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The politics of heterosexuality—a missing discourse in cancer nursing literature on sexuality: A discussion paper

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Abstract

In this article, a critique of cancer nursing literature on the issue of sexuality is presented, with particular reference to literature on cancers common to women. The paper begins with an account of two competing perspectives on sexuality. The first is a version of sexuality rooted in sexology, underpinned by biomedical science that makes a claim to having identified 'normal' sexuality. The second is a version of sexuality developed within feminist scholarship that tends to reject biological determinism as a basis for understanding sexuality, instead favouring **constructivist** perspectives, with the socio-political context of sexual relations problematised. The focus of the article then shifts to cancer nursing literature on sexuality that deals primarily with cancers common to women, to appraise the extent to which either of the above perspectives on sexuality is invoked. Within this body of nursing knowledge, I argue that there has largely been an uncritical endorsement of biomedical constructions of sexuality, rooted in orthodox sexology, with a dominant focus on sexual functioning and on sexual rehabilitation for women with cancer. Moreover, in this knowledge base, phallogentric heterosexuality over and above other forms of sexual expression is privileged, and the socio-political context of unequal gender power relations is largely excluded. References to the social sphere as a dimension of nursing care are focused almost exclusively on maintaining normality, and reflect the emphasis on functional restoration. The largely individualistic, uncritical and biocentric emphasis in this literature may serve inadvertently to reinforce and maintain existing gender inequalities in heterosexual relationships. Finally, I consider the difficulties for oncology nurses in dealing with contradictory truth claims or conventional wisdoms about sexuality from **disparate** disciplines of which holism is comprised.

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Keywords: Cancer; Gender; Holism; Nursing; Sexology; Sexuality

What is already known about this topic?

- Depending on the particular disciplinary field (biomedical science or gender politics) from which knowledge is sourced about sexuality, fairly disparate validity claims emerge in relation to it.
- Within cancer nursing literature, the dominance of a

biomedical perspective on sexuality makes it (at least) appear that little is known about the socio-political context of sexual relations.

What the paper adds

- The paper identifies a limitation in cancer nursing literature insofar as it is largely framed within a biomedical perspective on sexuality.

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- This paper adds a critical gender political perspective on sexual issues around cancer care.

1. Introduction

Sexuality was identified as an aspect of nursing care in 1979, by the American Nurses' Association and the Oncology Nursing Society (Thaler-DeMers, 2001). The notion of 'sexual dysfunction' entered the list of nursing diagnoses of the prestigious North American Nursing Diagnosis Association in 1980, and 'altered sexuality patterns' a little later in 1986 (Carpenito, 1989). Across the ocean in Britain, the publication of *The Elements of Nursing* (Roper et al., 1980) in 1980, with 'expressing sexuality' featured among the 'Activities of Daily Living', put the realm of sexuality officially within the jurisdiction of nursing in the United Kingdom. Since the recognition of sexuality as a legitimate 'health' concern for nurses, a considerable body of knowledge has developed about sexuality within the nursing literature. This article is concerned with a critical analysis of one large subset of this literature base, namely, cancer nursing literature on sexuality. My analysis is confined primarily to accounts of cancers common to women, and is limited in this regard.

Discourses about sex and sexuality vary widely, depending on their source. There are, for example, conventional wisdoms about sexuality within biology that express a particular version of reality through the lens of that discipline, and likewise within psychology, sociology and so forth. In the case of cancer nursing literature on sexuality, my interest is in analysing the extent to which in it, certain perspectives over others are prioritised.

2. Methodology

This analysis of cancer nursing literature on sexuality did not develop in the more conventional way that a literature review does, where one trawls through the literature to identify gaps in knowledge in existing works. Rather, it emerged as a consequence of having supervised the Master's dissertation of a cancer nurse, who herself had undertaken a literature review of cancer nursing literature in relation to sexuality. She located very little literature relating to the political dimensions of sexuality within cancer nursing literature. Since my own background in both nursing and sociology meant that I was heavily steeped in theories of gender politics around health issues, I embarked upon this literature critique myself, to determine the extent to which the socio-political context of heterosexuality was indeed absent from this literature, and what discourses were in fact dominant. A search was conducted using the

Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline and Pub Med, from 1990–2005, using the words 'sexuality' 'sex', 'nursing', 'cancer' and 'gender'. Articles included those written by nurses and non-nurses, although the strongest emphasis here is on articles written by nurses in nursing journals. Also included were some book chapters on the topic, and a small number of older articles. The number of papers to be included in this review was whittled down to focus primarily on those that referred to the nurse's role in relation to sexuality in the care of women with cancer.

I begin this paper by presenting two possible theoretical paradigms, namely a biomedical perspective and a feminist perspective, as approaches to conceptualising sexuality. These perspectives are not exhaustive of all possible theorisations on sexuality, but they constitute the most dominant in international scholarship. I then explore the extent to which these are invoked in cancer nursing accounts of sexuality.

3. The biomedical model: sexology and the social construction of 'normality'

What is 'normal' sexual behaviour? This has been a central question in understanding sexuality, and theorists from all sorts of backgrounds have spent decades trying to work out 'the riddle of human sexuality' (Maushart, 2001, p. 189). Some scholars have dispensed with the notion that there is a normal sexuality 'out there' to be discovered, instead acknowledging that sexuality is a 'capacity' that may (but need not) be developed through social shaping (see Walby, 1990). However, orthodox sexology is one school that claims to have come up with some of the answers as to what 'normal' sexuality is. Potts (2002, p. 15) describes scientific orthodox sexology as:

... a particularly powerful branch of sexology, which, through its affiliation with science and biomedical understandings of the body and sexuality, has perhaps the most authority or influence over *what counts* [original emphasis]—what gets recognised and legitimised—as healthy and normal sex ... Through its explicit links to a strictly scientific or biomedical paradigm, this branch of sexology claims to know the origins of normal and abnormal, healthy and unhealthy sexuality, and develop appropriate treatments or 'cures' for those who may stray from the norm.

Potts (2002) traces the development of the science of sexuality from the ancient Greeks through to the 19th and 20th century scholars, namely Freud ([1905] 1986), Kinsey (1948), Reich (1968) and Masters and Johnson

(1966). The work of the latter continues to be extensively referred to in contemporary sexology discourse. In particular, reference is made to the 'human sexual response cycle', consisting of four phases, namely, excitement, plateau, orgasmic and resolution, underpinned by the notion that men and women respond sexually in a similar way (Potts, 2002, p. 29). The most sensational finding claimed by Masters and Johnson was the notion of multiple orgasms in women, hitherto deemed to be sexually passive (I will revisit this issue a little later). Although sexology is concerned with the physiological processes of sex, by the admission of its most renowned scholars, Masters and Johnson, their work was dedicated to preserving heterosexual marriage (Potts, 2002). As Masters and Johnson (1970, p. 14) noted: 'The ultimate level of marital-unit communication is sexual intercourse.'

A number of commentators have criticised 'the coital imperative' within sexology discourses (Potts, 2002, p. 34), that is, the centrality afforded to the ultimate objective of penetrating the vagina with the penis (Jackson, 1984; Stock, 1988). Non-penetrative sexual activities tend to be constructed as secondary or supplementary to 'real sex'. In this sense, a genitally focused masculine version of sexuality becomes normalised (Tiefer, 1995). Women in heterosexual relationships who display a lack of interest in penetrative sex may be constructed as dysfunctional and abnormal, and are potentially at risk of being labelled with a diagnosis of DSM IV 'hypoactive sexual desire disorder' (Hare-Mustin, 1991). Maushart (2001) notes that in writings on sexuality (including, she adds, feminist literature on sexuality), male sexuality is usually taken as the norm, and theories and pathologies are advanced to try and account for the 'depressed' sexuality of women. Maushart made the critical observation that male sexual 'pushiness' is rarely problematised and reports that she has not heard of a sex therapist 'who strives to dampen down a man's libido to harmonise more naturally with his wife's' (p. 187).

Popular sexology passes on messages to women who might be exhibiting features of sexual 'reluctance.' Reminders that sustained (penetrative) sex is important in long-term heterosexual partnerships regularly appear in the pages of women's magazines. In the best-selling self-help manual, *Mars and Venus in the Bedroom*, author John Gray (1995) advises women that having sex (including 'quickie' sex to satisfy the male impulses) will remind men how much they love their partners, and without regular sex a man might look elsewhere for love. Potts (2002, p. 53) criticises Gray's depiction of what women accomplish through sex, namely, a sense of 'wholeness' achieved by 'a process of surrendering to the

mastery of her mate, while he delves deeper, discovering and exposing her sensual inner being.'

Meanwhile, in her popular best seller, *The Surrendered Wife*, Laura Doyle's (2001) advice for a sustained and happy marriage is for women to make themselves available for sex with their husbands once a week, and to never say 'no', whether or not they are in the mood. Amazingly, for many women, these messages are interpreted as helpful hints (or blueprints) rather than blatant examples of male sexual dominance.

More broadly, for both men and women, messages about how central expressing sexuality is to our being and sense of humanity; this cultural propensity towards being sexual in order to experience a full sense of humanity are consistent with those produced within sexology. (I will consider various definitions of sexuality presented in cancer nursing literature a little later on.) However, very recently, this construction of sexuality as a central dimension of humanity has begun to be challenged, with the emergence in 2003 of a social group, The Asexual Visibility and Education Network. Members of this group resist the charge that they have a pathological medical or psychological condition. They argue that their failure to feel sexually aroused does not necessarily impede their ability to form life-long and committed relationships with others (AVEN, 2005).

4. Feminist perspectives: the politics of heterosexuality

Sexuality has for decades been a central political issue within feminism. Although feminism is highly diverse in how it views heterosexuality, the potential for heterosexuality to be a source of female oppression that colonises women's bodies has been the subject of ongoing debate since the 1970s (Jackson and Scott, 1996). The possibility of oppression rests in the notion that men's bodies are usually physically taller and heavier than females and the former therefore have greater physical resources to draw upon to canvass for their sexual needs to be met. In a wider sense of power differentials, heterosexual relations are not usually relations between equals; women as a whole continue to earn less than their male partners (see Rubery, 2004; Russell et al., 2005; Tomlinson et al., 2005), and are less well represented in wider social institutions (Women and Equality Unit, 2005), placing them in positions of dependency. Their relatively weaker social and economic position makes it more difficult to negotiate for their own sexual needs to be met, or to refuse to service male sexual demands. Even in ostensibly 'equal' relationships, the physical and social advantages that men have over women mean that patriarchal dominance can resurface at any time when women align themselves sexually with individual men.

One group of feminists—radical feminists—interpret all acts of heterosexual sex to be a manifestation of male power and have instead opted for lesbian sex. Other feminist theorists, however, instead endeavour to obviate heterosexual inequalities through greater negotiation with men in having women's needs met through the redefinition of traditional notions of the female passive body (Dhavernas, 1996; see also Meadows, 1997). In particular, they have proposed that equal cultural significance should be given to expressions of heterosexuality that do not involve penile penetration (Holland et al., 1998; Potts, 2002; see also Irigaray, [1984] 1993).

The power dynamics of heterosexuality have featured in empirical studies over the past few decades (Kelly, [1988] 1996; Holland et al., 1996, 2003; Hilliard, 2003; Hyde and Howlett, 2004). In this literature base, the types of disadvantage that women experience in sexual encounters with men range from verbal persuasion to engage in sexual activities to outright physical bodily force. It was not until as late as 1990 in Ireland, and 1991 in Britain, that marital rape was criminalised. Prior to this, women were deemed to consent to unlimited sexual access on marriage. Sexuality as a site of patriarchy may also operate in such a subtle way that many women do not recognise it as oppressive, and may even hold themselves responsible for male sexual arousal (Kelly, [1988] 1996; Hyde and Howlett, 2004).

What of female sexual pleasure in heterosexual relationships? Female heterosexual pleasure became the subject of discussions in the 1960s when women began to challenge their passive socialisation, and engage in the 'free love' ideals prevalent at the time, without the limits of derogatory labels. As Jackson and Scott (1996, pp. 5–6) note:

They [women] began to demand the right to define their own sexuality, to seek forms of pleasure not constrained by the set heterosexual pattern of foreplay (if you were lucky) followed by penetration, to see themselves as sexually active rather than passive objects of male desire.

Around the same time, leading sexologists Masters and Johnson (1970) made the sensational discovery of women's capacity for orgasms during heterosexual, as indicated earlier, and Alex Comfort's (1970) publication, *The Joy of Sex*, showing heterosexual couples how to maximise sexual pleasure, became a best seller. However, in spite of the need to shake off the influence of generations of female sexual repression and the view that women were merely sexual objects rather than sexual subjects, the possibilities identified in *The Joy of Sex* did not quite transpire for many women. For these, the actual experience of heterosexual did not live up to the erotic heights about which Comfort and others wrote.

Moreover, *The Joy of Sex* has come under criticism for its focus on identifying techniques that turned men on (Maushart, 2001). In addition, while Masters and Johnson were attempting to dispel the myth that women were not really sexual at all, their 'one-sex' model suggesting that men's and women's sexual response was similar has been admonished for continuing 'to rely on the male sexual response as providing a norm for sexual functioning, which can then be (super)imposed upon female experience' (Potts, 2002, p. 29). Drawing on Jackson (1984), Few (1997, p. 618) notes that while the 'marital manuals' that followed on from Masters and Johnson's work suggested that marital sex should consider the needs of both partners, the needs identified appeared to be more consistent with those of men. Another problem was the greater access to women's bodies that a discourse of 'free love' conceded to men; declining sex could be constructed as failing to engage with the liberal discourses that emerged in the 1960s and 1970s.

Jackson and Scott (1996) assert, however, that heterosexuality and penetrative sex are not interpreted or experienced in the same way by all women. Some women report very positive experiences of heterosexual even in long-term relationships (Gott and Hinchliff, 2003; Meadows, 1997). In addition, there have been attempts within feminism to develop a positive discourse of female heterosexual experiences through women asserting their sexual needs (see Wilkinson and Kitzinger, 1993; Meadows, 1997), and to move beyond viewing heterosexual as an inevitable locus of danger for women (Franke, 2001). Nonetheless, there is empirical evidence suggesting that women in long-term marriage report lower levels of sexual satisfaction compared with their male counterparts (Liu, 2003). It has been argued that for some women, engaging in penetrative sex is just another form of routine work that comes with the deal of marriage or partnership as an internalisation of the female role (Maushart, 2001; see also Delphy and Leonard, 1992). Yet we know that women voluntarily continue to marry in droves; as Walby (1990) notes, many women believe that they will benefit by marrying and this is indeed the case in many instances in light of the more limited options available to them.

Overall then, while biomedical discourses attempt to medicalise issues around female sexuality, turning women's ambivalence about heterosexual into clinical pathologies, feminists have tended to problematise heterosexual, and debate the extent to which penetrative sex is a manifestation of male power. Thus, sexologists are disposed to problematise women for defects in their biology or psychological responses to sex, while feminists tend to problematise the sexual practices themselves and their social context.

5. Cancer nursing literature on sexuality

When one turns to cancer nursing literature on sexuality, a number of dominant themes emerge which give some indication as to the discourses invoked in constructing this knowledge base. Here, I will explore some of these, and consider the extent to which the theoretical paradigms outlined above are brought to bear.

Various definitions of sexuality have been used within cancer nursing literature, in particular broad-based definitions that have attempted to move beyond phallogocentric notions of sexuality that focus on penetrative sex. However, some are so broad that they appear almost meaningless, and with little or no association with the erotic. Stupak Shah (1991, p. 275), for example, drawing on Masters et al. (1985) defines sexuality as 'a dimension of personality rather than the capacity for erotic response.' Lamb (1995, p. 120) invokes an equally vague definition from the World Health Organisation (1975, p. 6) whereupon sexuality is constructed as 'the integration of the somatic, emotional, intellectual and social aspects of a human being in ways that will enhance personality, communication and love'. As Few (1997, p. 620) observes, a further difficulty with official definitions of sexuality is their lack of acknowledgement of power imbalances in heterosexual relations.

Overall, in virtually all definitions of sexuality presented in cancer nursing literature, there is almost unanimously agreement that sexuality is more than the act of sexual intercourse (Thaler-DeMers, 2001; Muir, 2000). Yet, a somewhat contradictory feature of this knowledge base is a simultaneous heavy endorsement of discourses from orthodox scientific sexology which, as I have indicated earlier, are notably phallogocentric.

It is almost predictable in many articles that while the notion of sexuality as merely the act of penetrative sex is rebuked at the outset, the multiphasic penetrative sexual response cycle of desire, arousal, orgasm and resolution is presented (Muir, 2000; Cartwright-Alcarese, 1995). Where the notion of clinical assessment is introduced, this is almost invariably coined in terms of how a cancer diagnosis and/or treatment can interfere with this sexual response cycle, placing women 'at risk' of sexual dysfunction (Knobf, 2001, p. 208; Shell, 2002, p. 55) for which interventions are devised to correct.

Both the physical and psychological aftermath can affect the sexual response cycle (i.e. excitement plateau, orgasm, and resolution), causing the couple to consequently avoid sexual intimacy. Interventions may be derived from behavioural, nursing, medical and surgical domains (Shell, 2002, p. 58).

It is this heavy focus on heterosexual functioning and symptom management that dominates nursing literature

on sexuality and cancer most consistently (Shell, 2002; Rogers and Kristjanson, 2002). In fairness to Knobf (2001, p. 208), she does refer to the context of women's lives when considering the assessment of sexual functioning, but this is very much done in passing, and is not in any way explored or developed:

Do symptoms interfere with functioning? What are the available approaches to symptom management? What is the context of the woman's current life that may affect appraisal and action? and finally, What are the woman's evaluation criteria for symptom relief measures?

By far the most dominant set of models on sexual functioning promoted within nursing literature on cancer care is a plethora originating in biomedical sexology. These include the PLISSIT model of sexual functioning (Annon, 1976; see Hughes, 2000) which incorporates altered body structure or function (for example, vaginal dryness and stenosis in women, and impotence or premature ejaculation in men), as well as the psychological dimension (that I will consider a little later). Also featured among these models is the ALARM assessment method (Andersen, 1990), with each letter of the title focused around deviations from the normative sexual response cycle (A = activity, L = libido/desire, A = arousal, R = resolution, M = medical history relative to disruption of sexual activity/response). Similarly endorsed is The Derogatis Interview for Sexual Functioning (DISF) (Derogatis, 1987, cited in Shell, 2002, p. 55). This is 'a sexual function assessment tool that measures the quality of current sexual functioning in a format that parallels the phases of the sexual response cycle'. Clearly, baseline 'normality' is prescribed, maintained and reproduced in the use of these 'baseline' measurement tools.

5.1. Sexual solutions

Most of these models offer 'solutions' to the problems of difficulties with penetrative sex, such as the use of sexual aids, lubricants, vaginal dilators and relaxation techniques. (For example, the advice proposed to prevent vaginal stenosis after brachytherapy for the treatment of gynaecological cancer is to have regular intercourse or use vaginal dilators (Lancaster, 2004)). If these do not restore functioning, the final stage is to refer the person for intensive sexual counselling. One sex therapist, Paul Brown (1993), reflects on the advice that he and his colleagues used to give women in the 1960s to use lubricants to aid penetration. In retrospect, Brown equates this advice with proposing that a man wear a splint on his penis to achieve an erection when there is little sexual desire. Drawing on conventional discourses rooted in sexology, many nursing interventions seem to

be aimed at easing the entry of the erect penis into the vagina, even when the problems identified are most likely to be associated with sexual desire. Indeed, a lack of sexual desire is considered to be the most frequently observed 'sexual dysfunction' in relation to cancer diagnosis and treatment (Ofman, 1993; see also Barni and Mondin, 1997). This is acknowledged as an issue within cancer nursing literature, and related to both physiological and psychological factors (Thaler-DeMers, 2001).

Thus, the emphasis is on restoring sexual functioning, and making intercourse bearable for women, even, it seems, in the face of biological or psychological obstacles.

It is the responsibility of the oncology health care professional to become educated about options that preserve sexual function and fertility and inform patients before treatment decisions are made' ...

... water-based lubricants generously applied to the vulva, clitoris and inside the vagina will help to compensate for vaginal dryness; using lubricant on the penis will facilitate penetration; use of an Estring will also help alleviate vaginal dryness. (Thaler-DeMers, 2001, p. 255, 258).

In an article published in the *Journal of Advanced Nursing* in 1996, Hazel Colyer (1996), a radiotherapy professional, succinctly summarised the assumptions underpinning the medical approach to women with cancer as follows:

... real women are feminine in aspiration and assumption. In order to feel good about themselves they need to fulfill a feminine sexual role, be sexually available to their partners and have two breasts, an intact vagina and reproductive capability (p. 500).

The few qualitative studies located within cancer nursing literature on sexuality are more revealing of the experiences of women with cancer in relation to heterosex. While these studies have tended to be descriptive rather than analytical, the raw quotations are rich and telling. For many participants in Watkins Bruner and Boyd's (1999) study, for example, desire, arousal and orgasm were 'impaired' after cancer therapy. One participant in their study reported experiencing a good deal of pain during intercourse but did not tell her husband. Another indicated that she could not even think erotic thoughts anymore, while yet another stated, 'I can still perform the [sex] act, but I might as well be dead' (p. 444). Chamberlain Wilmoth's (2001) qualitative study of women following cancer therapy unveiled similar difficulties for participants, who reported decreased to no sexual desire and a loss of sexual sensations. One participant revealed that during sex she thought, 'Let's get this over with so that I can do

something else' (p. 282). The author noted that most participants required reassurance that they could still perform sexually. However, in neither of these qualitative studies were questions raised about the complex socio-political reasons as to why women were performing sexually when there was no desire.

5.2. Discourses from psychology within cancer nursing literature on sexuality

Although discourses on the politics of sexuality are largely ignored within the sexuality and cancer knowledge base accessed and developed by nurses, the strong emphasis on psychological factors within this knowledge base must be acknowledged. Biomedical models of sexual functioning, such as those referred to above, are mediated by references to the psychological domain, as is suggested in the following extract from Shell (2002, p. 58).

The concept of symptom management to rehabilitate sexual function is not restricted to only restoring sexual activity. It is about integrating physiologic symptoms with emotions and creating interventions that affect patients' body image and relationship satisfaction along with physical desires.

Thaler-DeMers (2001, p. 256, 257) similarly incorporate psychological issues:

... Sexual dysfunction caused by cancer treatment is not limited to those organs we associate with the sexual response. Nurses must also pay attention to the impact of symptoms such as ... fatigue, anxiety ... altered body image ... Remember that the sexual response cycle begins in the mind. Without appropriate intervention, it can also end there.

Altered body image, low self-esteem, and anxiety and depression are frequently mentioned as mediating psychological factors in 'sexual dysfunction' (Watkins Bruner and Boyd, 1999, p. 439). Yet the inclusion of these symptoms in many ways exacerbates the medicalisation of sexuality, insofar as it reinforces the notion that pathology (of whatever aetiology) underlies deviations from the sexual response cycle, and can be identified, labelled and corrected. There is frequently also some reference to the importance of communication between partners about sexual matters, assuming consensual and egalitarian relations in an unproblematic politico-sexual context.

5.3. The normality restoration imperative

Practising nurses may well argue that a return to normal through symptom management is what women with cancer actually want, and there is evidence that this

is indeed the case. In her qualitative study, [Knobf \(2002\)](#) found that 'carrying on' in terms of work and home activities was the way in which women with breast cancer responded to the overriding problem of vulnerability that they identified. [Cowley et al. \(2000\)](#) similarly found that women sought to re-establish their usual role (for example, as wife or mother) following chemotherapy treatment. In another study, it was found that women who had post-breast cancer treatment indicated that they no longer felt adequate in their roles as women and partners ([Holmberg et al., 2001](#)).

[Young-McCaughan \(1996\)](#) notes that anecdotally, women in breast cancer support groups often raise issues related to sexuality and have concerns about vaginal dryness and dyspareunia (painful or difficult intercourse experienced by women) and manifest frustration that these symptoms are untreated. Research with gynaecology patients suggests that they identify a lack of advice and information about sexuality from nurses and doctors as a deficiency in their care ([Webb and Wilson-Barnett, 1983](#); [Webb, 1986](#)). However, nursing efforts to meet women's sexuality needs may sometimes be misguided attempts to facilitate such women in adapting to inequitable power situations at a time when consensual relationships with heterosexual partners are particularly important to them. [Anlo \(2000, p. 246\)](#), a sex therapist, notes that women 'whose sexual capacity is compromised by breast cancer may fear that they are depriving their partners of sex and that their partner's secret wish is to abandon them for someone healthy'.

Much of the problem with cancer nursing literature on sexuality is that any reference to the social realm is focused almost exclusively on maintaining 'normality'. A good example of this type of approach is to be found in an article by [Adams et al. \(1997\)](#). The researchers developed a 'culturally sensitive sexual functioning instrument' (p. 251) that measured sexual functioning in Hispanic women with gynaecological cancer in order to achieve 'a better understanding of the Hispanic woman's perception of herself as a sexual being'. This would in turn 'aid the clinician in the development of culturally sensitive interventions' in order to 'promote recovery and rehabilitation' (p. 251). The authors note how women with gynaecological cancer are likely to experience 'disruption in sexual functioning' (p. 252) as a consequence of the disease and its treatment. The instrument was designed using a vignette depicting a fictitious woman called Maria with a similar diagnosis to those completing the tool (real women with gynaecological cancer). Maria was presented as a woman feeling tired and with vaginal bleeding. Respondents were asked various questions about Maria's situation designed to indirectly elicit their perceptions of sexuality. One group of factors (consisting of 8 items) was designed to elicit the extent to which respondents adopted a traditional

sexual role, and included the following items about how they might behave if they were Maria:

- have sex with your husband only because he wants to,
- feel helpless in the situation,
- have sex only to please your husband,
- think your husband will be angry if you refuse to have sex ([Adams et al., 1997, p. 257](#)).

Given that this tool acknowledged the potential for the sexual exploitation of women in heterosexual relationships, it could be very useful for highlighting persistent issues of gender injustices in the realm of sexuality. But actually, and amazingly, there was no reference whatsoever to gender oppression in this article. Rather, the authors suggest that this instrument might be used for looking at the relationship between sexual functioning and other variables, or in 'evaluating the effectiveness of conducting specific nursing interventions with this ethnic group' (p. 259). Given that the backdrop to the article was sexual rehabilitation, one can only conclude that such interventions would include heavy doses of lubricating gel, vaginal dilators, pelvic floor exercises and so forth, to rehabilitate women as quickly as possible back into the role expected within their culture.

Let us also consider two case studies that have been presented in cancer nursing literature that were designed to illustrate the sexual difficulties of patients that nurses might encounter in practice, and how they might be resolved. The first was cited in [Muir \(2000\)](#) in a nursing journal, in the context of nurses learning to provide counselling for people with 'sexual difficulties'. It reads:

A thirty-year-old female diagnosed with acute myeloid leukaemia during the seventh month of pregnancy was, after successful delivery, immediately started on a six-month course of chemotherapy treatment. After the initial cycle of chemotherapy and a five-week spell in hospital, she was discharged for a short break at home.

When returning for a check-up, the woman nervously explained to a nurse that her husband wanted to resume a sexual relationship and that she was having difficulty explaining her reluctance to him. The patient and her husband were reassured by the nurse, who explained that tiredness and loss of libido were normal problems faced by cancer patients receiving treatment. The nurse also offered medical advice regarding safety, provided support, and suggested that the couple refrain from sexual intercourse at times when platelet counts and white cell counts were low. This simple information and support eased the temporary conflict and difficulty both were experien-

cing, and helped them to regain a happy marital relationship (Muir, 2000, p. 723).

This case, the nurse seemed to be giving the medical 'go-ahead' for sexual intercourse based on physiological safety (apart from during the medically prohibited times), with a woman who recently had a baby, followed immediately by chemotherapy, based on the information that the husband apparently wanted sex. There was no exploration of the ethics of this, and it is also notable that the intervention was constructed as playing a part in restoring marital harmony, feeding into the ideology that a happy marriage needs sex to sustain it.

The second example is a case study from a chapter by Webb and O'Neill (1988) involving a 60-year-old woman, Mrs. Short. The case is presented in an abbreviated version as follows:

Mrs Short was a 60-year-old woman with advanced metastatic malignant melanoma. She was being cared for at home by her 63-year-old husband with help from their three daughters ... For some time Mrs Short had been dependent on her husband to help her with hygiene and dressing. He also did the housework and one of the daughters provided the meals. Five days after the birth of her grandchild, Mrs Short became very tearful, lost all interest in her appearance and made no effort at all to care for herself. She said that she felt useless as a wife because she was unable to look after her husband ... (p. 133)

Following this case outline, the care plan is presented, in which Mrs. Short's depression associated with her ~~not being able~~ to carry out her expected social role is identified. The goal was that Mrs. Short would be able to accept a modified version of her role as wife and mother by focusing on the emotional and psychological aspects of the role rather than the physical. The nursing intervention planned was that Mrs. Short would be asked to consider the emotional support that she might be able to continue to give to her family, and to list the characteristics of the wife and mother roles other than that of physical carer. A discussion would then follow about ways that would enable her to carry out this role. Now, at an individual level, this intervention might well help to make Mrs. Short feel better about her sense of uselessness, and as such is to be commended, given her poor prognosis. However, what problematises this case study—particularly as a learning exercise for nurses and nursing students—is the manner in which there is no acknowledgment for learners of the exploitative potential of the wife/mother role in contemporary society.

A plethora of sociological literature has been evaded here that problematises the female domestic role. This knowledge base draws attention to the lack of pay for women's often boundless domestic service, their lack of leisure time, the demanding emotional labour they

undertake and the low societal value associated with it (see Walby, 1990, and Maushart, 2001). As it stands, this case study may well reinforce existing gender-based inequalities, and does not join up easily with the type of knowledge presented in sociology of health and illness courses to which nurses or student nurses may also be exposed.

Before concluding, it is worth acknowledging a small number of articles located in nursing journals that do indeed address the issue of the politics of heterosexuality to varying degrees (Pryce, 1991; Shell, 1995; Taylor, 1995; Few, 1997; Irwin, 1997; Coggins and Bullock, 2003; Sinding et al., 2004). However, they tend to be located primarily in mainstream nursing journals rather than in cancer nursing journals, with occasional exceptions (Shell, 1995; Sinding et al., 2004). Anthony Pryce's (1991) article, for example, draws attention to historical accounts of how the apparently objective stance of the medical profession has played a part in constructing sexuality and gender in a manner that reinforces gender inequalities as part of the 'natural order'. In the context of a discussion on safer sex practices in relation to HIV/AIDS, both Taylor (1995) and Few (1997) examine the gender-power dimension of heterosexual relations and discusses the implications for women with regard to the practice of safer sex in the context of power inequalities. In reviewing sexual health promotion and nursing, Irwin (1997) notes the dominance of psychological, rational-choice models of health education and points to criticisms of this approach for failing to take into account the contextual constraints emanating from the social, political and cultural context. In a rare challenge to the conventional sexual care of women with cancer, Sinding et al. (2004) elucidated the manner in which the experiences of lesbians with cancer is shaped by homophobia and heterosexism in contemporary nursing practice. Coggins and Bullock (2003) analysed the experiences of women in abusive heterosexual relationships with regard to their difficulties in avoiding intercourse. Incidentally, the majority of the more politically inspired articles I located were written by nurses working in a British context, suggesting that socio-political issues may be a stronger feature of nursing educational programmes in the UK compared with the USA.

6. Conclusion

In this critical review of cancer nursing literature on sexuality, I argue that there has largely been an uncritical endorsement of biomedical constructions of sexuality rooted in orthodox sexology in this knowledge base. Furthermore, the biomedical version of sexuality appears to guide nursing assessments and interventions in cancer care. Moreover, phallogentric heterosexuality

over and above other forms of sexual expression is privileged, and most significantly, the socio-political dimension of sexuality associated with unequal gender power relations is largely ignored.

The marginalisation (or absence of) of a political view of the body in cancer nursing literature on sexuality has implications for the notion of holism in nursing. This construct of holism—an attempt to see the person as a unified whole comprised of physical, social, psychological and spiritual dimensions—has been the driving force behind nursing theory for the past number of decades. Yet how are nurses to manage the manner in which contradictory ‘truths’ about sexuality emerge from the various disciplines? Since various schools are at loggerheads with each other about how to interpret human sexuality, how should nurses proceed with their care? Mulholland (1997) argues that most attempts to theorise holism within nursing have relied upon a ‘hotchpotch’ approach in which all the dimensions are thrown in, without any serious effort to consider the manner in which such bodies of knowledge or ‘truth’ claims relate to and sometimes contradict one another. The relationship between the constituent knowledge forms, he argues, has not been critically explored. My analysis hits at the very core of the fundamental issue raised by Mullholland, in demonstrating how knowledge developed within orthodox scientific sexology is based on very different premises and produces a very different conventional wisdom to that of dominant schools of feminism. Masters and Johnson (1970) based their theory on the physiological responses that occur between heterosexuals. Masters, a gynaecologist, and Johnson, a behavioural scientist, emphasised that their theory was physiological as opposed to psychological and thereby produced a biological theory (Potts, 2002). By (almost complete) contrast, an extreme feminist deconstructionist position would deny biology completely, instead proposing that all sexual thoughts, desires, pleasures and urges are socially produced rather than biologically given. Within feminist scholarship more broadly, the power dynamics that mediate sexual relations are critical in understanding what kind of sex takes place, or whether it takes place at all.

There is the possibility that consciousness-raising with heterosexual women with cancer about the potential for oppression and exploitation in their sexual relations with men may actually serve to increase morbidity in the short-term, when such women are trying to re-establish their normative routines. Depleted and exhausted women may not have the energy demanded to negotiate for their position to be acknowledged, particularly in their vulnerable state of needing more than ever the emotional support of partners at a time when at least some fear being rejected and abandoned. Perhaps nurses working in areas where patients are less physically and emotionally vulnerable have greater scope for empow-

ering women. Nonetheless, a grounding in gender politics might enable oncology nurses working with cancer patients to develop creative ideas and practical suggestions for new ways of dealing with the thorny business of sexuality and sexual assessment in clinical practice. A starting point is to shift the emphasis in research from predominantly quantitative measures of sexual functioning to a thorough socio-political analysis of the context of women’s sex lives against the backdrop of a cancer diagnosis.

This critique is not intended as an attack on the work of well-meaning and committed cancer nurses who are genuinely striving to improve the lot of cancer patients. Rather, the aspiration is to challenge cancer nurses and nurse educators to take into account the wider socio-political dimension when considering the kind of sexuality care to provide.

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