Published in final edited form as:

Patient Educ Couns. 2019 March ; 102(3): 436–442. doi:10.1016/j.pec.2018.10.003.

Patient-Clinician Communication about Sexual Health in Breast Cancer: A Mixed-Methods Analysis of Clinic Dialogue

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Abstract

Objectives: Breast cancer patients' sexual health needs are frequently unmet. We examined the prevalence and content of communication about sexual health between breast cancer patients and clinicians.

Methods: Female breast cancer patients being seen in oncology clinic follow-up had a clinic visit audio recorded and self-reported sexual problems after the visit. Transcripts were coded for sexual health communication; data were analyzed descriptively or using Chi-square tests.

Results: We recorded 67 patients (81% participation rate) interacting with one of 7 cancer clinicians (5 physicians; 2 advanced practice clinicians). Approximately 1/3 of women (n = 22) reported sexual problems; sexual health communication occurred with 10/22 of those women (45%). Across all 67 patients, 27 (40%) visits contained communication about sexual health. Seventy-percent of sexual health communication was clinician-initiated. When in-depth sexual health discussions occurred, the most common topics discussed were sexual inactivity (6), body image (5), vaginal dryness (4), and safety of sexual activity (2).

Conclusion: Communication about sexual health was uncommon even for women reporting sexual problems and was largely initiated by clinicians.

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Declarations of Interest: none.

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Practice Implications: Because women with breast cancer often do not raise sexual concerns during clinic visits, breast cancer clinicians should raise the topic of sexual health for all patients.

Keywords

Patient-provider communication; Sexual Health; Breast Cancer; Dialogue Analysis

1. Introduction

Sexual health is a major concern for women living with breast cancer [1, 2]. At least half of women with breast cancer report sexual problems, and these problems tend to persist over time even after other clinical issues resolve, leading to the potential for long-term negative consequences for individual and relationship well-being [3–6]. Sexual problems that women experience after a breast cancer diagnosis can occur throughout the cancer trajectory and across different stages of disease [7–9]. As examples, women who are currently undergoing chemotherapy may avoid sexual activity due to concerns that it is not safe, women who are post-surgery may encounter negative feelings as they adjust to changes in the appearance of their breasts [10], and women who have completed their curative treatments (chemotherapy, surgery, radiation) may experience difficulties in resuming a sexual relationship due to longer-term sexual side effects such as loss of interest in sex and vaginal dryness related to chemotherapy-induced menopause and/or hormonal therapy use [11].

Although practice guidelines include discussion of sexual health for women who have been treated for breast cancer [12–14], most breast cancer patients do not report having such discussions with their cancer clinicians [15–17]. For example, a 2012 study examined breast cancer patients' experiences communicating with cancer clinicians about sex during and after treatment [17]; the vast majority (75%) reported that it was important to discuss treatment-related sexual problems with clinicians, yet only 33% reported ever receiving such information. Communication about sexual health is hampered by both patient and clinician barriers, including time pressures, inadequate training and embarrassment or discomfort in discussing sex [15, 16, 18, 19]. Yet sexual health is an important dimension of quality of life that most women with breast cancer want to discuss [2, 20].

Major gaps persist in knowledge with regard to patient-clinician communication about sexual health in breast cancer. Few studies have examined the extent to which discussions of sexual health occur and how such discussions occur. The primary objectives of this study were (1) to examine the extent to which communication about women's sexual health occurs during routine follow-up appointments for breast cancer (i.e., prevalence), overall, and among women who reported versus did not report sexual problems and (2) to explore the content of this communication when it occurs, including who would initiate sexual health communication and what topics would be discussed.

2. Methods

2.1. Study Design and Setting

Data for this study were collected as part of a baseline assessment prior to the development and implementation of a clinician educational intervention focused on communicating with patients about sexual health in the context of breast cancer care. The study setting was a standalone comprehensive cancer center located in an urban setting.

2.2 Study Sample

Participants in the study consisted of breast cancer clinicians and patients. The study was approved by the Institutional Review Board at Fox Chase Cancer Center (IRB Protocol #14–833). All participants completed written consent which included audio recording of clinic visits.

2.2.1. Clinician participants—Breast cancer clinicians within medical oncology clinics (e.g., physicians or advanced practice clinicians) at Fox Chase Cancer Center were approached to participate in a study pilot testing a clinician communication training intervention focused on sexual health and quality of life. Clinicians were reimbursed \$200 for their time completing baseline assessments and audio recording visits.

2.2.2. Patient participants—Women were eligible if they had a diagnosis of any stage breast cancer and were patients of participating clinicians, if they were being seen in follow-up (i.e., had attended at least a consultation visit previously) and if they were either receiving treatment for breast cancer or had completed treatment within 10 years. Women were ineligible if they were unable to speak English, had poor physical performance (Eastern Cooperative Group Score (ECOG) [21] score > 2 signifying patients were incapable of most self-care or work-related tasks, and were up and about less than half the time), or if they evidenced significant psychiatric or cognitive concerns.

Patients were identified through clinicians' schedules, pre-screened for eligibility using their medical records, and approached by a study recruiter in-person in the oncology clinic with clinicians' approval. Patients were asked to participate in the study because their clinician was participating in a study testing a program focusing on communication about quality of life and health-related topics. Sexual health was not mentioned to avoid sensitizing patients to the topic of sexual health. Third parties (e.g., spouse, family member) who were present during the clinic visit gave consent to be audio recorded and were given no instructions regarding their communication during the clinic visit. Patients were given a \$10 gift card for participating.

2.3. Data collection

2.3.1. Audio recording data—Two audio recorders were placed in different locations in the room immediately prior to the clinic visit to capture all dialogue.

2.3.2. Patient-reported data—Immediately after the clinic visit, patients completed a questionnaire assessing sociodemographic characteristics and a sexual problems item from

the Patient Care Monitor (PCM) [22] which assesses problems with sexual interest, enjoyment, or performance over the past week with response options ranging from 0 (*not a problem*) to 10 (*as bad as possible*). This item has been found to be a reliable and valid indicator of sexual problems in several cancer populations [5, 23, 24].

2.3.3. Additional data—Medical data pertaining to patients' cancer stage, menopausal status, and types of treatments received were obtained through chart review, with patients' permission. Clinicians completed brief self-report surveys immediately after consent assessing demographic and practice characteristics.

2.4. Data Analysis

2.4.1 Dialogue coding—All audio recordings were transcribed and coded for sexual health communication using two levels. First, two study staff members determined the absence or presence of any sexual health communication, defined broadly as containing at least one mention of sexual health (e.g., safety of sexual activity), function (e.g., vaginal dryness, low libido), activity (status as sexually active), relationships (e.g., in an intimate relationship), or any body image or appearance changes related to sex or relationships. Questions about coding were resolved through discussion with senior coders (JBR, MCB). All transcripts were double-coded for quality assurance at this stage of analysis. Then, two senior researchers (JBR, MCB) individually read, identified and coded all dialogue separately for important themes and concepts. JBR and MCB then discussed each transcript in detail to arrive at a final list of higher-level codes which were then applied to the transcripts and entered into SPSS to facilitate quantitative analyses. Codes included who initiated the communication, how sexual health communication was raised, the patient's response (e.g. indication or denial of need for a discussion by confirming or denying a sexual problem), whether an in-depth discussion occurred (defined as occurring when there was back-and-forth in the dialogue between the patient and clinician), and the topic(s) discussed. The qualitative methods were informed by thematic analysis [25]. Disagreements were resolved through discussion.

2.4.2 Quantitative Analyses—Recruitment information, socio-demographic, and medical characteristics of the study sample and the scores on the sexual problems item were characterized using descriptive statistics. The prevalence of sexual health communication (using the code of any communication versus no communication) was explored using descriptive statistics. Women who had versus did not have any sexual health communication during their clinic visit were compared on whether they reported sexual problems, as determined by a score of 0 vs. > 0 using Chi-Square tests. Clinician practice patterns were explored by calculating the percent of clinic visits per clinician containing any sexual health communication.

3. Results

3.1. Clinician Characteristics

Seven of eight eligible clinicians who were approached about the study agreed to participate (88% participation rate); one refused due to personal reasons/time. Of the seven clinicians

who participated, 5 were medical oncologists, 1 was a nurse practitioner, and 1 was a physician assistant. Five of the clinicians were white and 2 were Asian. Four clinicians were female, and the same number had fewer than 5 years in practice, whereas 1 had 5–10 years in practice, and 2 had > 15 years in practice. The number of visits per clinician ranged from 4 to 15, with a mean of 9.6 visits per clinician (SD = 4.6).

3.2. Patient Characteristics and Sexual Problems

Of the 84 women approached about the study, one was ineligible (not speaking English) and 16 refused, leaving 67 women who consented and had their clinic visits audio recorded (81% participation rate). The most common reasons for refusal were not wanting to be recorded ($n = 5$) and not being interested ($n = 3$). Patient participant characteristics are shown in Table 1. The patient sample was predominantly white, married/partnered, and college-educated. The majority of the sample was diagnosed with non-metastatic cancer and was post-treatment, and most had received surgery, chemotherapy, and radiation and were on hormone therapy. Approximately one third ($n = 22$; 34%) reported sexual problems, and the mean score on this item was 1.8 (SD = 3.1).

3.3. Prevalence of Sexual Health Communication

Across the 67 audio recorded clinic visits, sexual health communication occurred in 27 visits (40.2%), which were subject to further analysis. As shown at the top of **Figure 1**, of the 22 visits with women reporting sexual problems, 10 visits (45%) contained sexual health communication whereas the remaining visits for women reporting sexual problems (12/22; 55%) did not have sexual health communication. Of the 45 visits with women not reporting sexual problems, 17 (38%) contained sexual health communication whereas 28 (62%) did not. Women reporting sexual problems were no more likely to have sexual health communication in their visit as those not reporting sexual problems, $\chi^2 = .41$ ($p = .52$).¹ The percentage of sexual health discussions relative to the total number of visits per clinician ranged from 13.3% to 100%, with a mean of 42.7% (SD = 27.8) and a median of 37.5%.

3.4. Nature of Sexual Health Communication

3.4.1. Overview—As shown at the bottom of **Figure 1**, for 10 women reporting sexual problems, an in-depth sexual health discussion occurred in eight of these visits, whereas in two clinic visits, the clinician initiated communication about sexual health and the patient denied a concern. For women not reporting sexual problems, in 8 visits, the clinician initiated sexual health communication and the patient did not indicate the need for a discussion; in 9 visits, a sexual health discussion occurred, either because the patient responded with anything other than outright denial of a concern, or because the patient (or third) party raised the topic and drove the discussion.

¹Exploratory Chi-square analyses of rates of sexual health communication by current treatment status or age revealed no differences. Nineteen of 44 women off-treatment (43%) and 8 of 23 women on-treatment (35%) had sexual health communication ($p = .51$); 19 of 46 older women (41%) and 8 of 21 younger women (38%) had sexual health communication ($p = .08$).

3.4.2. Sexual Health Communication among Patients Reporting Sexual Problems—The prevalence of sexual health communication for women who reported sexual problems is shown in **Figure 1**.

3.4.2.1. Visits with No In-Depth Discussion of Sexual Health: There were two visits with women reporting sexual problems who had sexual health communication but no in-depth discussion (**Table 2a**). In these two visits, the clinician initiated sexual health communication by asking about vaginal dryness and offering anticipatory guidance in the form of normalizing statements (i.e., “That can sometimes happen”). In both cases, the patients indicated no need for further discussion by denying vaginal dryness outright: no further discussion ensued. Both patients had a sexual problems score of 1.

3.4.2.2. Visits with an In-Depth Discussion of Sexual Health: There were eight clinic visits with women reporting sexual problems who had in-depth discussions (**Table 2b**). In these discussions, patients gave an affirmative indication of a problem in response to a clinician’s query or raised the issue themselves, and a discussion ensued. The clinician or patient each initiated the discussion in 4 (50%) encounters, respectively. When the clinician initiated the discussion, they twice explicitly referred to vaginal dryness (once by asking about vaginal dryness as a potential new symptom, and once by referring to a gynecologist’s note pertaining to the patient’s established vaginal dryness). In the other two visits, the clinician asked about the patient’s relationship and subsequently about whether they were “intimate.” When the patient initiated the discussion, this was done twice by mentioning negative feelings about breast appearance post-surgery. In one visit, a patient initiated the discussion by referring to an established problem of vaginal dryness, and the potential use of a hormonal treatment for this discomfort. Finally, in one visit, the patient initiated the discussion on behalf of her husband, which pertained to whether sexual activity was safe in the setting of chemotherapy. Across these discussions, the most commonly discussed topic was vaginal dryness (n = 3), followed by body image/breast appearance (n = 2), sexual inactivity (n = 2), and the safety of sexual activity (n = 1).

3.4.3. Discussions among Patients Not Reporting Sexual Problems—The prevalence of sexual health communication for women not reporting sexual problems is shown in **Figure 1**.

3.4.3.1. Visits with No In-Depth Discussion of Sexual Health: As shown in **Table 3a**, there were eight clinic visits with women who did not report sexual problems in which sexual health communication was initiated by the clinician, and no further discussion ensued. In five of the visits, the clinician raised the topic by asking about sexual concerns either with or without anticipatory guidance/normalizing statements, or by asking about the patient’s intimate relationship, and the patient denied any concerns outright, thus indicating no need for further discussion. In two visits, the clinician initiated communication about sexual health twice within a single visit, first when asking about the patient’s reaction to her breast appearance, and then later when providing anticipatory counseling about sexual side effects of hormonal therapy; both patients indicated no need for further discussion.² In two visits, the clinician asked the patient’s relationship status, the patient indicated she was not

in a relationship and (in contrast to the woman above in which a discussion ensued about wanting to be in a relationship) indicated that sexual health was of low priority. In one visit, the clinician asked the patient about her “intimate life,” and the patient indicated that sex was not a priority by laughing and responding, “I can’t even walk.”

3.4.3.2. Visits with an In-Depth Discussion of Sexual Health: There were nine clinic visits with women *not* reporting sexual problems who nevertheless engaged in an in-depth discussion of sexual health with their clinicians (see **Table 3b**). The clinician initiated the sexual health communication in 5 of these visits (56%), whereas the patient initiated the discussion in 3 visits and the patient’s husband initiated the discussion in 1 visit. As shown in **Table 3b**, when the clinician initiated sexual health communication, in three visits, they did so by asking about the patient’s relationship with her spouse or about whether the patient was sexually active. In two of those visits, the patient went on to talk about being in a relationship that no longer included sexual activity, whereas one of the patients denied being in any relationship at all but indicated a desire for such a relationship. In one visit, the clinician asked about vaginal dryness, with the implication that this had been a long-standing issue. In the other visit, the clinician asked whether the patient was happy about the cosmetic result of her surgery. In two visits, the patient initiated the sexual health discussion by bringing up negative feelings about the appearance of her breasts. In one visit, when told about a research study having to do with intimacy, the patient responded to this by stating that “there is no intimacy at my house,” thereby raising the topic of sexuality by indicating a lack of sexual activity in her relationship. Finally, in one visit, the husband initiated the discussion by asking whether sexual activity was safe while his wife was on chemotherapy. Within these discussions, the most commonly discussed topics were body image/breast appearance ($n = 3$), sexual inactivity ($n = 3$), vaginal dryness ($n = 1$), safety of sexual activity ($n = 1$), and lack of a partnered relationship ($n = 1$).

4. Discussion and Conclusion

4.1. Discussion

To our knowledge, this is the first study to examine the prevalence and nature of patient-clinician communication about sexual health for breast cancer outpatients through clinic dialogue analysis. Findings demonstrated that sexual health communication occurred in fewer than half of all clinic visits with breast cancer patients. Even more striking, more than half of the patients reporting sexual problems on a self-report survey item did not have sexual health communication occur during their clinic visits, indicating a substantial missed opportunity for discussions of sexual health. Given that sexual problems tend to persist if untreated [1, 26, 27], missed opportunities for communication about sexual health could lead to patients’ sexual problems going unidentified and untreated. Taken alongside findings of prior studies [15, 16], the results suggest substantial room for improvement in clinical communication about sexual health for breast cancer patients.

²There were three other clinic visits in which communication about sexual health was split up by time. All three of these instances included an in-depth discussion, twice about vaginal dryness, and once about a lack of intimate relationship. Because the discussions continued about the same topic after the break in time, these are described in the manuscript as single discussions rather than as multiple discussions.

Interesting discrepancies were seen in patients' endorsement of sexual problems on a written self-report item versus during the clinic visit with their clinician. For instance, nine women who did *not* report having sexual problems nevertheless engaged in relatively in-depth discussions of sexual health with their clinicians. It is possible that these women were experiencing sexual problems not captured by the screener (e.g., concerns about whether sexual activity was safe). Alternatively, two women reported mild sexual problems on the self-report item (i.e., scores of 1 on 0–10 scale) yet denied having sexual problems when asked by their clinicians, either because their sexual problems were not bothersome enough to warrant discussion, or because they were asked about vaginal dryness but experienced other problems (e.g., interest in sex). These discrepancies suggest the importance of using direct, clear, and explicit language and broad, inclusive items in assessing patients' sexual problems [28, 29]. They also suggest that complex, multi-method and mixed method designs are likely needed to adequately characterize clinical communication about sexual health.

One of the most common topics of the in-depth sexual health discussions that occurred – both for women reporting and not reporting sexual problems – was sexual inactivity. For most women, the reason for the sexual inactivity was unclear. Sexual inactivity is extremely common for breast cancer survivors [30], and for some, specific sexual problems (e.g., discomfort during sex) directly contribute to sexual inactivity [31]. Sexual inactivity could also be due, however, to long-standing sexual or body image problems predating the cancer diagnosis, to partner sexual problems (e.g., erectile dysfunction), or to other factors (e.g., stress). Thus, clinicians must clarify potential causes of sexual inactivity and determine whether patients wish to address this issue. Other commonly discussed topics were vaginal dryness and body image concerns. Interestingly, these topics were those most often raised by patients. As a physical type of concern, vaginal dryness may be perceived as less sensitive compared to emotional concerns, and clinicians and patients may feel more comfortable raising it for this reason. Body image concerns were often raised in the context of the breast exam, during which discussions of breast healing and appearance are common. Encouragingly, many of the topics discussed were consistent with breast cancer patients' preferences as reported in prior qualitative studies [18].

The current study had several limitations. The sample sizes of patients and clinicians were relatively small and the data were collected in the context of a comprehensive cancer center. Future studies could use multi-site designs with larger samples and different types of sites to examine whether the communication patterns would replicate across different settings. It will also be important to examine the role of clinician and patient factors (e.g., gender or race concordance/discordance) and of contextual factors (e.g., third parties in the room) in influencing the prevalence or nature of patient-clinician communication about sexual concerns. In addition, with a greater number of in-depth sexual health discussions, it would be possible to examine communication across the entire interaction, such as by analyzing topics that lead up to and follow the sexual health discussion. Moreover, to limit patient burden during potentially stressful consult visits, we examined patient-clinician communication about sexual health at follow-up appointments, yet an understanding how potential sexual side effects of breast cancer treatments are discussed during initial consult visits is also critical. We obtained clinicians' approval prior to approaching patients, in case certain clinical concerns (e.g., new scans showing disease progression) would make it

inappropriate for us to approach a patient. This was important given that women with advanced disease were included, yet this procedure may have increased the selectivity of the sample. We also examined communication at one patient visit only; sexual health communication could have occurred at a different visit, making it important to study this communication over time. Finally, we used a single validated item assessing patients' sexual problems; use of a multidimensional assessment tool [32, 33] could facilitate a more granular understanding of how specific sexual problems are experienced and discussed clinically.

4.2. Practice Implications

Findings of this study have several important practice implications. First, women reporting sexual problems were no more likely to have a sexual health discussion with their clinicians than those who did not report sexual problems, indicating that it is clinicians, rather than patients, who tended to drive the discussions. It was striking that the three women with the highest sexual problems scores did not raise the topic themselves, but rather responded to clinicians' inquiries. These findings cast doubt on the widely-held notion that "if it is important, a patient will bring it up" and support published guidelines recommending that clinicians raise the topic of sexual health for all patients with cancer [13, 14]. Screening patients for sexual problems is nonetheless important in identifying patients who could benefit from further evaluation and/or treatment. This can be accomplished using at least one clearly worded, broadly-framed oral or written screening item [28] or by using a checklist to capture more detailed information about patients' problems or concerns [29]. In addition, adding an introductory statement, such as by stating that sexual problems are common and that questions are asked of all patients, can help to normalize patients' concerns and facilitate open communication [34]. If necessary, clinicians should provide information or referrals as needed. To do this effectively, clinicians may require training. A few clinician communication training interventions have been tested [35, 36], although efforts to develop and evaluate such interventions are growing [18].

An additional finding with practice implications is that much of the sexual health communication that occurred seemed to be indirect (e.g., "I can't even walk"). To facilitate effective communication, clinicians and patients should be encouraged to use direct language in discussing sexual health. Past research suggests that patients' communication about sexual health is an important factor in driving clinicians' communication about this topic [18]. Thus, patient-focused interventions should be developed to encourage patients to raise the issue with their clinicians as well. Finally, the fact that in-depth discussions of sexual health, both for women reporting and not reporting sexual problems, tended to focus on one key topic as opposed to covering many different topics may come as encouraging news to cancer clinicians who are reluctant to raise the topic of sexual health for fear of opening a Pandora's box [37].

4.3. Conclusion

Communication about sexual health for breast cancer patients is critical not only because it can lead women with sexual problems to appropriate treatment pathways, but also because it underscores a trusting patient-clinician relationship [18, 38]. The evidence base for

interventions that can address a range of sexual problems that breast cancer patients experience continues to grow [14], making it more likely that clinical discussions of sexual health will lead to the implementation of effective solutions and better outcomes for patients.

Acknowledgements

This study was supported by a Mentored Research Scholar Grant (MRSG-14-031-CPPB) from the American Cancer Society and by P30CA006927 from the National Cancer Institute. I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

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Highlights:

- Sexual health communication occurs in fewer than half of patients' clinic visits
- Over half of women with sexual problems do not have sexual health communication
- Sexual health communication is most likely to be initiated by clinicians
- Dialogue analysis indicates sexual health topics that are most often discussed

Figure 1.

Schema of Sexual Health Communication across Patient Visits

Note: Two women (one with a discussion of sexual health, one without) did not answer the sexual problems question and are included in the “Did Not Report Sexual problems” group.

Table 1

Patient Characteristics (N = 67)

Characteristic	M (SD)
Age	56.6 (12.2)
	n (%)
Partnered (married or cohabiting)	50 (74.6)
Race	
White/Caucasian	55 (82.1)
Black/African American	4 (6)
Asian	1 (1.5)
Native Hawaiian or Pacific Islander	1 (1.5)
More than one Race	2 (3)
Other	3 (4.5)
Unknown or Not Reported	1 (1.5)
Ethnicity	
Non-Hispanic	63 (94)
Hispanic/Latina	4 (6)
Education	
High School or GED	13 (19.4)
Some college	18 (26.9)
Completed college/Graduate school	36 (53.7)
Menopausal Status	
Pre-menopausal	16 (23.9)
Post-menopausal	51 (74.1)
Disease stage	
Stages I-II	47 (70.2)
Stages III-IIIC	9 (13.4)
Stage IV	11 (16.4)
Current Treatment Status	
On active treatment	22 (32.8)
Completed adjuvant treatment, on hormonal therapy [†]	37 (55.2)
Off all treatments	7 (10.4)
Treatments obtained	
Surgery	60 (89.6)
Lumpectomy	36 (53.7)
Mastectomy	29 (43.3)
Chemotherapy	42 (62.7)
Radiation Therapy	40 (59.7)
Hormonal Therapy	49 (73.1)

Note: The following variables were dichotomized in statistical analyses: race (White vs. Other); Education (High school vs. Greater than high school), Menopausal status (Post-menopausal vs. Other); Disease Stage (Metastatic vs. Non-Metastatic); Current Treatment (On active, curative treatments vs. Completed active treatment); Hormonal therapy (On hormonal therapy vs. Not on hormonal therapy).

[†] One patient included in this group was taking hormonal therapy but had not completed other adjuvant treatments.

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Content of Sexual Health Communication for Women Who Reported Sexual Problems (N = 10)

Table 2

Patient Group	Quotes Illustrating How Sexual Health Communication is Raised	Major Topic of Discussion	Sexual Problems Score
a) Clinician Initiates / Patient Does Not Indicate Need (N = 2)	<ol style="list-style-type: none"> 1. And the other things that people report too [about Arimidex] are things like vaginal dryness...can be an issue for people. (Patient: No). Any of these things that are concerns for you? (Patient: No). 2. Vaginal dryness or issues like...? That can sometimes happen. (Patient: No). 	--	1
b) Sexual Health Discussion Occurs (N = 8)	<p><i>Clinician Initiates Discussion</i></p> <ol style="list-style-type: none"> 1. Any concerns? Vaginal dryness, discharge, anything like that? (Patient: I'm past menopause, so I have issues. But I just use lubricant). 2. And I read [gynecologist]'s note recently and I know that you're seeing her for a couple different things (Patient: Yeah. As they say: it's angry. It's not even mildly irritated, it's angry. It's not happening down there, at all). 3. And otherwise how is your relationship with him? (Patient: Good). Are you guys intimate and everything? (Patient: Yeah but no, I mean we don't...no intimacy). [discussion continues] 4. How's everything with your husband? (Patient: Okay.) Yeah. Are you and he still intimate? You're pretty young. (Patient: Not really. [Laughs]) [discussion continues] <p><i>Patient Initiates Discussion</i></p> <ol style="list-style-type: none"> 1. I'm nervous about...we'll see. I'll show you. Like, they're [my breasts are] weird. The shape when I wear a bra - like, it shapes it differently. But when I put a sports bra on they're fine. So I have to find a good shaped bra. This I'm probably gonna have to go back and get it like- (Doctor: A little tuck). Mhm. And then like right in here and I have to do that skin fat grafting. 2. It looks very ugly [my skin]. 3. I hear that you got a call from Dr. [name] about - tell me if this is right - she said she called you about using a very mild estrogen cream on me. 4. Yeah, well, [husband] had one other question. 	<p>Vaginal dryness</p> <p>Vaginal dryness</p> <p>Sexual inactivity</p> <p>Sexual inactivity</p> <p>Body image/breast appearance</p> <p>Body image/breast appearance</p> <p>Vaginal dryness</p> <p>Safety of sexual activity</p>	<p>1</p> <p>10</p> <p>10</p> <p>10</p> <p>4</p> <p>8</p> <p>8</p> <p>2</p>

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Patient Group	Quotes Illustrating How Sexual Health Communication is Raised	Major Topic of Discussion
	7. No. It's just one of my breasts looks different than the other and that bothers me but I know that that's the breast I had the surgery in. (in response to "Anything else that we need to discuss? Anything new?").	Body image/breast appearance
	8. There's no intimacy at my house. (in response to clinician mention of a research study about intimacy) [discussion continues]	Sexual inactivity
	<i>Partner Initiates Discussion</i>	
	9. Husband: I guess one more question I should ask (Clinician: Go ahead, ask.) What about sex, is that...? (Clinician: That's fine).	Safety of sexual activity