Psychological Problems Experienced by Women with Gynecological Cancer and How They Cope with It: A Phenomenological Study in Turkey

Şengül Yaman and Sultan Ayaz

This study was carried out to reveal, in detail, the psychosocial problems faced by women in Turkey during their illness with gynecological cancer, and how they cope with these problems. The phenomenological approach used for the methodology is consistent with that described by Clark Moustakas's transcendental phenomenology. The sample included 17 married women. A semistructured, in-depth question directive was used to collect the data. The psychological problems found in the women in the study included frustration and despair, depression, inability to control anger, disruption in body image, and problems with their sex lives. The women in the study stated that, among other activities, they prayed frequently. They also emphasized that social support from family and others was important in coping. The majority said that they were able to cope through denial. Women under treatment for gynecological cancer should be evaluated from a psychosocial standpoint, and spiritual care and social support should be provided as they frequently use these to cope with their illness. It is recommended that a team be created, consisting of nurses, psychiatrists or psychologists, and religious staff to meet these needs.

KEY WORDS: *coping; gynecological cancers; phenomenological study; psychological problems*

Cancer is a frequent and sometimes fatal health problem, and one of the leading causes of disease worldwide. In 2012, the worldwide burden of cancer rose to an estimated 14 million new cases per year, a figure that is expected to rise to 22 million annually within the next two decades. Over the same period, cancer deaths are predicted to rise from an estimated 8.2 million to 13 million yearly (Stewart & Wild, 2015). Globally, in 2012, the most common cancers diagnosed were those of the lung (1.8 million cases, 13.0 percent of all cancers), breast (1.7 million, 11.9 percent), and colon or rectum (1.4 million, 9.7 percent) (Stewart & Wild, 2015). In 2012, there were an estimated 14.1 million new cases of cancer in the world, with 7.4 million (53 percent) among men and 6.7 million (47 percent) among women, giving a male to female ratio of 10 to nine (Ferlay, Soerjomataram, & Ervik, 2012). The world age-standardized incidence rate shows that there are 205 new cancer cases for every 100,000 men in the world, and 165 for every 100,000 women (Cancer Research UK, 2015).

In Turkey, there were an estimated 205.08 cases of cancer per 100,000 adults in 2012, with an estimated 147,964 cases in total (Cancer Research UK,

2015). According to the Turkish Ministry of Health, the overall incidence of cancer is 228.6 per 100,000, showing a decrease among men from 279 to 275 per 100,000 from 2007 to 2011. In the same period, the incidence increased to 182.2 from 165.1 per 100,000 among women. The same report indicated that approximately 159,000 people are diagnosed with cancer every year, and 62,000 of them are women (Republic of Turkey Ministry of Health, Institution of Public Health, 2015).

Gynecological cancer, a common type of cancer, is the uncontrolled growth and spreading of abnormal cells originating in the female reproductive organs, including the cervix, ovaries, uterus, fallopian tubes, vagina, and vulva (Foundation for Women's Cancer, 2015). Each gynecological cancer is unique, with different signs and symptoms, different risk factors, and different prevention strategies. All women are at risk for gynecological cancer, and the risk increases with age (Centers for Disease Control and Prevention [CDC], 2015). In 2015, it was estimated that 98,280 women would be diagnosed with gynecological cancer, and that some 30,440 would die from the disease in the United States (American Cancer Society, 2015). Recently the International

Agency for Research on Cancer compared cancer incidence and mortality between the more developed areas, defined by the United Nations to include all regions of Europe plus Northern America, Australia, New Zealand, and Japan, to less developed areas, including all regions of Africa, Asia (excluding Japan), Latin America and the Caribbean, Melanesia, Micronesia, and Polynesia (Torre et al., 2015). The distribution of the age-standardized incidence rates of cancer suffered by women in more developed areas were as follows: endometrial cancer at 14.7 per 100,000, cervical cancer at 9.9 per 100,000, and ovarian cancer at 9.1 per 100,000. The distribution of the age-standardized incidence rates of cancer suffered by women in less developed areas were as follows: cervical cancer at 15.7 per 100,000, endometrial cancer at 5.5 per 100,000, and ovarian cancer at 5.0 per 100,000 (Torre et al., 2015).

According to the Turkish Ministry of Health, gynecological cancer cases increased between 2007 and 2011; in 2007, a total of 1,394 gynecological cases were reported, while a total of 2,453 were reported in 2011 (Republic of Turkey Ministry of Health, Institution of Public Health, 2015). Moreover, the distribution of the age-standardized incidence rates of cancer suffered by women in Turkey were as follows: endometrial cancer is the fourth most common at 9.3 per 100,000, ovarian cancer is the seventh most common at 7.3 per 100,000, and cervical cancer is the ninth most common at 4.5 per 100,000 (Republic of Turkey Ministry of Health, Institution of Public Health, 2015). Ovarian and endometrial cancer incidence rates in Turkey are higher than those in less developed countries and lower than those in developed countries; the incidence rate of cervical cancer is lower (Republic of Turkey Ministry of Health, Institution of Public Health, 2015; Torre et al., 2015).

Treatment is most effective when gynecological cancers are found early (CDC, 2015). Despite improvements in surgery, chemotherapy, and targeted therapy, women with advanced ovarian cancer, which cannot be diagnosed early, face poor prognoses, with more than 50 percent of them dying within five years of diagnosis (Coleman et al., 2011). Gynecological cancer has many psychological effects on women's health. For example, treatment interventions for gynecological cancer have negative impacts on patients' body images, sexuality, fertility and family, and professional and social lives, and can reduce the overall quality of life (Pinar, Algier, Colak, &

Ayhan, 2008). A diagnosis of cancer can be psychologically and emotionally challenging, and the associated needs must be addressed appropriately. The proponents of universal screening note a high prevalence of distress, as well as options for the successful treatment of such distress when detected (Stafford & Miller, 2014). Cancer patients require emotional support and psychosocial adaptation to soothe their fears and concerns (Eyigor, 2010), and high levels of psychological distress have been reported by gynecological cancer survivors, even at five years postdiagnosis (Ashing-Giwa et al., 2009; Hobbs, 2008; Matulonis et al., 2008; Mirabeau-Beale et al., 2009). Thus, it is important to consider the impact that surviving cancer may have on an individual's well-being, to provide better services following the completion of primary medical treatment. One way of investigating this is to understand the unmet supportive care needs of the survivors (Urbaniec, Collins, Denson, & Whitford, 2011). The review study conducted by Dahl, Wittrup, Vaggemose, Petersen, and Blaakaer (2013) established that the most frequently reported unmet need was help in dealing and living with the fear of recurrence. Determining which women with gynecological cancer are at risk of negative psychological outcomes from their ailments and treatment would be helpful in developing approaches to facilitate their adaptation to the disease (Evcili & Bekar, 2013). Women should be provided with holistic care, including interventions, to ensure their psychosocial adaptations to cancer.

This study was carried out to reveal, in detail, the psychosocial problems faced by women in Turkey during their illness with gynecological cancer, and how they cope with these problems.

METHOD

Phenomenology as a methodological framework has evolved into a process that seeks reality in individuals' narratives of their lived experiences (Moustakas, 1994). Phenomenology incorporates transcendental, existential, and hermeneutic theories (Cilesiz, 2011). *Transcendental philosophy* examines the experience of going outside one's self, a view of the world from above (Langdridge, 2007). This study used the transcendental phenomenological framework developed by Edmund Husserl, who provided the basis for phenomenology (Moustakas, 1994). When researchers use transcendental phenomenology, they focus on creating deep and rich descriptions of the participants' lived experiences of a phenomenon. This approach

is less interpretive than other qualitative methods, because researchers consider descriptions of the phenomenon to be more important than their interpretations of the data (Moustakas, 1994). The goal is to reduce participants' descriptions to their essence, much like one would boil down liquids to create an intense, thick, rich, and flavorful sauce. Transcendental phenomenology is unique in that it has a specific strategy built into the analysis that helps researchers identify and set aside the biases, stereotypes, and preconceived notions of both the phenomenon and the participants (Moustakas, 1994).

The general purpose of the phenomenological study is to understand and describe a specific phenomenon in depth and get at the essence of participants' lived experience (Cilesiz, 2011). Phenomenological research investigates the lived experience of participants. It is important to clarify the term "lived experience" to present the scope of this study. The phenomenon in this case is women's experiences with gynecological cancer and the resulting psychosocial problems.

Data Sampling

A phenomenological framework requires a relatively homogenous group of participants (Creswell, 2007). Therefore, in a phenomenological study, participants should have experience with the same phenomenon. Individuals selected to participate in the phenomenological study should have significant and meaningful experiences with the phenomenon being investigated (Creswell, 2007; Moustakas, 1994). Purposeful sampling is commonly used in qualitative studies. Creswell explained that the purposeful sampling strategy involves the researcher selecting the participants purposively because they can understand the phenomenon; thus, the researcher can decide whether participants share a significant and meaningful experience concerning the phenomenon under investigation. In addition, criterion-based selection is commonly used as a sampling method. In this approach, the researcher should specify some common criteria for all participants to select a group of participants with shared experiences (Marshall & Rossman, 2011). The criteria for this study were that the women agreed to participate, were married, at least 18 years of age, literate, and applied to the gynecology service for chemotherapy. A total of 35 women initially showed interest. Nine women did not meet the inclusionary criteria for the study, and another five decided not to participate. Four of the

remaining 21 women could not complete the interviews because of feeling poorly about themselves. These women were referred to a psychologist who was a liaison in the gynecology service. Therefore, the final sample consisted of 17 women, eight of whom had ovarian cancer, six had cervical cancer, and three had endometrial cancer. All of the women had undergone operations because of their disease and were receiving chemotherapy during the study. The mean age of the women was 54.8 years, with 48 percent of the women being primary school graduates and 83.3 percent of them not working.

Measurement

The goal and role of the researcher is to get into the experience of the participants and see it as they see it. In this phenomenological study, the major data-gathering method involves primarily in-depth interviews with participants (Creswell, 2007). The purpose of a phenomenological interview is to describe the meaning of a phenomenon that several individuals share (Marshall & Rossman, 2011). Because psychosocial problems and coping mechanisms vary with individual cases, an in-depth analysis method was chosen to obtain varied and detailed information from each individual and to help understand the individual points of view.

A semistructured, in-depth question path was used to collect the data. The path consisted of 10 questions, such as "How would you describe your illness?" "What problems have you had so far in your treatment?" "How have you coped with your illness or the problems related to it?" and "Has your sex life been affected by your illness and the treatments applied?"

Moustakas (1994) suggested that phenomenological interviews could start with a social conversation to create a relaxing and trusting atmosphere. The interview took place in a special room with only the interviewee and two researchers present, and no other people were allowed to disturb the interview. One researcher conducted the interviews while the other took notes. The objective of the study was explained to the participating women before the interview, and their verbal and written approvals were obtained. Permission was also obtained to create audio recordings of the interviews. The interviewers conducted only one interview per day, the interviewing lasted a total of 32 days, and there was only one interview with each woman. The research was stopped when data saturation was

achieved and the data received from the women began to repeat. Each interview lasted 30 to 45 minutes. All interviews were conducted in Turkish.

Validity and Reliability

Validity of qualitative research refers to the trustworthiness of the data interpretation (Cilesiz, 2011). In a phenomenological study, researchers may take several measures to address validity. In this process, we asked the participants about their interview transcription to verify our understanding. For further validation of the data, we presented the detailed description of the study to enable readers to understand how the data were interpreted. Question path was submitted to the assessment of three experts who specialize in this field. Questions were examined by the experts in terms of understandability, fitness for purpose, and compatibility with the culture. For external validity of the study, the statements of the women that were believed to best explain the subject were quoted directly from the research findings. The voluntariness of participation is important in terms of the validity and reliability of research. For reliability of the study, one researcher conducted the interviews while the other took notes and observed the participants.

Ethical Consideration

In Turkey, ethics committees and review boards play important roles in protecting the rights of both experimental subjects in scientific research and patients in health care institutions. Researchers followed these procedures and obtained ethical approval from the Gazi University Ethics Committee; written consent was also obtained from the Gazi University Health Practice and Research Center. Each woman was informed about the purpose and course of research, and that she had the right to withdraw her consent to participate in the research at any time. The information was given in oral and written form. Then, informed consent was obtained from the women without any pressure. No woman was forced to participate in research. Moreover, women were provided with sufficient time to decide on their participation. No payment was provided to the women. During the research, taking into account the sensitivities of women, the word “cancer” was not used. The women were told that if they felt uncomfortable, they could end the interview any time they wished. The participating women were provided with training on coping

with their illness-related physical, psychological, and social problems.

Analysis

The phenomenological analysis starts with bracketing the researchers’ subjectivity, that is, clarifying their preconceptions. This process, also referred to as “epoché,” involves setting aside one’s prejudgments and predispositions toward the subject of study (Moustakas, 1994). The researchers began with writing a complete description of the phenomenon. Before starting the data analysis, researchers read their subjectivity statement, including the description of their own experience with the phenomenon. First, researchers looked at all data, as every statement has equal value. Some statements were judged to be irrelevant to the subject under investigation or were repetitive or overlapping. Then, the transcribed data were split into meaning units. Next, the researchers clustered and thematized the invariant constituents. In the next step, the themes derived from participants’ experiences were compared by observer notes. Then, the researchers explained the meaning units in a narrative format to facilitate the understanding of participants’ experiences. The researchers created the structures and added the structures at the end of each paragraph to create structural description. Finally, researchers wrote composite narratives from the observer’s perspective. This step is the synthesis of all the narratives for the group as a whole. The composite structural description was combined into the composite textural description to create a universal description of the phenomenon of the investigation (Moustakas, 1994). The study themes included psychological problems (frustration and despair, depression, inability to control anger, disruption in body image, and sexual problems) and coping with those problems (denial, praying, focusing on the pursuits of daily life, and social support from family and friends).

RESULTS AND DISCUSSION

Psychological Problems Experienced by the Patients

Cancer is one of the diseases most commonly accompanied by psychosocial problems (Ozyurt, 2007), and cancer patients may suffer, over the long term, from psychosocial disorders like fatigue, sleep disorders, cognitive and functional limitations, sexual dysfunctions, infertility, psychological problems, and psychiatric disorders (Brearley et al., 2011). The psychological problems found in the women in our

study included frustration and despair, depression, inability to control anger, disruption in body image, and problems with their sex lives.

Cancer diagnoses, treatment methods, and their implications may result in thoughts and feelings of frustration. The women participating in our study gave the following statements, which indicated that they had such feelings:

I will not get up. I am not going to do anything else, like my hands are broken. I don't know. I am worried. I always want to cry. I couldn't accept it, you cannot do it. But you suffer inevitably what you face. What can you do? There is no cure.

Evil disease; cancer, you see. A fatal disease. It is incurable.

Chemotherapy treatment is given for cancer. Cancer is a fatal disease. It ends with death. This is how I perceive it.

It has been found that patients perceive cancer as a diagnosis of death and feel helpless because they cannot do anything to prevent it. Studies suggest that cancer patients have frequent feelings of frustration and despair (Sand, Strang, & Milberg, 2008; Shim & Hahm, 2011). Individuals know that one day they will die, but they tend not to think about death in their daily lives. Sigmund Freud explained this as an individual's subconscious wish to live forever; however, for cancer patients, death is an unavoidable reality. Even if a patient's first treatment is successful, his or her life is now at constant risk, and thoughts of death are inescapable (Weis & Faller, 2012). Individuals' feelings of frustration and constant thoughts of death may result in depression, withdrawing from their lives, and even suicide (Rodin et al., 2007). Depression was one of the psychological problems reported by the women in our study:

It feels different. I cannot accept it. Believe me, I sometimes want to throw myself out of that window.

I feel embittered. I cannot eat. I don't want to see anyone. I don't accept any visitors. I always sleep. I close my eyes and pretend to be sleeping.

Women diagnosed with cancer may feel depressed due to body image changes, the emerging effects of the disease, prognoses of treatment, and feelings of loss. One study showed that 21.3 percent of the women diagnosed with cervical cancer suffered from depression, and that 6 percent of the women diagnosed with ovarian cancer had depressive symptoms (Wenzel et al., 2002). Depression may have a negative impact on patients' daily life and communication with their environment. For example, one study showed that women diagnosed with gynecological cancer who are also facing changes in their marriages, work, or financial statuses have a greater tendency toward depression (McCorkle, Tang, Greenwald, Holcombe, & Lavery, 2006). The patient's reduced energy, difficulty finding pleasure in living, and tendency to constantly sleep may negatively affect the other members of their family. These factors especially affect the harmony between spouses.

Sexuality is an important factor in marital harmony. It is a complex and subjective concept, and is an important part of individuals' biological, psychological, and social lives that nurtures personal development and increases the quality of life (Evcili & Bekar, 2013). In our study, all of the women stated that they did not have sexual relations. They said that they refrained from sexual intercourse because they feared being hurt: They believed that their spouses would not get any pleasure from it and that their spouses were not attracted to them anymore. These sentiments are expressed in the following statements:

It [sexual intercourse] never takes place. ... Never, for sure. ... I have wounds everywhere, how could it happen? He sees the wounds and he doesn't want it.

No sexual intercourse for five years. How can a cancer patient have sexual intercourse? A wound with blood like a river. How can you have sexual intercourse?

I have had no [sexual] relations for two years since I got diagnosed. ... I hold off from my husband as they [sexual organs] all are gone. ... Can I have sexual intercourse with my husband? Can he have pleasure?

I am embittered. I don't feel like anything. I have no hair, no eyebrows. What would my husband do with me? We are not doing anything now.

In general, women diagnosed with genital organ cancer experience changes in their sexual functions because of the treatments they receive (Mercadante, Vitrano, & Catania, 2010; Reis, Beji, & Coskun, 2010). In cancer patients, sexual interest may be lowered not only by cancer and its effects, but also by the fear of physical harm from sexual activity (Nusbaum, Hamilton, & Leanahan, 2003). Sexual problems may arise as a result of cancer-related anxiety and depression (Boyle & Levin, 2011). The majority of the women participating in our study stated that they were not informed about the effects of treatment on their sexuality; therefore, they believed that they would no longer have sex lives. In a study conducted in Turkey, it was found that chemotherapy treatments negatively affected sexuality in 55.9 percent of the women. After receiving the diagnosis of cancer, 52.9 percent of the women experienced no sexual intercourse at all (Akkuzu & Ayhan, 2013).

In a similar study, the women stated that they wanted to be ready to face the health problems they would have at home and in daily life after their cancer treatments. One of them stated, "I would rather have the first step taken by them [doctors or nurses] to discuss sexuality. They should address sexuality from the very beginning. Patients will hear them when they are ready" (Wilmoth, Hatmaker-Flanigan, LaLoggia, & Nixon, 2011). In a qualitative study, Stead, Fallowfield, Brown, and Selby (2001) found that most women with ovarian cancer thought that a health care professional should discuss sexual issues with them, or provide written information. In reality, none of the women interviewed received written information, and only two received brief verbal information (Stead et al., 2001).

For patients with gynecological cancer, body image may be affected due to the loss of female organs, physical changes and sexual problems as a result of the illness, and the treatments applied. Indeed, the women in our study suffered from the disruption of their body image. Body image reflects a psychological experience and is focused on a person's feelings and thoughts (Pruzinsky, 2004). It is likely that a woman with disrupted self-feelings and thoughts will pull away from the outside world and experience social isolation. The following are the

statements of women indicating that they experienced disruption in their body image:

I used to go out, take care of myself, buy clothes. Does it suit me? Does that suit me? I used to have my hair done. Nothing suits me now. I have an abdominal hernia here. No hair, no eyebrows. I buy nothing for myself. If I do, it is only for necessity.

I cannot go to the bathroom alone. . . . I don't know why. . . . Do I fear? Is it because I am bald? I cannot look at a mirror. . . . Maybe I will go to the bathroom easier if my hair gets better.

Patients' Methods for Coping with Problems

Cancer patients usually face questions like Why me? What have I done to deserve this and to live with it? Is God punishing me? What will happen to me after death? How will my family live after I disappear? Will my absence make a difference? Will they remember me? Will I have time to complete the things I have left undone? These patients are challenged by changes and by trying to give new meaning to their lives (Hallac & Oz, 2011). The women in our study stated that, among other activities, they prayed frequently. They also emphasized that social support from family and friends was important in coping with cancer. The majority said that they were able to cope through "denial."

Studies on the effects of spirituality on cancer patients indicate that spirituality has a positive impact on mental health during cancer (Bostanci & Buzlu, 2010). Praying was the most frequent coping method for the women in our study. The following are the statements of the women on this matter:

I pray and always sleep.

I always read the Qur'an and pray. I say "Oh, Allah, please help me."

I have great spiritual feelings. I believe there will be a reward for this. I resort to Allah and console myself.

Studies have shown that spirituality plays an important role in coping with life-threatening diseases

like cancer, and that it is effective in maintaining the quality of life and wellness by creating feelings of peace, faith, and trust (Culliford, 2002; Wenzel et al., 2002). In a study by Camperson (2009), the participants stated that their spirituality helped in their adaptation to the diagnosis of gynecological cancer. In one study of women who had completed their treatments after the diagnosis of breast cancer or gynecological cancer, religion was shown to be a primary mechanism for coping with the illness (Lauver, Connolly-Nelson, & Vang, 2007). The majority of Turkish society is Muslim, and in Islam the belief in destiny (the eternal determination believed to have prearranged all events in an unchangeable manner) plays an important role for patients coping with health problems. Therefore, worshiping is an important way for patients to cope with cancer and feel closer to God. However, spiritual care is not a part of the health care system in Turkey, and the religious staff at hospitals only deal with funeral arrangements.

Focusing on the pursuits of daily life is another method used by cancer patients to postpone the thoughts of cancer and death. The women in our study stated that they cheered themselves up by reading books, shopping, and traveling. A similar study showed that the women coped with illness by being engaging in their lives; one described this approach by saying, "Short or long . . . this is my life as a cancer patient. I can still enjoy what I do. I noticed that I wouldn't think of cancer when I was busy with things" (Pilkington & Mitchell, 2004).

Dealing with daily pursuits is an effective way for women to cope, and it is important for preventing social isolation and a detachment from life. The support of the family and a patient's social circle is required during daily activities. For example, the majority of the women talked about the effects of social support from the family and others in coping with cancer:

I get support from my children, my family. I feel relieved when I am with my grandchildren, I forget it. . . . My husband, children, grandchildren are always with me.

I talked to a friend. "Don't be afraid or sad, we got well, you will too," she said. "Your hair will come back, relax." I didn't know how to get rid

of this trouble, but my friend always helped me in this matter.

The reactions of family and friends (regarded as important social support resources) to the physical changes experienced by women during the chemotherapy process helped them cope with body image disruptions and psychological problems. A woman in a study by Sekse, Raaheim, Blaaka, and Gjengedal (2012) explained this: "It is very important to have a supporting family . . . I am grateful for their support. They always stand by me."

During their treatment processes, women with cancer use methods such as worshiping, various daily activities, and support from family and friends to cope with their illness. They even rely on simple denial. Everyone knows they will die one day, but people do not spend their daily lives thinking about death. This phenomenon was explained by Sigmund Freud as the individual's subconscious wish to live forever (Weis & Faller, 2012). A study of cancer patients' emotional reactions postdiagnosis by Ozbek, Ozsenol, Oysul, Beyzadeoglu, and Pak (2003) showed that 58.5 percent of newly diagnosed people did not believe that they had cancer. Some of the women in our study did not use the word "cancer" during their interviews and spoke as if they did not know they had cancer. We used the words "your illness" and "your treatment" with these patients.

I never care about the illness. I never mind. I don't accept the illness. I try to inspire confidence in myself by saying, "I am not ill, I am good" . . . I cannot associate myself with it.

I don't like being with cancer patients. They talk about the illness, which makes me sad . . . I get sad. . . . I just get away from there. . . . I don't use the word "chemotherapy." I don't like it. I feel very bad. . . . I call it medicine. . . . I don't use the name of this illness.

The denial of reality is a defense against the feelings of fear, panic, and frustration created by a reality that is difficult or impossible to bear. In a sense, the patient protects himself or herself from unbearable concern by denying the reality of their situation (Ozkan, 2010). Women with cancer may use denial as a coping mechanism; sometimes, they maintain this denial until the moment of death.

CONCLUSION

This qualitative study was conducted in only one hospital, in Ankara in Turkey, with only 17 women, so generalizability is limited. Our study found that women with gynecological cancer experience psychological problems, such as frustration and despair, depression, lack of anger control, disruption in body image, and abstention from sexual life, and that they use methods like worshiping, various daily activities, support from family and friends, and even denial to cope with these problems. The results of our study indicate that women who live in Turkey experience psychological problems consistent with the literature, and that they use coping strategies that are similar to those of their counterparts in other countries. Women under treatment for gynecological cancer should be evaluated from a psychosocial standpoint, and spiritual care and social support should be provided as they frequently use these to cope with their illnesses. It is recommended that a team be created, consisting of nurses, psychiatrists or psychologists, and religious staff, to provide for these needs. **HSW**

REFERENCES

- Akkuzu, G., & Ayhan, A. (2013). Sexual functions of Turkish women with gynecologic cancer during the chemotherapy process. *Asian Pacific Journal of Cancer Prevention*, 14, 3561–3564.
- American Cancer Society. (2015). *Cancer facts and figures 2015*. Retrieved from <http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-044552.pdf>
- Ashing-Giwa, K. T., Tejero, J. S., Kim, J., Padilla, G. V., Kagawa-Singer, M., Tucker, M. B., & Lim, J. W. (2009). Cervical cancer survivorship in a population based sample. *Gynecologic Oncology*, 112, 358–364.
- Bostanci, N. D., & Buzlu, S. (2010). The effects of spirituality in breast cancer patients and spiritual care. *e-Journal of Nursing Science & Art*, 1, 73–78.
- Boyle, P., & Levin, B. (2011). *IARC World Cancer Report 2008*. Lyon: International Agency for Research on Cancer.
- Brearley, S. G., Stamatakis, Z., Addington-Hall, J., Foster, C., Hodges, L., Jarrett, N., et al. (2011). The physical and practical problems experienced by cancer survivors: A rapid review and synthesis of the literature. *European Journal of Oncology Nursing*, 15, 204–212.
- Camperson, C. (2009). *Women's emotional experiences with gynecological oncology*. Arlington: University of Texas at Arlington.
- Cancer Research UK. (2015). *Worldwide cancer incidence statistics*. Retrieved from <http://www.cancerresearchuk.org/cancer-info/cancerstats/world/incidence/#source1>
- Centers for Disease Control and Prevention. (2015). *Gynecologic cancers*. Retrieved from http://www.cdc.gov/cancer/gynecologic/basic_info/what-is-gynecologic-cancer.htm
- Cilesiz, S. (2011). A phenomenological approach to experiences with technology: Current state, promise, and future directions for research. *Educational Technology Research and Development*, 59, 487–510. doi:10.1007/s11423-010-9173-2
- Coleman, M. P., Forman, D., Bryant, H., Butler, J., Rachet, B., Maringe, C., et al. (2011). Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): An analysis of population-based cancer registry data. *Lancet*, 377, 127–138.
- Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Culliford, L. (2002). Spirituality and clinical care. *BMJ*, 325, 1434–1435.
- Dahl, L., Wittrup, I., Vaggemose, U., Petersen, L. K., & Blaakaer, J. (2013). Life after gynecologic cancer: VA review of patients quality of life, needs, and preferences in regard to follow-up. *International Journal of Gynecological Cancer*, 23, 227–234.
- Evçili, F., & Bekar, M. (2013). The psychosocial aspects of getting gynecological cancer diagnosis and nursing approaches. *Turkish Journal of Gynecologic Oncology*, 1, 21–28.
- Eyigor, S. (2010). Physical activity and rehabilitation programs should be recommended on palliative care for patients with cancer. *Journal of Palliative Medicine*, 13, 1183–1184.
- Ferlay, J., Soerjomataram, I., & Ervik, M. (2012). *Cancer incidence and mortality worldwide: IARC CancerBase No. 11*. Retrieved from <http://globocan.iarc.fr>
- Foundation for Women's Cancer. (2015). *About gynecologic cancers*. Retrieved from <http://www.foundationforwomenscancer.org/about-gynecologic-cancers/>
- Hallac, S., & Oz, F. (2011). Existential anxiety in diagnostic process of genital cancer. *Current Approaches in Psychiatry*, 3, 595–610.
- Hobbs, K. (2008). Psychosocial distress and cervical cancer. *Cancer Forum*, 32, 89–92.
- Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Harlow, Essex, England: Pearson Education.
- Lauver, D. R., Connolly-Nelson, K., & Vang, P. (2007). Stressors and coping strategies among female cancer survivors after treatments. *Cancer Nursing*, 30, 101–111.
- Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research* (5th ed.). Thousand Oaks, CA: Sage Publications.
- Matulonis, U. A., Kornblith, A., Lee, H., Bryan, J., Gibson, C., Wells, C., & Penson, R. (2008). Long-term adjustment of early-stage ovarian cancer survivors. *International Journal of Gynecological Cancer*, 18, 1183–1193.
- McCorkle, R., Tang, S. T., Greenwald, H., Holcombe, G., & Lavery, M. (2006). Factors related to depressive symptoms among long-term survivors of cervical cancer. *Health Care for Women International*, 27, 45–58.
- Mercadante, S., Vitrano, V., & Catania, V. (2010). Sexual issues in early and late stage cancer: A review. *Supportive Care in Cancer*, 18, 659–665.
- Mirabeau-Beale, K. L., Kornblith, A. B., Penson, R. T., Lee, H., Goodman, A., Campos, S. M., & Matulonis, U. A. (2009). Comparison of quality of life of early and advanced stage ovarian cancer survivors. *Gynecologic Oncology*, 114, 353–359.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.
- Nusbaum, M.R.H., Hamilton, C., & Leanahan, P. (2003). Chronic illness and sexual functioning. *American Family Physician*, 67, 347–354.
- Ozbek, O., Ozsenol, F., Oysul, K., Beyzadeoglu, M., & Pak, Y. (2003). Psychosocial analysis of patients undergoing radiotherapy. *Türkiye Klinikleri Journal of Medical Sciences*, 23, 189–194.

- Ozkan, S. (2010). Psychiatric and psychosocial support to colorectal cancer patients. In A. Baykan & A. Zorluoglu (Eds.), *Colon and rectal cancers*. Istanbul: Turkish Society of Colon and Rectal Surgery.
- Ozyurt, B. E. (2007). A descriptive study about social support perceived by cancer patients. *Kriz Dergisi (Journal of Crisis)*, 15, 1–15.
- Pilkington, F. B., & Mitchell, G. J. (2004). Quality of life for women living with a gynecologic cancer. *Nursing Science Quarterly*, 17, 147–155.
- Pinar, G., Algier, L., Colak, M., & Ayhan, A. (2008). Quality of life in patients with gynecologic cancer. *International Journal of Hematology and Oncology*, 3, 141–149.
- Pruzinsky, T. (2004). Enhancing quality of life in medical populations: A vision for body image assessment and rehabilitation as standards of care. *Body Image*, 1, 74–84.
- Reis, N., Beji, N. K., & Coskun, A. (2010). Quality of life and sexual functioning in gynecological cancer patients: Results from quantitative and qualitative data. *European Journal of Oncology Nursing*, 14, 137–146.
- Republic of Turkey Ministry of Health, Institution of Public Health. (2015). *Türkiye kanser istatistikleri [Turkish cancer statistics]*. Retrieved from <http://kanser.gov.tr/Dosya/kayitcilik/2011Caistatistikleri.pdf>
- Rodin, G., Zimmermann, C., Rydall, A., Jones, J., Shepherd, F. A., Moore, M., et al. (2007). The desire for hastened death in patients with metastatic cancer. *Journal of Pain and Symptom Management*, 33, 661–675.
- Sand, L., Strang, P., & Milberg, A. (2008). Dying cancer patients' experiences of powerlessness and helplessness. *Supportive Care in Cancer*, 16, 853–862.
- Sekse, R. J. T., Raaheim, M., Blaaka, G., & Gjengedal, E. (2012). Living through gynaecological cancer: Three typologies. *Journal of Clinical Nursing*, 21, 2626–2635.
- Shim, E. J., & Hahm, B. J. (2011). Anxiety, helplessness/hopelessness and 'desire for hastened death' in Korean cancer patients. *European Journal of Cancer Care*, 20, 395–402.
- Stafford, L., & Miller, B. (2014). Should every woman with gynecologic cancer undergo routine screening for psychological distress and sexual dysfunction? In J. A. Ledermann, C. L. Creutzberg, & M. A. Quinn (Eds.), *Controversies in the management of gynecological cancers*. London: Springer.
- Stead, M. L., Fallowfield, L., Brown, J. M., & Selby, P. (2001). Communication about sexual problems and sexual concerns in ovarian cancer: Qualitative study. *BMJ*, 323, 836–837.
- Stewart, B. W., & Wild, C. P. (2015). *World Cancer Report 2014*. Geneva: WHO Press.
- Torre, L. A., Bray, F., Siegel, R. L., Ferlay, J., Lortet-Tieulent, J., & Jemal, A. (2015). Global cancer statistics, 2012. *CA: A Cancer Journal for Clinicians*, 65, 87–108.
- Urbaniec, O. A., Collins, K., Denson, L. A., & Whitford, H. S. (2011). Gynecological cancer survivors: Assessment of psychological distress and unmet supportive care needs. *Journal of Psychosocial Oncology*, 29, 534–551.
- Weis, J., & Faller, H. (2012). Psychosoziale Folgen bei langzeitüberlebenden einer Krebserkrankung [Psychosocial consequences of long-term survivors of cancer]. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz*, 55, 501–508.
- Wenzel, L. B., Donnelly, J. P., Fowler, J. M., Habbal, R., Taylor, T. H., Aziz, N., et al. (2002). Resilience, reflection, and residual stress in ovarian cancer survivorship: A gynecologic oncology group study. *Psychooncology*, 11, 142–153.

Wilmoth, M. C., Hatmaker-Flanigan, E., LaLoggia, V., & Nixon, T. (2011). Ovarian cancer survivors: Qualitative analysis of the symptom of sexuality. *Oncology Nursing Forum*, 38, 699–708.

Şengül Yaman, PhD, is an instructor and **Sultan Ayaz, PhD**, is associate professor, Nursing Department, Faculty of Health Sciences, Gazi University, Ankara, Turkey. Address correspondence to Şengül Yaman, Nursing Department, Faculty of Health Sciences, Gazi University, Ankara, Turkey; e-mail: yamans@gazi.edu.tr. There are no conflicts of interest in connection with this article. The authors alone are responsible for its content and writing. The authors thank Mrs. Safiye Karakuzulu Doğrusoy for invitation of the participants.

Original manuscript received April 1, 2015

Final revision received September 3, 2015

Accepted September 8, 2015

Advance Access Publication June 1, 2016

PRACTICE FORUM

Have you worked with a practice innovation readers should know about? The Practice Forum editor can help you develop your insights into an article for this column. Describe your innovation in eight double-spaced pages or fewer and send as a Word document through the online portal at <http://hsw.msubmit.net> (initial, one-time registration is required).