to cope with them, patients often still are fearful and anxious about having sexual intercourse after treatment. Nurses and other healthcare professionals may need to encourage couples to have sexual intercourse; however, women also should know that they have the right to decide whether or not to do so. Partners also should be advised about their important roles and responsibility for the women's health, including their reproductive health. Nurses should understand their role in addressing and helping patients deal with issues related to sexuality (Hughes, 2000).

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